

FACTFILE

Healthcare Reform: Readmissions

Healthcare leaders must track many metrics to ensure that their operations are running efficiently. Among the measures that take on greater significance under the Patient Protection and Affordable Care Act is readmissions. That's because, starting in federal fiscal year 2013, the Centers for Medicare & Medicaid Services will be able to penalize hospitals based on readmission rates.

PERFORMANCE COUNTS

Pay for performance is specifically addressed in the 2010 healthcare reform legislation. For Medicare inpatients, CMS will be able to implement reimbursement withholding related to:

- > Readmissions (FFY 2013)
- > Value-based purchasing (FFY 2015)
 - Core measures
 - Patient satisfaction
- > Hospital-acquired conditions (FFY 2015)

SOURCE: Patient Protection and Affordable Care Act, 2010.

WHY READMISSIONS MATTER

Readmissions are considered a marker for poor quality care, wasted revenue, and inefficient use of resources. Consider these statistics:

- > The Medicare Payment Advisory Commission has concluded that two-thirds of all readmissions are avoidable.
- > Medicare is spending and additional \$15 billion a year on readmissions (about \$7,200 per readmission).
- > MedPAC estimates that about 12.5% of Medicare heart-failure admissions were followed by a readmission within 15 days, accounting for more than 90,000 admissions at a cost of \$590 million.
- > All-cause 30-day readmission rates per thousand patients discharged with heart failure increased by 11% between 1992 and 2001.

SOURCE: MedPAC.

FINANCIAL IMPACT

The new healthcare reform law allows CMS to withhold a percentage of inpatient Medicare payments. These percentages will be calculated on a hospital's aggregate Medicare payments for all discharges, not just heart failure, acute myocardial infarction, and pneumonia patients. The impact is as follows:

- > **Up to 1%** in FFY 2013
- > **Up to 2%** in FFY 2014
- > **Up to 3%** in FFY 2015 and thereafter

SOURCE: Patient Protection and Affordable Care Act, 2010.

FINANCIAL CALCULATION

No loss of revenue can be taken lightly in the current economic climate. And the impact of the readmission penalties is something that can add up very quickly. Here is an example of a financial calculation of excess payments for Medicare fee-for-service patients for heart failure, AMI, and pneumonia. In this case, we see excess payments of about \$1 million. If, for example, the hospital's total inpatient operating payments from Medicare were \$25 million, then the excess payments represent about 4%. And while the penalty is capped at 1%, 2%, and 3% in years 2013, 2014, and 2015, respectively, the penalty is assessed on the hospital's aggregate Medicare payments for all discharges, not just the ones measured.

	Medicare FFS patients	Avg Medicare payments	Observed/expected minus 1	Excess payments
Heart failure	264	\$6,851	0.25	\$452,166
AMI	55	\$8,321	0.12	\$54,919
Pneumonia	306	\$5,247	0.33	\$529,842
Total				\$1,036,927

SOURCE: Thomson Reuters.

NOVEMBER 2010

Discharges per Medicare Enrollee

There is considerable variation among states in the number of discharges from short-stay hospitals per 1,000 Medicare enrollees. This 2008 data shows that Alabama, with 412 per 1,000, is well above the national average of 343. Hawaii is lowest, with 201 discharges per 1,000.

