Hospital Readmission Prevention Program - Time for a Paradigm Shift

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The Hospital Readmission Prevention Program - Time for a Paradigm Shift

Background - Section 3025 of the Accountable Care Act (ACA) outlines the details of the Hospital Readmission Reduction Program (HRRP) which limits payments to hospitals with excessive Medicare readmissions. The HRRP provides a financial incentive to hospitals to lower readmission rates. Effective Oct. 1, 2012, CMS began penalizing hospitals for what it determined to be excessive avoidable readmissions, arbitrarily set at >14%. The penalties are grounded in the belief that clinicians should and would improve transitions of care and ensure that patients and caregivers are educated about their care before they leave the hospital. Additionally, hospitals are held accountable for the collaboration and coordination with patients, caregivers, physicians and community agencies in the transition of care processes to improve patient care post discharge.

Available data at that time painted a very gloomy picture of care provided in hospitals. According to the Agency for Healthcare Research and Quality (AHRQ), 90% of readmissions within 30 days appeared to be unplanned, the result of clinical deterioration, and 75% were reported to be preventable in a MedPAC (Medicare Payment Advisory Commission) report of June 2008. The figures remain mostly unchanged as evidenced by a recent article in Annals of Internal Medicine (12/05/2018) indicating that 36% of readmissions within seven days of discharge were preventable [1].

The HRRP does not apply to all conditions. Rather, it focuses on specific disease conditions cited in the 2007 "Report to Congress: Promoting Better Efficiency in Medicare." MedPAC identified several conditions and procedures that accounted for 30% of potentially preventable readmissions. Currently HRRP includes: Acute Myocardial Infarction (AMI), Coronary Artery Bypass Grafting (CABG) surgery, Heart Failure (HF), Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, and Total Hip Arthroplasty/Total Knee Arthroplasty. At present, 81% of the acute care hospitals in the US are receiving readmission penalties [2]. It is important to note that HRRP does not include Cancer hospitals, Acute Rehabilitation hospitals, Long-Term Acute Care, Pediatric and Behavioral Health inpatient admissions.

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Definition of Readmission - “An all-cause admission to an acute care hospital within 30 days of a discharge from the same or another hospital for the same or a different diagnosis” [3]. Based on this definition, if a patient is readmitted but expires during the readmission, it

will be excluded from calculation. The rate of patient death during readmissions is not known.

Program Faults and Shortcomings - HRRP has several major flaws:

1- **Program Design**:
   A. There is no scientific data that supports 30 days as the interval for readmissions. (Our analysis indicates that for most diagnoses, the accurate measure is between 45 and 60 days).
   B. By allowing only a limited number of diagnoses, HRRP allowed potential gaming of the system such as by allocating resources to only a subsection of admissions that count rather than improve the overall delivery of care. This may have resulted in unintended consequences such as an increased rate of death following premature discharges for congestive heart failure. It should be noted that the 21st Century Cures Act asked MedPAC to assess the decline in relation to increases in observation stays and emergency department (ED) visits. MedPAC found that the penalty program did lead to lower readmission rates but was not the sole cause of increases in observation stays and ED visits [2]. Another factor is coding changes permitted by CMS that may have driven reductions in readmission rates by allowing an increase in reported diagnosis codes that impacted the risk-adjustment calculation CMS uses to determine changes in readmission rates [4].
2- The program does not require proof of continuous quality improvements.
3- There are no penalties or denied reimbursement for those physicians who inappropriately discharged patients when their care was not optimized or if patients were discharged to the wrong destination or level of care.
4- Hospitals classified as "Number of Cases Too Small" are exempt from inclusion.
5- The penalties are minimal, and most hospitals are treating them as just a cost of doing business.
6- The analysis is based on the use of raw claim-based data and with no provisions for Social Determinants of Health or Risk severity [5].
7- There is a major flaw in the formula that calculates the penalty. For example, this results in receiving penalties for joint replacements with penalties several time the cost of the original DRG. This is evidenced by MedPAC, who in their June 2013 Report to Congress [6] provided a simplified example of how the calculation overly penalizes providers.

