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Fiscal year 2019 HRRP impact to hospitals

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Healthcare payment systems continue to evolve in the 21st century in a slow transition away from strict fee-for-service (FFS) reimbursement. These new systems can be complex to monitor and cumbersome to implement and understand, but understanding them is important because their impact on revenue and ultimately profitability can be material.

One such change affecting hospitals is the Hospital Readmission Reduction Program (HRRP). Historically, HRRP has reduced payments to hospitals with higher-than-average readmission rates. Now this program is being modified, incorporating measurements of the socioeconomic status of the beneficiaries served by each hospital. These changes will have a significant impact on the HRRP payment adjustments, and there will be clear winners and losers. In this paper, we describe the changes the new rule brings as well as what the likely effects will be.

Background

The Centers for Medicare and Medicaid Services (CMS) announced major changes to HRRP in fiscal year (FY) 2018 and has just finalized those changes with the release of the FY 2019 Inpatient Prospective Payment System (IPPS) final rule.[1] The rule implements changes required by 2016's 21st Century Cures Act, which directed the Secretary of the U.S. Department of Health and Human Services (HHS) to assign hospitals to peer groups and establish payment calculations separately for each peer group.[2] This adjustment will address "the positive correlation between shares of low-income patients and readmissions rates."[3]

This revised methodology is only the first step in the process for CMS to adjust for socioeconomic differences. The next steps are still in development, but will likely be other risk-adjustment methodologies.[4]

WHAT'S THE HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)?

In 2010, the Patient Protection and Affordable Care Act (ACA) created four Medicare value-based programs: Physician Value-Based Modifier, Hospital Value-Based Purchasing Program (HVBP), Hospital-Acquired Condition Reduction Program (HAC), and Hospital Readmission Reduction Program (HRRP).[5] HRRP was designed to reduce payments to impacted hospitals with high readmission rates. The penalties for HRRP, starting at 1% in 2013 and growing to 3% in 2015, were a way for CMS to incentivize hospitals to reduce their numbers of readmissions, thereby conserving taxpayer funds. According to a statistical brief from the Agency for Healthcare Research and Quality (AHRQ), hospital readmissions cost $41.3 billion in 2011 with 58.2% of that figure being Medicare patients.[6] The potentially preventable rate of readmission has decreased since the implementation of HRRP, resulting in approximately $2 billion in annual net savings to Medicare. However, with the potentially preventable rate of readmission still at 9.7%, HRRP still has room for improvement.[7]

The 21st Century Cures Act was passed into law in 2016 with the express purpose of decreasing readmissions. The HHS Secretary was directed to assign hospitals to peer groups and establish calculations of the payment adjustment factors separately for each peer group.[8] This effectively adjusted payments to reflect the socioeconomic status of patients served at facilities. The idea of adjusting for socioeconomic status in HRRP was studied in the report the Medicare Payment Advisory Commission (MedPAC) released to Congress in June 2013. In the report, MedPAC showed the positive correlation of socioeconomic status and readmission rates.[9]

Additional information on the calculation of the payment adjustment factor can be found at the end of this article.

Major changes for FY 2019

The major change to HRRP in the FY 2019 final rule is to alter the benchmark that readmission rates are measured against. The new rule groups hospitals into "peer groups;" these peer groups are defined in terms of the proportion of patients with dual eligibility for both Medicare and Medicaid. Rather than one benchmark applying across the board to all hospitals, different benchmarks will now apply for each peer group.

Specifically, CMS added this provision by adjusting the benchmark by which hospitals are compared for each of the six excess readmission ratio (ERR) measures. The payment formula replaces the 1.0 comparison with the median ERR for the hospital's peer group. This provision will minimize the payment reduction impact to hospitals with high proportions of beneficiaries of low socioeconomic status. CMS implements this change as follows:[10]

