

LegalNotes

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LegalNotes is a regular online *Aligning Forces for Quality* (AF4Q) publication that provides readers with short, readable summaries of developments in the law that collectively shape the broader legal environment for efforts to improve quality, reduce health care disparities, and improve the transparency of price and quality information.

Medicare Hospital Readmissions Reduction Program

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Introduction

On average, about 20 percent of Medicare patients discharged from hospitals in the United States will be readmitted to a hospital within 30 days.¹ These readmissions cost the Medicare program an estimated \$12 billion a year and may indicate poor quality of care when the readmission was potentially preventable.² Two primary factors are often cited as likely contributors to high rates of readmission among Medicare beneficiaries:

- First, Medicare pays hospitals based on diagnosis-related groups, or DRGs, which allow a single payment for services related to a specific diagnosis and not the actual level of services required for a particular patient.³ Inherent in this DRG-based payment system is an incentive for hospitals to deliver necessary care at or below the DRG rate. In 2007, the Medicare program transitioned to the use of Medical Severity DRGs to better reflect the acute health care needs of Medicare beneficiaries.⁴ While this change increased reimbursement rates, the incentive to treat patients at or below the MS-DRG rate remains, as no reimbursement is provided for the cost of care delivered beyond the MS-DRG rate.⁵ If a hospital discharges a patient before it is medically appropriate, the patient is more likely to return to the hospital for additional care that may be more costly, due to exacerbation of the underlying condition(s).⁶
- Second, there is often a lack of communication between physicians or other health professionals delivering care in the hospital and a Medicare beneficiary's primary care physician, other physician, or outpatient setting.⁷ This can lead to conflicting or additional care, necessitating readmission.⁸

Given the active role the Aligning Forces for Quality Alliances play in quality improvement and public reporting of provider performance information, the Alliances are uniquely positioned to work with hospitals to reduce potentially preventable readmissions and provide meaningful information to consumers and patients concerning hospital admission rates. —See page 3 for details

In its June 2007 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) classified many hospital readmissions as potentially preventable.⁹ For example, MedPAC suggested that hospitals could reduce readmission rates by better coordinating prescriptions and educating family members on appropriate methods of home care.¹⁰ MedPAC also proposed making hospital readmission rates public to encourage hospitals to lower their rates as well as changing the Medicare payment system to eliminate the early discharge incentive.¹¹

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Based on these recommendations, Congress included the Hospital Readmissions Reduction Program (HRRP) in the Patient Protection and Affordable Care Act of 2010 (ACA).¹² The Centers for Medicare & Medicaid Services (CMS) issued the final rule implementing the HRRP on August 18, 2011.¹³ The Alliances participating in the Robert Wood Johnson Foundation's *Aligning Forces for Quality* initiative are in an ideal position to educate hospitals and consumers about HRRP and inform efforts to reduce readmissions for Medicare patients. This note will explain the framework of the HRRP based on the statute and the CMS final rule and discuss the implications for Alliance members.

Hospital Readmissions Reduction Program and Quality Improvement Program

Overview

The HRRP will reduce Medicare payments to “applicable hospitals” that have an excessive readmission rate for the “applicable conditions”¹⁴ (these and other key terms are defined below). CMS will calculate the payment reduction by applying an “adjustment factor” to the base-operating DRG payment that a hospital would receive without the HRRP.¹⁵ Further, the HRRP requires the Secretary of the United States Department of Health and Human Services (HHS) to collect and publish readmission data from “specified hospitals” on the Hospital Compare website.¹⁶

The ACA includes a Quality Improvement Program (QIP) along with the HRRP to help hospitals that struggle to reduce their readmission rates.¹⁷ The QIP allows the Secretary to pair hospitals with poor readmission rates with a patient-safety organization (PSO) for the purpose of lowering readmission rates.¹⁸