Penalties - Attention to the readmission issue was due to its identification as a cost containment initiative, and this initial focus resulted in a brief decline in the national rate of readmissions from 19.8% in 2008 to 17.8% in 2013. The next phase of expansion included the addition of more diagnoses, increasing maximum penalties from 1% to 3%, and then changing the calculation base from an annual to a 3-year average performance [7]. Recent

analysis of penalty data from 2013 to 2017 for 3,229 acute care hospitals revealed that 52.4% were penalized all five years [5]. And hospitals that were penalized in the first year of the program were more likely to continue to be penalized, and to be penalized more, throughout the program. In 2017, the total financial penalty for the hospitals which received the maximum 3% penalty was approximately $11.6M, or an average of about $305K per hospital. The average penalty in 2018 was $217K [2] which indicates more hospitals are receiving penalties and the number of those with maximum penalty doubled to 6% in 2018 [2].

The reality is that the US is dealing with an inefficient and fragmented healthcare delivery system that resists regulatory and financial pressure

This abatement failure is multifactorial and may be the result of a continued lack of understanding of the root causes, lack of resources, lack of market demand or differentiation, and/or insignificant penalties. It also may signal that certain hospitals are indifferent to or non-supportive of this national initiative.

It is the authors' experience, that the current reported readmission rates are understated. Exclusion of patients who expired during readmissions artificially reduces the readmission rate. The Two-Midnight-Rule may erroneously classify an Inpatient admission as an Observation. Observation stays and prolonged care in the ED, by increasing the time interval between admissions, also results in underreporting of the incidence of readmissions. Finally, coding changes also artificially lower the readmission rate by allowing more diagnoses to be listed on inpatient claims [4].

Surprisingly, there has been very little focus on best practices and sharing those best practices that have resulted in better readmission rates for the 19% of the acute care hospitals that are not penalized. It should also be noted that there is no additional reimbursement for best-in-class (lowest) readmission rates. There has been little valid information made available not only to the public but also to patients deciding on where or where not to receive care at a selected hospital.

Over the past decade, readmissions have refused easy solutions and resisted penalties. This is a perfect example of a need for a paradigm shift

More troubling is the fact that in 2018, CMS implemented a similar program for Skilled Nursing Facilities (SNFs) [8]. The program impacts 73% of SNFs, or roughly 11,000 facilities nationwide, and may have more deleterious effects on SNFs as their operating margins are lower than those of hospitals and the potential cost reduction activities needed to mitigate the losses from the penalties may further impact care delivery and outcomes.

In summary, readmissions have become an increasingly painful and public problem for hospitals in financial, competitiveness and patient care related issues. Nationwide, in 2017 the all-cause 30-day readmission rate for acute care facilities and SNFs was 17.8% and 28.2% respectively**.** While no easy fix exists to prevent readmissions, hospitals and health systems must take a proactive approach by accepting readmissions as a real problem and allocating the appropriate resources needed to fully understand the problem at hand, as well as enlisting the involvement of the many different groups that can contribute to a successful readmission prevention initiative. As a public policy matter, the readmission problem remains a disturbing national issue, one that reflects a fragmented care delivery system with divergent interests, misaligned incentives, lack of focus on patient needs, absence of information sharing and interoperability, as well as an antiquated, ineffective payment model. Over the past seven years HRRP has failed to achieve its desired goals, warranting the need for a paradigm shift [9]**.**

Potential Solution - In a recently published article in NEJM, it was suggested that HRRP needs rebooting [14]. However, while the NEJMs findings and recommendations have merit and deserve some consideration, HRRP needs to be overhauled, not rebooted. Rebooting will bring us to the same starting point and will not improve outcomes nor lower readmission rates. What is needed is a new system based on two fundamental components: **patient-centered care** and a **new financial model** for hospitals.

