

issue brief

Bridging Research and Policy to Advance Medicare's Hospital Readmissions Reduction Program

Executive Summary

The Medicare Hospital Readmissions Reduction Program (HRRP) established by the Patient Protection and Affordable Care Act of 2010 (the ACA) took effect in Fiscal Year 2013 (October 2012). The HRRP establishes a formula for applying Medicare payment reductions for excess hospital readmissions. Initially, the program focused on readmissions for patients with heart attack, heart failure and pneumonia that occurred between July 2008 and June 2011. Penalties for excessive readmissions are set to increase from a maximum of 1 percent in 2013 to a maximum of 2 percent in 2014 and a maximum of 3 percent in 2015. In Fiscal Year 2015, the program will expand the applicable conditions to include excess readmissions for acute exacerbation of chronic obstructive pulmonary disease, elective total hip arthroplasty, and total knee arthroplasty.

In November, 2013, health care practitioners, administrators, clinical and health services researchers, and policy experts from private sector and government agencies and offices participated in a one-day meeting focused on the HRRP. The meeting was conducted by AcademyHealth for the Robert Wood Johnson Foundation's Changes in Health Financing and Organization (HCFO) Initiative. There was a clear consensus among meeting participants that the HRRP has become a focal point for hospitals' efforts to respond to growing pressure to reduce costs and increase the effectiveness and quality of patient care. But the discussion turned on more difficult questions about the HRRP:

1. What changes are actually taking place in admissions, outpatient and post-acute care, and readmissions as providers try to address readmissions in the wider context of Medicare reforms?
2. Do providers have the information and resources they need to help them design and implement changes that reduce avoidable inpatient stays (admissions and readmissions)? and
3. How well are payment incentives for reducing excess readmissions aligned across fee-for-service and more integrated delivery system models?

Meeting participants reached consensus on the need for some refinements to the current HRRP. There was clear support for the Medicare Payment Advisory Commission's proposed approach for balancing concerns about higher incidence of HRRP penalties being levied on hospitals serving low-income patients with the need to retain data transparency and meaningful incentives for all hospitals to reduce excess admissions. The proposed refinement would divide hospitals into deciles based on the share of low-income patients, and assess the HRRP penalties based on hospitals' performance compared to other hospitals in their decile. Participants also agreed that an all-condition readmissions measure would offer important advantages over the limited set of conditions addressed by the HRRP. This refinement would, however, require a change in law, and additional research, including analyses focused on the utility of separate measures for categories of care (e.g. surgical versus medical conditions), and on the comparative merits



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of measures focused on readmissions rates at the hospital level versus population-based measures.

A consistent theme that emerged from the discussion of HRRP incentives was the difference between the potential for driving quality improvement in the traditional Medicare fee-for-service program versus the innovative models that combine payments across groups of services, such as condition-based bundled payments and accountable care organization (ACOs) or other integrated care models.

There was general agreement that integrated care systems can provide a better foundation than fee-for-service Medicare for coordination of care and accountability that is prerequisite to reducing excess hospital admissions. They also agreed, however, that better alignment of financial incentives alone is not sufficient to drive improvements in care delivery and management needed to reduce excess hospital readmissions. Addressing significant gaps in both knowledge and practice that contribute to excess readmissions is equally, if not more important.

Overview

The Medicare Hospital Readmissions Reduction Program (HRRP) established by the Patient Protection and Affordable Care Act of 2010 (the ACA) took effect in Fiscal Year 2013 (October 2012). One component of the broader set of reforms designed to promote better coordination of care and drive improvements health care quality and reign in health care costs, the HRRP program administered by the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) initially established a formula for applying Medicare payment reductions for excess hospital readmissions for patients with heart attack, heart failure and pneumonia that occurred between July 2008 and June 2011. In the first year of the program, hospitals with readmissions exceeding the national average readmission rate for any of these conditions 3 conditions faced up to a 1 percent reduction in Medicare payments. As required by statute, the payment adjustment grew to a maximum of 2 percent

in 2014 and a maximum of 3 percent in 2015. In Fiscal Year 2015, the program will expand the applicable conditions to include excess readmissions for acute exacerbation of chronic obstructive pulmonary disease, elective total hip arthroplasty, and total knee arthroplasty.

While the HRRP applies precise definitions of excess readmission base set out in law and regulations, the effect of the payment incentives can be measured in terms of a variety of related but not always congruent policy goals. Is the goal to reduce admissions for the selected high-volume, high-risk conditions or all Medicare hospital discharges, or all Medicare readmissions? To reduce the total number of readmissions to acute care hospitals, or to reduce the percentage of hospital discharges that lead to a readmission within a fixed period (30 days)? To drive individual hospitals that have relatively poor performance on the readmission measures to improve, or to foster better care coordination that can reduce excess readmission throughout communities? Or are there multiple goals, and, if so, are the incentives embedded in the HRRP aligned across Medicare hospital and other service sectors?

