Refining the Hospital Readmissions Reduction Program

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Reducing readmissions is important

- Commission recommended readmission reduction program in 2008
- Avoidable readmissions represent poor outcomes for patients
- Medicare spending on readmissions is substantial
- While feasible for hospitals to reduce readmissions, FFS incentives impede action to do so
Hospitals can reduce readmissions

- Identify patient population at increased risk of readmission
- Reduce hospital complications
- Improve transitions
  - Provide patient education (such as teach-back) and self management
  - Schedule follow-up visits and medication reconciliation before discharge
  - Call or visit with patients after discharge
- Communicate better with providers outside hospital
Overall readmission rates have fallen slightly over the past 3 years

<table>
<thead>
<tr>
<th>Readmission measure</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>Percentage point change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cause</td>
<td>15.6</td>
<td>15.5</td>
<td>15.3</td>
<td>-0.3</td>
</tr>
<tr>
<td>PPRs</td>
<td>13.0</td>
<td>12.5</td>
<td>12.3</td>
<td>-0.7</td>
</tr>
</tbody>
</table>

Note: All condition readmission rates adjusted to control for changes in the mix of patients (age, gender, and DRG). Source: MedPAC analysis of 2009 through 2011 Medicare claims files.

- Reduction in PPR rate greater than reduction in “all cause”
- Reductions for three conditions in policy (AMI, heart failure, pneumonia) equal or greater than overall average

Data preliminary and subject to change
Variation in readmission rates, 2011

- At hospital level:
  - Limited variation across hospital type (teaching status, ownership, add-ons)
  - More variation within groups than across
- At patient level rates vary by demographic factors
  - Slight differences by age and gender
  - Larger differences by race and income
PPACA hospital readmission reduction program

- Starts in October using 3 conditions
  - AMI, heart failure, pneumonia
  - At least 4 more conditions added to policy in 2015
- Hospitals with above average readmission rates for condition receive penalty (non-IPPS hospitals excluded)
  - Readmission rates based on Hospital Compare methodology
  - Penalty applied to all cases
- Penalty capped
  - 1%—2013, 2%—2014, 3%—2015 and thereafter
  - Penalty applied to base operating payments, does not apply to IME, DSH, or special rural payment add-ons
Impact of PPACA readmission policy

- 33 percent of hospitals have no penalty—6 percent because they do not have enough cases
- 67 percent of hospitals have penalty—9 percent of hospitals at payment penalty cap
- In aggregate penalties equal about 0.24 percent of total inpatient hospital payments in 2013
- Average penalty for hospitals with penalty about $125,000

Source: MedPAC estimate
Penalty varies little by type of hospital

<table>
<thead>
<tr>
<th>Hospital group</th>
<th>Share with penalty</th>
<th>Penalty as % of total payment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>67%</td>
<td>0.24%</td>
</tr>
<tr>
<td>Urban</td>
<td>69</td>
<td>0.24</td>
</tr>
<tr>
<td>Rural</td>
<td>64</td>
<td>0.29</td>
</tr>
<tr>
<td>Major teaching</td>
<td>88</td>
<td>0.29</td>
</tr>
<tr>
<td>Other teaching</td>
<td>70</td>
<td>0.21</td>
</tr>
<tr>
<td>Nonteaching</td>
<td>64</td>
<td>0.24</td>
</tr>
<tr>
<td>No DSH or IME</td>
<td>48</td>
<td>0.24</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>69</td>
<td>0.25</td>
</tr>
<tr>
<td>For profit</td>
<td>65</td>
<td>0.25</td>
</tr>
</tbody>
</table>

Note: *Total payment includes base operating payments, indirect medical education payments, disproportionate share payments, outlier payments, hospital specific rates, and capital payments.