Rank (1=high 51=low)	Total Discharges	Discharges per 1,000 Enrollees
United States	11,768,400	343
1. Alabama	268,195	412
2. Maryland	277,000	402
3. Mississippi	173,935	398
4. Illinois	628,045	396
4. District of Columbia	26,000	396
6. Pennsylvania	543,345	388
6. Ohio	528,515	388
8. Louisiana	200,490	385
9. Michigan	473,230	384
10. Oklahoma	190,505	381
11. Tennessee	302,640	380
11. Kentucky	235,830	380
13. New Jersey	421,400	373
14. West Virginia	106,480	368
15. New York	762,235	367
16. Missouri	286,795	365
17. Massachusetts	298,045	360
18. Florida	828,790	355
19. Arkansas	154,335	346
20. Minnesota	169,740	345
21. Texas	797,275	344
22. Indiana	286,185	341
23. Connecticut	157,745	338
24. Delaware	45,390	337
25. Rhode Island	37,465	335
26. North Carolina	391,220	332
27. South Carolina	204,300	328
27. Georgia	324,865	328
29. Virginia	305,500	325
30. Kansas	120,655	319
31. Wisconsin	197,685	299
32. Arizona	163,470	298
33. Nevada	67,080	292
34. California	818,050	289
35. Nebraska	68,700	286
36. Iowa	126,850	285
37. Colorado	109,275	284
38. North Dakota	26,190	267
39. Maine	63,270	266
40. New Mexico	58,225	261
41. Wyoming	18,695	260
42. South Dakota	30,630	257
43. New Hampshire	51,125	255
44. Washington	174,345	248
44. Montana	33,790	248
46. Utah	44,870	237
47. Alaska	13,530	229
48. Oregon	77,295	225
49. Idaho	33,925	210
50. Vermont	20,890	207
51. Hawaii	24,360	201

NOTE: Medicare enrollees in managed care plans are not included in the denominator used to calculate utilization rates.

SOURCE: Kaiser State Health Facts, www.statehealthfacts.org/comparetable.jsp?typ=1&ind=335&cat=6&sub=80&sortc=2&o=a. From Table 5.4, Medicare and Medicaid Statistical Supplement, 2009 Centers for Medicare & Medicaid Services, Office of Information Services: Data from the Medicare Data Extract System; data development by the Office of Research, Development, and Information. Available at: www.cms.hhs.gov/MedicareMedicaidStatSupp/LT/list.asp#TopOfPage.

Upcoming Topic:

- > Utilization

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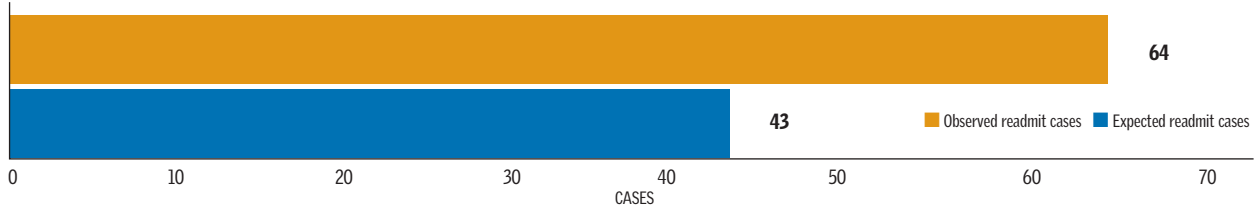
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FINDING ANSWERS

Healthcare executives need to set the goals that will drive performance. To identify the opportunities, compare the hospital's performance against risk-adjusted expected models. Such models and benchmarks may not be readily available in-house, but may be found externally with some state associations, group purchasing organizations, and business partners, such as Thomson Reuters. This is an example of the benchmarking a hospital can do to highlight opportunities for improvement. By dividing the observed readmission rate by the expected readmission rate, you can track the index, which in this example, is statistically significant; anything greater than a 1.0 will trigger an excess payment cost.

