

RESEARCH BRIEF

HEALTHCARE REFORM: PENDING CHANGES TO REIMBURSEMENT FOR 30-DAY READMISSIONS

AUGUST 2010

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HEALTHCARE REFORM: PENDING CHANGES TO REIMBURSEMENT FOR 30-DAY READMISSIONS

Healthcare reform is incorporating pay for performance methodologies. One of the first high-profile efforts will be focused on reducing unnecessary readmissions to the hospital.

To accomplish this, the Patient Protection and Affordable Care Act (PPACA) statute will penalize hospitals and integrated delivery systems with higher than expected readmission rates. They will focus initially on:

- Heart Failure
- Acute Myocardial Infarction
- Pneumonia

Followed by focusing on:

- Chronic Obstructive Lung Disease
- Coronary Bypass Grafting
- Percutaneous Coronary Interventions
- Vascular Procedures

This paper provides insight into healthcare reform and its clinical and financial implications for hospital readmissions. It is a call to action now. Hospitals and integrated delivery systems have little time to prepare for the reimbursement changes beginning in 2013.

BACKGROUND

High readmission rates have long been considered a marker of lower quality care. In its 2008 recommendation to Congress, the Medicare Payment Advisory Commission (MedPAC) reported that in 2005, 17.6 percent of admissions were readmitted within 30 days of discharge. That same year, readmissions accounted for \$15 billion in Medicare spending, of which \$12 billion was related to potentially preventable readmissions, equating to an average payment of about \$7,000 per case.

Congress has taken notice and acted. Lawmakers specifically addressed the issue in the healthcare reform legislation, the Patient Protection and Affordable Care Act, with the intent of holding care providers responsible and of managing healthcare spending.

HEALTHCARE REFORM OF 2010

With the passage of PPACA in March 2010, Congress gave Centers for Medicare and Medicaid Services (CMS) the authority to penalize hospitals for excess readmission rates starting federal fiscal year (FFY) 2013. Initial efforts will focus on heart failure (HF), acute myocardial infarction (AMI), and pneumonia. CMS is already reporting readmissions rates for these conditions on its Hospital Compare Web site. Beginning FFY 2015, CMS may also begin withholding payments for excessive readmissions related to chronic obstructive pulmonary disease, coronary artery bypass grafts, percutaneous coronary interventions, and some vascular surgery procedures.

FINANCIAL IMPACT

How much will this hurt hospitals financially? It could hurt a lot. PPACA allows CMS to withhold up to 1 percent of all inpatient Medicare payments starting in FFY 2013, up to 2 percent of payments in FFY 2014, and up to 3 percent in FFY 2015 and thereafter. These percentages will be calculated on a hospital's

aggregate Medicare payments for *all discharges*, not just HF, AMI, and pneumonia patients, so the resulting penalties could be quite high.

To calculate the exact penalty, one must first determine the amount of excessive payments made for each applicable condition. PPACA defines excessive payments as the product of the number of patients with the applicable condition, the base DRG payment made for those patients, and the percentage of readmissions above expected. Take heart failure (HF) as an example. If a hospital treated 250 HF patients, the average reimbursement for those patients was \$5,000 (arguably a low figure, but convenient for this example), and the readmission rate was 20 percent higher than expected, then the excessive payments for HF would be calculated as follows:

$$\begin{aligned} \text{HF Excessive Payments} &= (250 \text{ patients}) \times (\$5,000 \text{ per patient}) \times (0.20) \\ &= \$250,000 \end{aligned}$$

Next, add this value to the excessive payments calculated for AMI and pneumonia, say \$0 and \$100,000 respectively. Then the total excessive payments would be:

$$\begin{aligned} \text{Total Excessive Payments} &= \$250,000 + \$0 + \$100,000 \\ &= \$350,000 \end{aligned}$$

If the hospital's total inpatient operating payments from Medicare were \$25 million in FFY 2012, then their excessive payments were 1.4 percent of total operating payments ($\$350,000 \div \$25,000,000$). However, the maximum penalty in FFY 2013 is 1 percent of the total operating payments, less than this hospital's total excessive payments. Based on the above example, this hospital would lose \$250,000 of its inpatient operating payments in FFY 2013 (PPACA, 2010, Section 3025).

And what happens if private payers follow suit? Obviously the pain just gets worse.

TIME TO ACT IS NOW

Clinical outcomes in FFY 2012 will dictate the penalties leveraged in FFY 2013. This means that patients discharged as soon as October 1, 2011, will have an influence on future reimbursement.

As such, hospitals have little time to evaluate their current performance, forecast potential reimbursement withholdings, and implement changes to reduce the number of readmissions. Administrators and care providers must take steps to address the issue by focusing on opportunities with the greatest clinical and financial performance improvement potential. To do so, answers for the following questions should be proactively sought:

- What are our hospital's current 30-day readmission rates?
- Are these rates excessive (i.e., how many readmissions should the hospital expect given its patient mix)?
- How will reimbursement payments be impacted?
- What can the hospital do to address the issue?