Key Terms and Definitions

- Applicable Hospital:* The ACA defines “applicable hospital” as all hospitals except children’s hospitals, certain cancer and research centers, and hospitals that provide primarily long-term, rehabilitative, or psychiatric care.¹⁹ Applicable hospitals include those participating in a Medicare reimbursement demonstration project, but the Secretary may exempt these hospitals if their state demonstrates the existence of a state program designed to reduce costs and improve quality.²⁰
- Applicable Condition:* Starting in 2013, the HRRP will apply to readmissions for Heart Failure (HF), Acute Myocardial Infarction (AMI), and Pneumonia (PN).²¹ These conditions are prevalent and costly, and their incidence can be tracked using measures endorsed by the National Quality Forum (NQF)—thus fulfilling the criteria established in the ACA for applicable conditions.²² CMS will consider adding additional conditions in 2015.²³
- Readmission:* CMS defines readmission as the admission of a patient to a hospital within thirty days of their discharge from a hospital pursuant to one of the applicable conditions.²⁴
- Base-operating DRG Payment:* The ACA defines base-operating DRG payment as the amount a hospital would normally receive for the discharge of a Medicare patient.²⁵ The amount does not include certain Medicare payments made to teaching hospitals, low-volume hospitals, urban hospitals, rural hospitals, small community hospitals, and hospitals serving low-income populations.²⁶
- Adjustment Factor:* The ACA establishes the adjustment factor as the greater of a floor value or the ratio of “aggregate payments for excess readmissions” to “aggregate payments for all discharges.”²⁷ The ACA defines “aggregate payments for excess readmissions” as the product of: (1) the “excess readmissions ratio” minus one; (2) the number of admissions for each applicable condition at a hospital during a specified time period; and (3) the base operating DRG payment for the condition.²⁸ The ACA defines “excess readmissions ratio” as the ratio of “risk-adjusted actual readmissions” to “risk-adjusted expected readmissions.”²⁹ Readmissions will only be included in this ratio if the number exceeds a minimum established by the Secretary.³⁰ The ACA defines “aggregate payments for all discharges” as the total of all DRG discharge payments at a hospital during the specified period.³¹
- Specified Hospital:* All hospitals, including hospitals exempted from the readmission penalty, must submit data regarding their readmissions to the Secretary.³² However, entities or states may submit the data on behalf of specified hospitals.³³
- Administrative and Judicial Review:* The ACA prohibits administrative and judicial review of the readmission measures, base-operating DRG payment, and adjustment factor formulas.³⁴

Implications for the *Aligning Forces For Quality Alliances*

Given the active role the *Aligning Forces for Quality Alliances* play in quality improvement and public reporting of information about provider performance, they are uniquely positioned to work with hospitals to reduce potentially preventable readmissions and provide meaningful information to consumers and patients concerning hospital readmission rates. The following issues will be important for Alliances to consider and address as appropriate. In addition, Alliances might consider or continue working with private payers to implement programs that reinforce the Medicare HRRP.

Control over Readmissions

The CMS definition of readmission includes readmissions that are unrelated to the initial discharge and over which hospitals have little or no control.³⁵ For example, if a hospital discharges a pneumonia patient and that patient later returns to the hospital due to severe injuries sustained in an accident, the readmission counts for purposes of the HRRP, even though the hospital had no control over the circumstances that necessitated the readmission. Additionally, the readmission is attributed to the discharging hospital even if the patient is readmitted to a different hospital.³⁶ Thus, if an ambulance carries the pneumonia patient from the site of the accident to a different hospital, the discharging hospital will be penalized for the readmission and will not be able to lessen the penalty amount by providing care for the acute injury.

Given the limitations imposed by CMS's definition of readmission, Alliances should work with hospitals in their communities to monitor their ability to control readmissions and consider remedies if the penalty in practice presents an unnecessary burden that does not achieve the desired result of reducing potentially preventable readmissions.

Risk-adjustment Readmission Measure

The HRRP could have a disparate impact on hospitals that serve largely minority populations or those of low socioeconomic status (SES) because the risk-adjusted readmission measure does not include race or socioeconomic status.³⁷ Research indicates that readmission rates for minorities are higher than those for whites, but whether that disparity is the product of poorer quality of care in hospitals that predominantly serve minorities or of increased disease prevalence is unclear.³⁸

On the one hand, if higher readmission rates are due to a sicker minority population, then the failure to adjust for race-related risk would effectively penalize hospitals that provide care to large numbers of minority patients. On the other hand, if the readmission rate disparity

is due to poorer quality of care in hospitals that serve large minority populations, then inclusion of race and socioeconomic status would undermine the efficacy of the HRRP by shielding poorly performing hospitals from the penalty. CMS erred on the side of the latter view, but recognized that the selected measure could have a harmful impact.³⁹ Alliances should work with hospitals in their communities that predominantly serve racial minorities or persons of low SES to monitor the effect of the HRRP and report any adverse results to CMS.

Applicable Hospital and Payment Calculation

CMS will refine and clarify the definitions of "applicable hospital," "base-operating DRG payment amount," and "aggregate payments for excess readmissions," as well as establish the adjustment factor, in an upcoming cycle of rulemaking. Because the HRRP will take funding away from hospitals while simultaneously asking them to implement costly measures to lower readmission rates, CMS must consider the operating margin of hospitals when defining these terms.⁴⁰ Failure to do so could result in the HRRP penalizing a hospital that lacks the means to reduce their readmission rates. The Alliances are in an ideal position to understand the complex cost and efficacy considerations posed by the HRRP and therefore should comment on these issues through the rulemaking process.

