

THOMSON REUTERS ON HEALTHCARE REFORM



PREPARING FOR READMISSION PAYMENT REDUCTIONS KNOW YOUR RISK AND OPPORTUNITIES

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One of the first financial impacts to hospitals as a result of PPACA legislation is a reduction in reimbursement for excessive readmission of Medicare inpatients. Starting with discharges in October 2011, the impact of the payment penalties may be significant.

The Medicare Payment Advisory Commission (MedPAC) has estimated that nearly one out of every five Medicare patients admitted to the hospital is readmitted within 30 days and unplanned readmissions are estimated to cost Medicare approximately \$17.4 billion annually.[1] Understanding and decreasing unnecessary readmissions can help hospitals develop the analytic foundation, process, and culture that they need for performance improvement.

Readmissions are a widely accepted measure of hospital effectiveness. Although they are only one of many performance metrics, low readmission rates do correlate with overall clinical excellence. Read further to learn more about the nuances of accurately measuring readmissions and important steps in calculating your risk, so you can get ahead of potential payment reductions.

READMISSION RATES: A QUALITY AND EFFECTIVENESS MEASURE

As part of the CMS value-based purchasing program, 30-day readmission rates are a performance measure already closely watched in the industry. Now PPACA legislation allows CMS to withhold a portion of all inpatient Medicare payments due to excessive readmissions, starting with up to 1 percent in federal fiscal year 2013, and rising to 3 percent in 2015 and beyond.

Why are 30-day readmission rates a widely accepted measure of the effectiveness of hospital care? They allow us to understand how the inpatient care for these particular conditions may have contributed to issues with post-discharge medical stability and recovery. Tracking readmissions may help hospitals identify patients who are at risk for post-discharge problems if discharged too soon, and target improvements in discharge planning and in aftercare processes.

Thomson Reuters recently added readmission rates as a new objective measure of quality performance in the 100 Top Hospitals® research. In the most recent study, we added extended outcome measures to help round out the balanced scorecard in the area of clinical excellence. The additional measures included both 30-day readmission and mortality rates, as defined by the CMS Hospital Compare dataset.

Before including the new extended outcomes measures in the program, we

RESOURCES

Learn how to predict your risk. See the calculations and examples in our new Research Brief: [Pending Changes to Reimbursements for 30-Day Readmissions](#).

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evaluated readmissions as a measure of performance consistent with the 100 Top Hospitals balanced scorecard approach. Our results found a significant correlation between winning hospitals and extended outcome measures. That is, hospitals that score well on the 100 Top Hospitals performance metrics also have lower 30-day readmission and mortality rates. Low 30-day readmissions rates are associated with overall quality and effectiveness. For more details, see the Findings section of the 100 Top Hospitals: National Benchmarks, 2009 [study abstract](#).

What does this mean? Hospitals that score well on 30-day readmission rates may be better prepared overall for a pay-for-performance structure.

CALCULATING YOUR RISK

Although reimbursement reductions don't begin until 2013, clinical outcomes in federal fiscal year 2012 will dictate the penalties leveraged in 2013. This means that patients with heart failure, heart attack, and pneumonia who are discharged as early as October 1, 2011 will have an influence on future reimbursement.

A key to evaluating where you stand is getting a reliable measure of both observed and expected readmissions based on your patient mix. CMS calculates 30-day readmission rates from Medicare enrollment and claims records using sophisticated statistical modeling techniques that adjust for patient-level risk factors and account for the clustering of patients within hospitals. CMS' three readmission models estimate hospital specific, risk-standardized, all-cause 30-day readmission rates for patients discharged alive to a non acute-care setting with a principal diagnosis of heart attack, heart failure, or pneumonia. Patients may have been readmitted back to the same hospital or to a different hospital or acute-care facility. They may have been readmitted for the same condition as their recent hospital stay, or for a different reason (this is to discourage hospitals from coding similar readmissions as different readmissions).

Your risk is the number of patients with the applicable condition readmitted above the expected readmissions. The exact penalty is based on the amount of excessive payments made for each applicable condition using the base DRG payment made for those patients. While CMS will initially use only heart failure, heart attack, and pneumonia readmission rates to calculate the excessive payment amount, the total penalty will be applied to the aggregate Medicare payments for all hospital discharges. The resulting penalties could be quite high.

To learn more about these calculations, and how to compare your performance against risk-adjusted expected models, read our Research Brief: [Pending Changes to Reimbursements for 30-Day Readmissions](#).

GET THE FACTS

Assess your baseline on readmissions now using risk-adjusted benchmarks for a reliable view of your top opportunities for improvement. See our resources and related research, and [contact us](#) to learn more about how Thomson Reuters can help you with the intelligent information to support decisions with facts.

[1] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. *New Engl J Med*. 2009;360:1418-28.