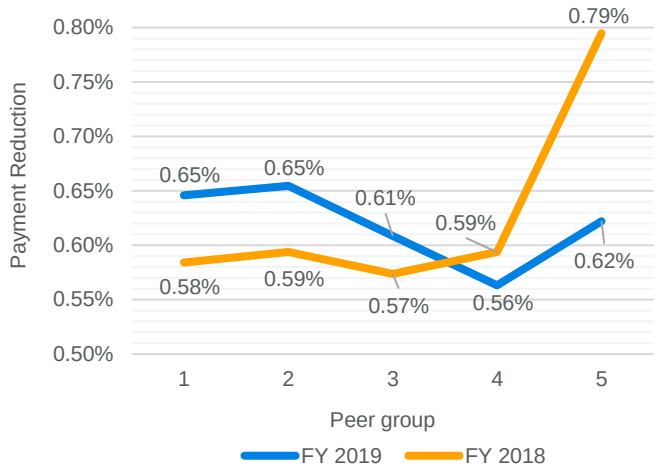
1. **Definition of dual-eligible:** An individual would be counted as a full-benefit dual-eligible patient if that person were identified as full-benefit dual-eligible status in the state Medicare Modernization Act (MMA) files for the month he or she was discharged from the hospital.
2. **Define the proportion of full benefit dual-eligible beneficiaries:** The proportion of dual-eligible patients among all Medicare FFS and Medicare Advantage (MA) admissions. The inclusion of MA admissions in the dual-eligible proportion differs from the ERR calculation, where MA readmissions are not considered.
3. **Define the data period for determining dual eligibility:** The three-year data period corresponding with the "applicable period" (e.g., July 1, 2014, through June 30, 2017, for FY 2019).
4. **Determination of peer groups:** Stratify hospitals into quintiles based on their proportions of dual-eligible patients.

The effects of these changes are explored in more detail in the rest of this article.

Impact of peer groups to hospitals

The introduction of peer groups will have the largest impact on hospitals with higher proportions of dual-eligible discharges. On average, these hospitals will have their HRRP payment adjustment factors reduced by approximately 21.7%, which will result in their inpatient Medicare reimbursement amounts increasing by 0.174%. The payment reduction percentage for each peer group is shown in Figure 1.

FIGURE 1: HRRP PAYMENT REDUCTION BY PEER GROUP



An important consideration for hospitals is the impact of moving between peer groups. For example, one hospital had a dual-eligible proportion of 32.2% and is thus in Peer Group 4. If its dual-eligible proportion were increased just slightly, to 32.5%, this hospital would be in Peer Group 5. This very slight change on the edge between peer groups has a leveraged impact: being in Peer Group 5 would reduce the payment adjustment (i.e., increase revenue) for this hospital by 0.16%.

Using estimated values for this hospital's inpatient Medicare FFS reimbursements, the revenue impact would be approximately $300,000 in FY 2019. Figures 2 and 3 show the dual-eligible proportion and median ERR by peer groups. In Figure 3, the median peer group ERR is shown for each of the six measures used for HRRP: acute myocardial infarction (AMI), chronic obstructive pulmonary disease (COPD), heart failure (HF), pneumonia (PN), coronary artery bypass graft (CABG), and elective primary total hip and/or knee arthroplasty (THA/TKA).

FIGURE 2: DUAL-ELIGIBLE PATIENT PROPORTION BY PEER GROUP

PEER GROUP	HOSPITAL COUNT	AVERAGE	LOW END	HIGH END
1	636	9.5%	0%	14.0%
2	637	16.6%	14.0%	19.0%
3	636	21.3%	19.0%	24.0%
4	637	27.6%	24.0%	32.4%
5	636	46.5%	32.4%	99.3%

FIGURE 3: MEDIAN EXCESS READMISSION RATIOS BY PEER GROUP

PEER GROUP	AMI	COPD	HF	PN	CABG	THA/ TKA
1	0.996	0.993	0.979	0.986	0.993	0.988
2	0.996	0.991	0.986	0.978	0.995	0.991
3	0.995	0.992	0.990	0.989	0.993	0.993
4	0.997	0.998	1.006	1.002	0.994	1.000
5	1.004	1.010	1.025	1.028	1.021	0.997

Source: Median ERRs from CMS using FY 2018 data

Conclusions

As CMS continues to shift payment adjustments for socioeconomic factors, it is important for providers to stay abreast of the latest changes. The changes to HRRP starting in FY 2019 could have significant monetary impacts to a provider's reimbursement. This is especially important given the level of contracting done on a percentage of Medicare FFS basis. Providers should take into consideration how they can improve the quality of care for their low-income populations to reduce readmissions and think about the impacts of contracting with Dual Eligible Special Needs Plans (D-SNPs) to adjust their positioning in the peer groups in the future.