Health care practitioners, administrators, clinical and health services researchers, and policy experts from private sector and government agencies and offices participated in a one-day meeting focused on HRRP conducted by AcademyHealth for the Robert Wood Johnson Foundation's Changes in Health Financing and Organization (HCFO) Initiative. The structured discussion built on participants' substantive knowledge of the available evidence as well as their experience as nationally recognized innovators in health care system redesign. Because the session was "off the record" participants were free to discuss issues openly and in-depth. The goals were to help inform decision makers who are responsible for implementing Medicare's HRRP about how the program is working now and to develop actionable recommendations for refining

the program going forward. Participants also identified gaps in knowledge that need to be addressed to better inform policy decisions about refining hospital readmissions payment incentives as well as more comprehensive strategies for aligning readmission policies with other reforms aimed at restructuring payments and quality improvement across the full spectrum of Medicare services. This brief summarizes participants' analytical insights and recommendations.

Hospital and Provider Responses to the HRRP

There was a clear consensus among meeting participants that the HRRP has become a focal point in hospitals' efforts to respond to growing pressure to reduce costs and increase the effectiveness and quality of patient care. CMS has announced that in FY 2014, there will be HRRP penalties of \$227 million levied against 2,225 hospitals.¹ Hospitals are actively engaged in efforts to reduce readmissions, and health care providers are seeking ways to redesign hospital processes as well as care coordination across hospital, subacute care facilities, and home and community-based primary care in response to HRRP.

Readmission rates are changing. Some limited preliminary analyses have shown a reduction in Medicare readmissions since passage of the ACA. Medicare Quality Improvement Organizations (QIOs) are using data reports to analyze readmissions data to work with local providers to identify problematic patterns or trends, and to identify areas for improvement. A descriptive analysis of Medicare 30-day, all-cause readmissions from 2007 to 2012 posted recently on the CMS website found a "meaningful decline" in 2012 for all Medicare fee-for-service beneficiaries.² Without more detailed analysis, however, it is not clear what may be driving declines in readmissions. Changes in readmissions could be the result of improved care management. But readmission rates could also be related to changes in the number and types of hospital admissions, reflecting

the changing Medicare patient case mix (e.g. the growing number of baby boomers entering the Medicare program along with the increasing population of older patients with multiple chronic conditions). Innovations that move the locus of care to outpatient and post-acute care settings may also be factors affecting readmission rates.

Participants also stressed that incentives to reduce excess readmissions are only one component of Medicare payment policy that might drive hospital behavior. Prospective payment provides clear incentives to limit the length of hospital stays. One participant noted, for example, that even when physicians know that a particular post-acute care facility can provide higher quality of care for patients discharged with a specific diagnosis, and that the facility has a better record of avoiding patient returns to the hospital, it can be very difficult for to convince administrative staff that the patient should remain in the hospital an extra day or two until a bed at that facility is available.

Quality reporting incentives are also taking on greater importance. In 2013, Medicare's Value-Based Purchasing program will redistribute a portion of hospital payment to inpatient hospitals based on performance measures that include mortality rates as well as readmissions for selected conditions, adding to hospitals' need to manage these patients effectively. Beyond hospital-specific payment incentives, the development of bundled payment and accountable care models may fundamentally change incentives to manage care across settings.

Observation status complicates efforts to evaluate readmission trends. A particular point of interest in the analysis of changes in readmission rates is the use, or overuse, of hospital observation status. Medicare payments for patients classified as receiving observation care are made under outpatient-based rules; observation stays are not counted as inpatient admissions. Hospitals may therefore have had an incentive to classify patients who need hospital care within 30 days of discharge as being in the hospital on observation

status to avoid having them identified as avoidable, or excess readmissions under the HRRP criteria. Some meeting participants indicated that observation status is increasing in response to HRRP. But others discussed data they have been analyzing that appear to show that observation stays within the 30 day window are not increasing more rapidly than observation stays to 31 to 60 days after discharge, suggesting that other incentives may be driving use observation status.

To address concerns about billing for observation status, CMS issued new rules (initially to take effect October 1, 2013, but with enforcement subsequently delayed to January 1, 2014) that define when hospitals can bill for extended observation rather than regular inpatient care. The new rules require that when patients remain in observation care for periods of time that encompass two midnights, the stays be reclassified as inpatient care. This could result in future increases in readmission counts.