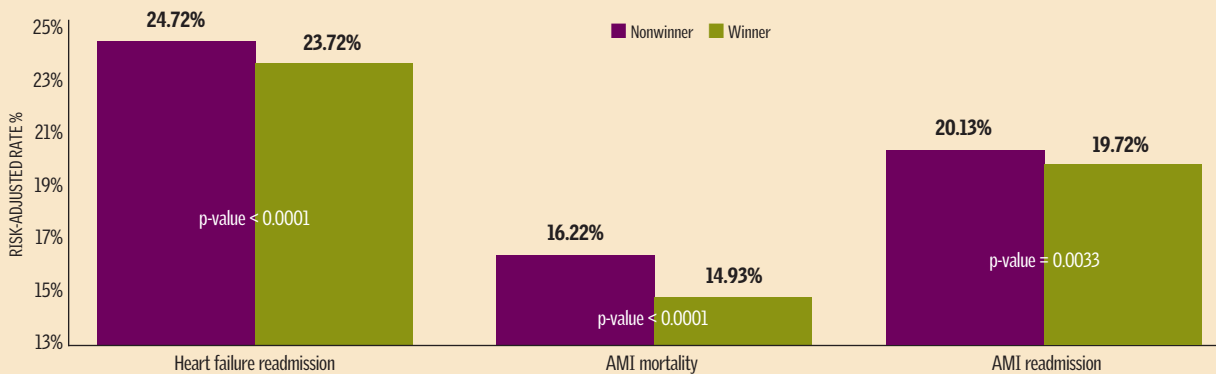


Heart failure readmit cases	Observed readmit cases	Expected readmit cases	Observed readmit rate (%)	Expected readmit rate (%)	Index (Observed/Expected)	Statistically Significant
249	64	43	25.70	17.15	1.50	SS

SOURCE: Thomson Reuters.

WINNING WAYS WILL HELP

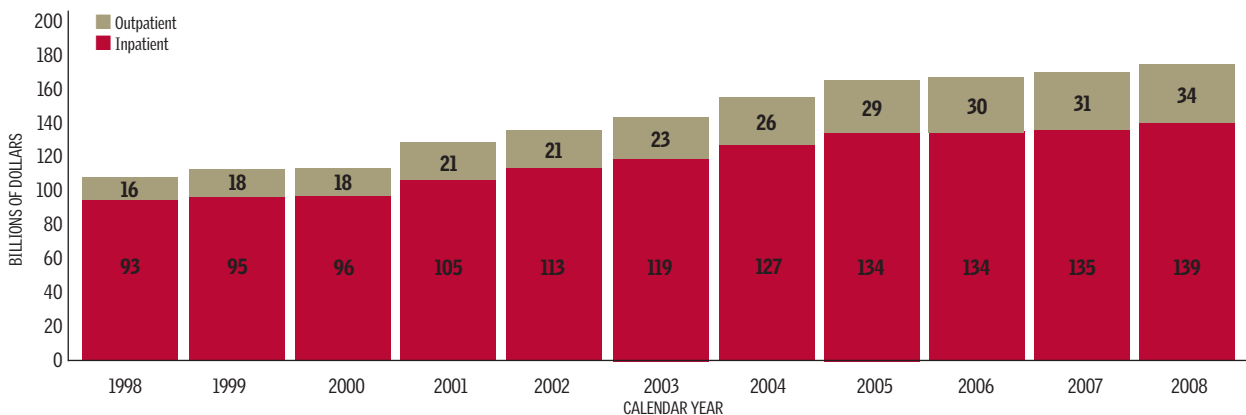
Clearly, keeping the readmission rates controlled will help mitigate the Medicare penalties. And the top-performing hospitals show that this is possible. Here we see the difference between those designated as winners in the Thomson Reuters 100 Top Hospitals Cardiovascular study and those designated as non-winners.



SOURCE: Thomson Reuters.

GROWTH IN MEDICARE FFS PAYMENTS

The focus on readmissions may be in part driven by the growth of Medicare FFS payments over the years, for both inpatient and outpatient services. That growth was slowed in 2006, with the large number of Medicare Advantage enrollees, who are not included in these aggregate totals.



Note: Data represents inpatient services covered by the acute inpatient prospective payment system; psychiatric, rehabilitation, long-term care, cancer, and children's hospitals and units; outpatient services covered by PPS; and other outpatient services. Payments include program outlays and beneficiary cost sharing.

SOURCE: CMS, Office of the Actuary. Chart 7-4 of MedPAC's Healthcare Spending and the Medicare Program, June 2010, www.medpac.gov/documents/Jun10DataBookEntireReport.pdf