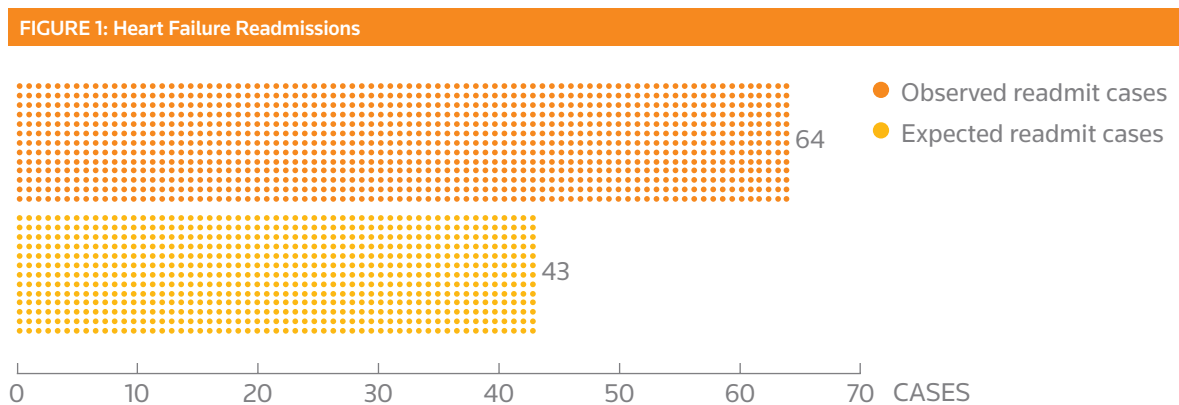
MONITOR OUTCOMES AND COMPARE AGAINST RISK-ADJUSTED EXPECTED VALUES

Executives and administrators are responsible for setting the goals that will drive performance across the organization. A common and wise approach is to go after the low hanging fruit — find those opportunities with the largest room for improvement and assemble performance improvement teams with the greatest chance for success.

The first step is to identify the opportunities. This should be done by comparing the hospital's performance against risk-adjusted expected models. Ideally, the models used will be similar to those employed by CMS. Risk-adjusted models and benchmarks may not be readily available in-house, but may be found externally with some state associations, Group Purchasing Organizations (GPOs), and business partners, such as Thomson Reuters. For example, the Thomson Reuters all-payer methodology and the Medicare fee-for-service (FFS) methodology were both designed using the same Yale-based research. Statistical

testing shows that the two models make similar predictions when measuring hospital-specific, risk-standardized, 30-day, all-cause readmission rates for adult inpatients discharged from the hospital with a principal diagnosis of HF (Foster, Young & Heller, 2010).

Benchmarking will allow your organization to identify those clinical pathways with the greatest opportunity for improvement. Figure 1 is one example of the benchmarking a hospital can do to highlight opportunities for improvement.



HF CASES	OBSERVED READMIT CASES	EXPECTED READMIT CASES	OBSERVED READMIT RATE (%)	EXPECTED READMIT RATE (%)	INDEX (OBSERVED/EXPECTED)	STAT SIGN
249	64	43	25.70	17.15	1.50	SS

PERFORMANCE IMPROVEMENT

A multi-disciplinary team must be used to address issues related to readmissions. Very rarely will one individual have the insight, political clout, and skills necessary to reduce the number of readmissions. Whether a patient returns to the hospital is determined not only by the care provided during the original stay, but also by a patient’s adherence to discharge instructions, the care setting the patient was discharged to (e.g., home or other), and the follow-up outpatient care. Complex processes and multiple touch-points are involved. Undoubtedly, several minds are better than one when trying to understand the processes, diagnose the problems, create simple solutions, and implement changes. Figure 2 is an example of patient discharge data that ties readmission rates to discharges instruction practices.

FIGURE 2: Diagnosing the Problem

DISCHARGE INSTRUCTIONS	HF CASES	RATE OF READMISSION (%)
Yes	173	22.5
No	15	60.0
NA – Patients not discharged to home	61	26.2

ADOPT BEST PRACTICES

With the growing body of literature on best practices, hospitals can ensure that the care they provide not only fulfills local standards, but also meets and exceeds that of the best performing hospitals nationally. With regard to readmissions, areas of improvement are often focused around:

- Better quality care during hospitalizations – effective use of diagnosis-specific clinical decision support tools embedded into the workflow has demonstrated effectiveness.
- Improved communication among providers and with patients and caregivers – particularly between the inpatient and outpatient providers of care.

- Care planning that begins with an assessment at admission — nurse care managers representing the insurer, the hospital, and the primary providers must collaborate.
- Clear discharge instructions with particular attention to medication management — incorporating the input of the inpatient and outpatient pharmacist has proven effective.
- Discharge to a proper setting of care — Hospital case management screenings should determine rehab/skilled nursing requirements before discharge to outpatient care.
- Timely physician follow-up visits — with primary care provider and appropriate specialists; preferably the appointment should be scheduled prior to discharge.
- Appropriate use of palliative care and end-of-life planning should be built into the hospital discharge process. Palliative specialists and hospice expertise need to be integrated components of post-hospital planning.

CONCLUDING THOUGHTS

Hospital readmission rates have long been a concern for clinicians, administrators, payers, and patients. With healthcare reform legislation signed into law, hospitals have a renewed financial incentive to focus on readmissions.

The key to achieving and maintaining good clinical outcomes and financial standing rests in the hospital's ability to effectively identify opportunities for improvement and successfully implement solutions within the organization. It can be a slow and arduous process, but it can also be extremely rewarding. The time to act is now.

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