The revised CMS rule does not address a second aspect of observation status cited by some providers and consumer advocates as a barrier to appropriate patient placement, however. Like observation days under current policy, stays initially assigned observation status that are redesignated as inpatient care under the revised rule still do not count toward the 3-day inpatient requirement that patients must meet to qualify for Medicare-covered skilled nursing facility care.³ Some experts believe that appropriate use of skilled nursing care could play a role in improving care management and avoiding both hospital admissions and readmissions.

Improving care management to reduce readmissions is a work in progress.

Hospitals focused on reducing readmissions are working actively to improve both inpatient processes and to do more to understand how to coordinate care post-discharge. Training programs such as the Care Transitions Education Project in Massachusetts have developed and implemented a curriculum for nurses within and across care settings (and in this example,

also brought in a local community colleges to promote education and training).⁴ Programs focused on linkages with community-based systems appear to show particular promise. Participants talked about some innovative programs that are linking different parts of the delivery system together using electronic patient data to identify patterns across different services. Other participants, however, have found that some new technologies targeted to helping consumer manage their care at home are not working as well as anticipated. Interactive monitoring or reminder systems may be too complicated for beneficiaries with serious, complex health care problems, many of whom have cognitive or sensory limitations. In one example, staff experimenting with an interactive home monitoring technology designed for patients with heart failure ended up deleting most of its content, leaving only a written message posted where the beneficiary could see it that said "If you weigh more than (___) call your doctor."

Meeting participants discussed a wide variation in hospitals' ability to respond effectively to HRRP incentives. Several participants described the frustration that clinical staff and patients and their families can experience when they receive confusing and sometimes conflicting information about post-discharge care options. One participant described efforts to work with hospitals to implement comprehensive management strategies that included training clinical staff in the use of data analysis methods, implementing specialized protocols, and developing relationships with subacute and community-based providers. He noted that sometimes when hospitals call to inquire about getting help, they are dismayed to hear how much might need to be done to achieve meaningful improvement in reducing excess admissions.

Participants expressed concerns about the limited utility of predictive models in identifying patients at risk of readmission. Even when hospitals or integrated care systems have clear financial incentives to reduce excess readmissions and the resources and leadership to take action, there are gaps in knowledge about what strategies are actu-

ally effective for which types of patients, both with respect to clinical care and to the even less understood aspects of care transitions and coordination with community-based primary care. They suggested that there needs to be greater emphasis on understanding condition-based care coordination, but also more research on how clinical management interacts with factors such as individual patients' cognitive and emotion status, home situations, community resources, cultural factors and provider cultural competence. Participants said that gaps in evidence-based research leave them having to cobble together what evidence-based information there is on techniques and tools that can address distinct aspects of care management, post-hospital care, and primary care to address readmissions. They also expressed the view that in the current environment resources for quality improvement (e.g., QIO technical assistance and education initiatives) are being redirected to program integrity and oversight.

Strengthening Medicare Readmissions Reduction and Associated Payment Policies

Meeting participants reached consensus on some refinements to the current HRRP program and on broader charges that could help drive Medicare's fee-for-service program toward greater coordination and accountability of care that is prerequisite to reducing excess hospital admissions and health care costs.

Revise payment penalties for hospitals serving lower-income patients Among the most serious concerns about the HRRP is whether the methodology leads to an unfair level of penalties for hospital serving a greater than average percentage of low income patients or patients living in areas where income and community resources are limited. Analysis conducted by the Medicare Payment Advisory Commission (MedPAC) found that under current policy major teaching hospitals incur the largest penalties. But MedPAC also found that hospitals incurring the highest penalties are more likely to be receiving Disproportionate Share Hospital (DSH) supplemental payments, intended

to defray the cost of treating high shares of low-income patients.⁵ Hospitals with a higher share of low-income patients measured as the proportion of patients eligible for Supplemental Security Income (SSI) tended to have more readmissions and higher penalties under the HRRP program. MedPAC's analysis showed that the percentage of patients eligible for SSI was a stronger and more consistent predictor of readmissions than either race or DSH percentage.⁶

Meeting participants expressed clear support for MedPAC's proposed approach for balancing concerns about unintended burden on hospitals serving low-income patients with the need to retain meaningful incentives for all hospitals to reduce excess admissions. After extensive discussion, the meeting participants generally agreed with the arguments articulated by CMS and the National Quality Forum and MedPAC, that incorporating income into the risk adjustment methodology would have the effect of "accepting poor performance by hospitals that serve poorer patients." Rather than including income in the risk-adjustment model used in calculating expected rates that are then compared to actual readmissions, MedPAC proposed a refinement that would divide hospitals into deciles based on share of low-income patients, and assess the HRRP penalties based on hospitals' performance when compared to other hospitals in their decile. This would reduce or eliminate penalties for better performing hospitals with higher shares of low income patients even though their readmission rates are not as low as the best performing hospitals with lower shares of low-income patients. At the same time, this approach would still provide incentives for all hospitals to reduce excess admissions.