PAYMENT ADJUSTMENT FACTORS AND CALCULATIONS

CMS uses three years of Medicare FFS and Medicare Advantage discharge data to calculate the dual-eligible proportion and three years of Medicare FFS discharge data to calculate excess readmission ratios (ERRs) and payment adjustment factors. The ERR is the predicted-to-expected readmission ratio calculated by CMS. The expected number of readmissions is calculated based on how a hospital is expected to perform given the hospital-specific patient mix and the average hospital readmission risk.[11] The predicted number of readmissions is calculated based on how the specific hospital performs given its patient mix and readmission risk. For each year, an ERR is calculated for six different readmissions measures: acute myocardial infarction (AMI), chronic obstructive pulmonary disease (COPD), heart failure (HF), pneumonia (PN), coronary artery bypass graft (CABG), and elective primary total hip and/or knee arthroplasty (THA/TKA). Starting in FY 2019, the ERRs are compared to the median peer group ERR instead of a 1.0. Each of the six measures with 25 or more eligible discharges and an ERR greater than the median peer group ERR will be used in the payment adjustment factor formula shown in Figure 5. The difference between the calculated ERR and the median peer group ERR then gets weighted based on the base operating diagnosis-related group (DRG) payments (i.e., Payment(dx) and All payments in the formula) for each of the measures. Because the 21st Century Cures Act required the new payment adjustment formula to be budget-neutral, a neutrality modifier (NM) is calculated to make the total payment reduction equal to the reduction using the FY 2018 formula. Finally, the payment reductions are capped at 3% and are applied to the Medicare base operating DRG payments for the fiscal year.[12]

FIGURE 4: HRRP FORMULA FOR FY 2018

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

FIGURE 5: HRRP FORMULA FOR FY 2019

$$= 1 - \min\{.03, \sum_{dx} \frac{NM * \ Payment(dx) * \max\{(ERR(dx) - Median\ peer\ group\ ERR(dx)), 0\}}{All\ payments}\}$$

The readmissions adjustment factor calculated from the formula in Figure 5 will be applied to all Medicare FFS base operating DRG payments.

Footnotes

[1] See p. 1098 of the HHS final rule, available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-16766.pdf.

[2] See p. 761 of the 21st Century Cures Act legislation, available at https://docs.house.gov/billsthisweek/20161128/CPRT-114-HPRT-RU00-SAHR34.pdf.

[3] MedPAC (June 2013). Report to the Congress: Medicare and the Health Care Delivery System. Chapter 4: Refining the Hospital Readmissions Reduction Program. Retrieved August 29, 2018, from http://www.medpac.gov/docs/default-source/reports/jun13_ch04.pdf.

[4] HHS final rule, ibid.

[5] CMS.gov (July 25, 2018). Medicare: What Are the Value-Based Programs? Retrieved August 29, 2018, from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html.

[6] Hines et al. (April 2014). Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011. AHRQ H-CUP Statistical Brief. Retrieved August 29, 2018, from https://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf.

[7] MedPAC (June 2018). Report to the Congress: Medicare and the Health Care Delivery System. Chapter 1: Mandated Report: The Effects of the Hospital Readmissions Reduction Program. Retrieved August 29, 2018, from http://www.medpac.gov/docs/default-source/reports/jun18_ch1_medpacreport_sec.pdf?sfvrsn=0.

[8] 21st Century Cures Act, ibid.

[9] MedPAC, Chapter 4, ibid.

[10] HHS final rule, ibid.

[11] Krumholz et al. (June 9, 2008). Hospital 30-Day Acute Myocardial Infarction Readmission Measure: Methodology. CMS. Retrieved August 29, 2018, from http://www.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228873653724&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3DAMI_ReadmMeasMethod.pdf&blobcol=urldata&blobtable=MungoBlobs (PDF download).

[12] CMS.gov (November 2017). New Stratified Methodology Hospital-Level Impact File User Guide. Retrieved August 29, 2018, from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/HRRP_StratMethod_ImpctFile_UG.PDF.

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