Advising the Congress on Medicare issues

Refining the Hospital Readmissions Reduction Program

David Glass, Craig Lisk, Jeff Stensland

September 7, 2012

MEDPAC

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

Readmission measure	2009	2010	2011	Percentage point change
All cause	15.6	15.5	15.3	-0.3
PPRs	13.0	12.5	12.3	-0.7

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

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

Note: *Total payment includes base operating payments, indirect medical education payments, disproportionate share payments, outlier payments, hospital specific rates, and capital payments.
Source: MedPAC analysis of Medicare claims files, Medicare Compare data base 2008 through 2011, and MedPAC 2012 hospital payment model

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 = (Payment rate for the initial DRG) X (adjusted number of excess readmissions) X 1 / national readmission rate for the condition

Excess cost

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

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

MEDPAC

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