Move toward all-condition readmission measures in HRRP. Meeting participants also discussed a set of issues that are associated with the HRRP program's focus on a small albeit important set of conditions. For small hospitals, the number of cases does is insufficient to generate reliable performance measures, and, as MedPAC noted in its June 2013 report, it is difficult

to distinguish between random variation and performance problem based on a small number of conditions. Further, hospitals are subject to HRRP penalties when they are found to have excess readmissions for any condition of the HRRP conditions; hospitals that have a low rate of readmissions for other HRRP conditions or for Medicare admissions as a whole are penalized along with hospitals that are performing poorly across the board.

Measuring readmissions for all Medicare admissions would alleviate methodological issues related to small numbers of cases and the uneven penalties associated with the focus on a small number of cases. In addition, it could help focus attention on how a spectrum of quality measures and care coordination processes fit together. The researchers and practitioners discussed the complex interaction between readmissions, quality measures such as mortality and complication rates, and socio-demographic factors that need to be explored. While there was consensus that all-condition measures should be used in the HRRP, they did not believe that this could be accomplished quickly. Although hospitals are already required to publicly report all-condition readmission rates, replacing the current HRRP methodology with an all-condition measure or set of measures would almost certainly require a change in the law. More discussion may also be needed on how to define readmission measures that would be fair to both providers and consumers and provide useful information that would drive quality improvement.⁷ In particular, discussants cited the need to explore the utility of separate measures for categories of care (e.g. surgical versus medical conditions), and of measures focused on readmissions rates at the hospital level versus population-based measures.

Work toward a better understanding of what readmissions rates should be.

The HRRP methodology pushes hospitals to continually decrease excessive readmissions. Some analysts argue that incentives should be based on performance relative to the appropriate rate of readmissions, that is, target rates that are derived by research

on effective care delivery and management.⁸ There was consensus among the meeting participants, however, that the knowledge base for setting targets is lacking. Several experts also argued that the weight of evidence now suggests that there are far too many avoidable readmissions, and that the benefits of keeping hospitals focused on continuous improvement outweigh threats that HRRP incentives could eventually lead hospitals to not readmit patient when it is appropriate.

Focus on longer-term reforms to better align acute and post acute services. A consistent theme that emerged from the discussion of HRRP incentives was the difference between the potential for driving quality improvement in the traditional Medicare fee-for-service program versus the innovative models payment models, specifically, condition-based bundled payments and ACOs or other integrated care models. Hospital-based providers have only a limited understanding of “what went wrong” when there are readmissions that should not have been needed. Home and community-based primary care can be essential components of post-discharge care, but the flow of information between hospital and post-acute care providers is sparse. Most hospitals do not generally know if discharged patients are readmitted to other hospitals, much less have information on the primary and supportive services discharged patients receive. Several meeting participants called for more systematic studies that follow patients after discharge to provide insights about the interaction of post-hospital care, home environment and physical and mental health affect the risk of return to the hospital

Conclusion

The Medicare program is just beginning to grapple with strategies to align payment incentives for subacute care providers to promote appropriate and effective care that can reduce both hospital admissions and readmission.⁹ Other reforms, including the physician quality incentives that are now coming on line, offer opportunities to look across entire episodes of care.

Some participants raised the possibility of linking the physician payment modifier calculation to hospital readmission rates. At the same time, a number of discussants expressed the view that refinements to fee-for-service payment, including the HRRP, were less likely to lead to the system-wide changes in care coordination needed to substantially reduce excessive readmissions.

Participants agreed that integrated care models provide stronger, clearer incentives to understand and improve care transitions, communication with post-acute care providers, and to create better linkages with community-based primary care providers. They noted that in one market where ACOs are responsible for a large proportion of Medicare patients, hospitals have gained leverage because they can steer a high volume of Medicare patients to facilities that provide effective, high-quality, post-hospital care.