Data preliminary and subject to change
Long-term issues with readmission reduction program

1. Computation of penalty multiplier
2. Random variation and small numbers of observations
3. Unrelated and planned readmissions
4. Socio-economic status and risk adjustment
Principles for refining the policy

- Maintain or increase average hospitals’ incentive to reduce readmissions
- Increase share of hospitals that have an incentive to reduce readmissions
- Make penalties a consistent multiple of the costs of readmissions
- Be at least budget neutral to current policy, with a preference for lower readmission rates rather than higher penalties
Issue 1. Computation of penalty multiplier

How the readmission multiplier is computed:

Penalty = \frac{\text{(Payment rate for the initial DRG)} \times \text{(adjusted number of excess readmissions)}}{\text{1/national readmission rate for the condition}}

Excess cost \times Penalty multiplier
Issue 1. Computation of the penalty multiplier (continued)

- **Issues** (multiplier = 1 / national readmission rate)
  - Penalty increases as industry readmission rates decrease
  - Penalty multiplier differs for each condition

- **Possible solutions**
  - Use fixed multiplier
  - Use all-condition readmissions
  - Eliminate the multiplier and set a lower target readmission rate to maintain budget neutrality
Issue 2. Random variation and small numbers of observations

- Issue--Difficult to distinguish between random variation and true performance improvement for hospitals with small number of cases

- Possible solutions
  - Use all-condition readmissions (to increase n)
  - Use more years of data (currently uses 3)
  - Allow hospitals to aggregate performance within a system for penalty purposes (continue to publicly report individual hospital performance)
Issue 3. Unrelated and planned readmissions

- **Issue**—Some readmissions are not preventable and others are planned but current system has very few exceptions

- **Possible solution**—Shift to all-condition measures that have exceptions for planned and unrelated readmissions
  - 3-M all conditions model – used in New York and Maryland
  - Yale all conditions model – recently received NQF endorsement
### Issue 4: Socio-economic status and risk adjustment

<table>
<thead>
<tr>
<th>Share of beneficiaries on SSI</th>
<th>Heart failure readmission rate as a share of the national average</th>
<th>Median penalty</th>
<th>Share with no penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2%</td>
<td>0.92</td>
<td>0.00%</td>
<td>57%</td>
</tr>
<tr>
<td>2-4</td>
<td>0.91</td>
<td>0.02</td>
<td>46%</td>
</tr>
<tr>
<td>4-5</td>
<td>0.94</td>
<td>0.07</td>
<td>43%</td>
</tr>
<tr>
<td>5-6</td>
<td>0.95</td>
<td>0.09</td>
<td>41%</td>
</tr>
<tr>
<td>6-7</td>
<td>0.97</td>
<td>0.13</td>
<td>36%</td>
</tr>
<tr>
<td>7-9</td>
<td>0.99</td>
<td>0.14</td>
<td>35%</td>
</tr>
<tr>
<td>9-10</td>
<td>1.03</td>
<td>0.29</td>
<td>26%</td>
</tr>
<tr>
<td>10-13</td>
<td>1.04</td>
<td>0.32</td>
<td>24%</td>
</tr>
<tr>
<td>13-18</td>
<td>1.06</td>
<td>0.42</td>
<td>21%</td>
</tr>
<tr>
<td>Over 19</td>
<td>1.12</td>
<td>0.33</td>
<td>25%</td>
</tr>
</tbody>
</table>

Source: 2013 IPPS proposed rule penalty and SSI files from CMS

*Data preliminary and subject to change*
Ways to address the effect of socio-economic status on readmissions

- Current incentives may close the gap
- Add SES to risk adjustment models
- Compare hospitals against similar hospitals to compute penalty
- Provide financial assistance to hospitals with high low-income shares
Summary

- Readmissions policy going in right direction: decreasing avoidable readmissions better for beneficiaries and the Medicare program
- Magnitude of penalty about 0.24 percent of payments in FY2013
- Four issues need to be addressed for longer term
- Need to consider savings from avoided readmissions as well as size of penalty
Discussion

- Policy refinements will require change in law: must proceed carefully.
- More detailed analysis will be forthcoming to inform policy refinements e.g., modeling all-condition readmission measures
- Are the principles appropriate given your experience?
Principles for refining the policy

- Maintain or increase average hospitals’ incentive to reduce readmissions
- Increase share of hospitals that have an incentive to reduce readmissions
- Make penalties a consistent multiple of the costs of readmissions
- Be at least budget neutral to current policy, with a preference for lower readmission rates rather than higher penalties