Reducing Readmissions

Congress appropriated, in the ACA, \$20 million for the Center for Quality Improvement and Patient Safety (the Center), part of the Agency for Healthcare Research and Quality (AHRQ), to conduct research on quality and safety issues.⁴¹ Specifically, the ACA directs the Center to research "practical methods" of reducing readmissions for the purpose of establishing "practice recommendations."⁴² The Center has not released practice recommendations to date and has not indicated they are forthcoming. Consequently, hospitals will have little guidance as they begin to implement readmission reduction methods in preparation for the 2013 penalty.

The Alliances are well-positioned to provide information and practical recommendations for reducing readmissions based on their own quality improvement efforts. Alliances can do this by publishing a guidance document on implementation methods that focuses on issues such as cost-effectiveness, hospital size, and patient demographics. Additionally, Alliances can open lines of communication so that hospitals may learn from the successes and failures of others and facilitate the development and implementation of best practices.

- 1 Jenks SF, Williams MV and Coleman EA. "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program." *New England Journal of Medicine*, 360:1418, 1420 (2009).
- 2 Medicare Payment Advisory Commission (MedPAC). "Report to the Congress: Promoting Greater Efficiency in Medicare," 105, 108 [Hereinafter, "MedPAC Report"].
- 3 MedPAC Report, 105.
- 4 "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates" 72 Fed. Reg. 47130 (Aug. 22, 2007).
- 5 *ibid.*
- 6 Medicare Program, 105–106
- 7 Minott J. *Reducing Hospital Readmissions*. Washington: AcademyHealth, 5, 2008, <http://www.academyhealth.org/files/publications/Reducing%5FHospital%5FReadmissions.pdf>.
- 8 *ibid.*
- 9 MedPAC Report, 108.
- 10 MedPAC Report, at 112–113.
- 11 MedPAC Report at, 114–117.
- 12 Patient Protection and Affordable Care Act of 2010 (PPACA), (Pub. L. No. 111–148) § 3025 (a) 124 Stat. 119, 408 (2010).
- 13 Hospital Readmissions Reduction Programs (HRRP), 76 Fed. Reg. 51660 (Aug. 18, 2011).
- 14 PPACA § 3025(a), 124 Stat. 119, 408.
- 15 *ibid.*
- 16 PPACA § 3025(a), 124 Stat. 119, 411–12.
- 17 PPACA § 3025(b), 124 Stat. 119, 412.
- 18 *ibid.*
- 19 PPACA § 3025(a), 124 Stat. 119, 408–09.
- 20 *ibid.*
- 21 HRRP, 76 Fed. Reg. 51660, 51665 (Aug. 18, 2011).
- 22 *ibid.*; PPACA § 3025(a), 124 Stat. 119, 410.
- 23 PPACA § 3025(a), 124 Stat. 119, 410–11.
- 24 HRRP, 76 Fed. Reg. 51666.
- 25 PPACA § 3025(a), 124 Stat. 119, 408.
- 26 *ibid.*
- 27 PPACA § 3025(a), 124 Stat. 119, 409.
- 28 PPACA § 3025(a), 124 Stat. 119, 409–10.
- 29 *ibid.*
- 30 PPACA § 3025(a), 124 Stat. 119, 410.
- 31 *ibid.*
- 32 PPACA § 3025(a), 124 Stat. 119, 411–12.
- 33 *ibid.*
- 34 PPACA § 3025(a), 124 Stat. 119, 411.
- 35 *Trendwatch: Examining the Drivers of Readmissions and Reducing Unnecessary Readmissions for Better Patient Care*. Washington: American Hospital Association, September 2011, <http://www.aha.org/research/reports/tw/11sep-tw-readmissions.pdf> (accessed October 19, 2011).
- 36 HRRP, 76 Fed. Reg. at 51666.
- 37 Axon RN and Williams MV, "Hospital Readmission as an Accountability Measure." *Journal of the American Medical Association*, 305(5): 504, 505 (2011).
- 38 *ibid.*; Joynt KE, Orav EJ and Jha AK, "Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care." *Journal of the American Medical Association*, 305(7): 675 (2011).
- 39 HRRP, 76 Fed. Reg. at 51670–71.
- 40 *See generally* Stauffer BD, Fullerton C, Fleming N, et al. "Effectiveness and Cost of a Transitional Care Program for Heart Failure: A Prospective Study with Internal Controls." *Archives of Internal Medicine*, 171(14): 1238, 1241–42 (2011). (Describing the cost limitations of a transitional care program that appears successful in reducing readmissions for HF patients.)
- 41 PPACA § 3051, 124 Stat. 119, 508.
- 42 PPACA § 3025(a), 124 Stat. 410.