There was general agreement among meeting participants that the better alignment of financial incentives in integrated care systems provides a foundation for improving care management and reducing excess readmissions. But they also noted that hospitals have limited experience and expertise working with community-based providers and support services. One participant suggested that care systems could become “too integrated”, referring to concerns about hospitals’ historical focus on acute care in isolation from primary care. Integrated care systems will need new investments in education, technical assistance, and ongoing research and evaluation to overcome a historical lack of involvement subacute and primary care management. In concluding remarks, participants agreed that better alignment of financial incentives alone will not be not enough to drive improvements needed to reduce excess hospital readmissions. Addressing significant gaps in both knowledge and practice that contribute to excess readmissions is equally, if not more important.

About the Author

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Endnotes

1. Eighteen hospitals will be assessed the maximum 2 percent fine, and 154 will be penalized by one percent or more. Jordan Rau, “Armed with Bigger Fines, Medicare to Punish 2,225 Hospitals for Excess Readmissions” Kaiser Health News, August 2, 2013. Available at <http://www.kaiserhealthnews.org/stories/2013/august/02/readmission-penalties-medicare-hospitals-year-two.aspx>. Accessed November 7, 2013.
2. The descriptive analysis drew on claims information from the Chronic Condition Data Warehouse, and compared unadjusted monthly readmissions for hospitals participating in the Partnership for Patients program to hospitals not participating both overall and by number of inpatient beds at each facility. Claims information for 2012 was not complete at the time of the analysis, but the preliminary analysis found that during 2012 readmission rates fell by 1 to five percent in 166 out of a total of 306 hospital referral regions nationally, and by more than 5 percent in another 73, while increasing in only 30 regions. Readmission rates fell among both the participating Partnership for Patients program and non-participating hospitals. Gerhardt, Geoffrey, Yemane, Alshadye, Hickman, Peter, et al, “Medicare Readmission Rates Showed Meaningful Decline in 2012”, Medicare & Medicaid Research Review, Vo; 3, No 2, 2013. The article is posted at <http://www.cms.gov/mmrr/Briefs/B2013/mmrr-2013-003-02-b01.html>.
3. The revised rule has been opposed by the hospital industry and patient advocates, the former believing that the new policy is confusing and difficult to administer, and the latter that it leaves beneficiaries who do not meet the two midnight criteria exposed to considerable outpatient cost sharing. A letter signed by 109 members of the U.S. House of Representatives urged CMS to delay enforcement of the new rule for 6 months to allow time to rework the rules. Susan Jaffee, Medicare Delays Enforcement of Observation Rule, Kaiser Health News, September 27, 2013. Found at <http://capsules.kaiserhealthnews.org/index.php/2013/09/medicare-to-delay-enforcement-of-new-observation-rule/?referrer=search>. Accessed November 7, 2013.
4. A Description of the CTEP program can be found at http://www.maseniorcarefoundation.org/initiatives/care_transitions.aspx.
5. Addressing perceived burden on hospitals serving lower-income patients takes on additional importance in the light of ACA provisions reducing DHS payments. Beginning in 2014, provisions of the ACA will significantly reduce Medicare (as well as Medicaid) DHS payments because fewer patients, including low-income

patient, are expected to be uninsured and unable to pay for inpatient services. Effective for discharges occurring on or after FY 2014, hospitals will receive 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The other 75 percent of what otherwise would have been paid as Medicare DSH will become available for an uncompensated care payments after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive an uncompensated care payment based on its share of insured low income days (that is, the sum of Medicaid days and Medicare SSI days) reported by Medicare DSH hospitals. CMS, “Changes to Medicare DSH: Section 3133 of the Affordable Care Act” posted at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html>.

6. MedPAC’s analysis of the readmission program and recommendations for refining the program are presented in its June, 2013 Report to the Congress, Medicare and the Health Care Delivery System, Chapter 4, available at http://www.medpac.gov/documents/Jun13_EntireReport.pdf.
7. The participants noted that several readmissions measures are currently being used widely, and noted in particular National Quality Forum’s endorsement of two measures that address all-cause unplanned readmissions in hospitals, available at http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_All-Cause_UnplannedReadmissions_Measures.aspx/
8. MedPAC’s analysis of readmissions (note 6) presented in its June 2013 Report to the Congress included a discussion of establishing target rates for readmissions.
9. Several discussants suggested that there are important opportunities for augmenting readmissions reduction incentives as part of a larger effort to introduce value-based payment in sub-acute care sector (home health, skilled nursing facility, long-term care hospital, and inpatient rehabilitation facility care). A letter signed by Majority and Minority Chairs of the Medicare committees of jurisdiction expressed a strong interest in moving to value-based purchasing, bundled payments, and other quality incentives for sub-acute services to reduce Medicare costs and drive better care coordination and management of care for beneficiaries. The letter is available at http://waysandmeans.house.gov/uploadedfiles/pac_letter.pdf.