- **Patient-centered Approach -** CMS should require hospitals to readily demonstrate a readmission prevention and quality program based on continuous quality improvement. This may include implementation of new tools to identify individuals who are at high risk, proof of a fully implemented and functional Transition of Care Program [10], and ensuring that every single person is discharged with an evidence-based, real-time, readmission prevention plan that provides care and information continuity. New performance measures focused on APU (avoidable / preventable / unnecessary) readmissions, individuals with multiple readmissions within a 12- month period, and the correct calculation of readmission rates should all be included. Creation of new partnerships is critical for the success of the program [11]. New technologies, such as Artificial Intelligence, Mobile Platforms, Virtual Healthcare**,** Nanomedicine, Decision Support, Virtual Reality, 3D Printing and Robot-Assisted Surgery, will revolutionize care delivery and will be major partners in the coming years. In addition, technology companies such as Amazon, Google,

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Apple and Facebook will play a major role in providing technology solutions and provision of direct care to consumer care.

- **Replacement of the penalties with a new reimbursement model for readmissions** - An all-inclusive single payment that combines all the costs (the index admission and readmission, OP surgery, ASC, ED, specialty drugs, imaging, SNF, transportation, dialysis, professional fees, etc.) for 60 days after the discharge day and for every single discharge. The new model would make the hospital the PAP (Principal Accountable Provider), the one who is responsible to pay all other costs anywhere after a discharge. This approach will be geared towards what matters, drive the use of proven and evidence-based care, and ultimately will result in the elimination of waste and inefficiencies, utilization and overutilization of less effective treatments (e.g., duplicative imaging, low yield procedures), and confront underutilization of effective but less used techniques (e.g., patient and caregiver engagement, home-based care). It should be noted that this proposed model is very different than the abandoned CMS bundled payment model [12] [13].

Few industries are as complex as healthcare, and at the same time, many healthcare organizations are run by a culture that is not geared to collaboration and integration. There is a very high likelihood that the new approach will make hospitals and their staff physicians more attentive, cooperative and focused on improving quality of care and satisfaction which will result in improved health outcomes and lower readmissions.

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References:

1. Preventability of Early vs. Late Hospital Readmissions in a National Cohort of General Medicine Patients https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6247894/
2. Data Points: Reducing readmissions, Modern Healthcare, https://www.modernhealthcare.com/safety-quality/data-points-reducing-readmissions?utm_source=modern-healthcare-am-friday&utm_medium=email&utm_campaign=20190412&utm_content=article9-readmore
3. Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program
4. http://kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/
5. Decreases In Readmissions Credited To Medicare's Program To Reduce Hospital Readmissions Have Been Overstated https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05178
6. Readmission reduction program persistently penalizes some hospitals, study finds

http://www.beckershospitalreview.com/quality/readmission-reduction-program-persistently-penalizes-some-hospitals-study-finds.html

7. CMS Penalty Calculations
   https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html
8. 2,573 hospitals will face readmission penalties this year. Is yours one of them?
   https://www.advisory.com/daily-briefing/2017/08/07/hospital-penalties
9. Most skilled-nursing facilities penalized by CMS for readmission rates
   https://www.modernhealthcare.com/article/20181128/NEWS/181129930
10. Readmission Prevention Management Program, A reliable solution for managing the problems and costs associated with hospital readmissions
    https://avixena.com
11. Hospitals must create stellar post-acute care networks to meet new Medicare payment models
    https://home.modernhealthcare.com/clickshare/authenticateUserSubscription.do?CSProduct=modernhealthcare-metered&CSAuthReq=1:SVhKQjQ0VittRmNTTW9lVzlrb:AID:3D50C12C0E01FF9643FFAC796EC270AB&AID=/20161214/NEWS/161219982&title=Hospitals%20must%20create%20stellar%20post-acute%20care%20networks%20to%20meet%20new%20Medicare%20payment%20models&CSTargetURL=http://www.modernhealthcare.com/article/20161214/NEWS/161219982?utm_source=modernhealthcare&utm_medium=email&utm_content=20161214-NEWS-161219982&utm_campaign=dose
12. Viewing post-acute care in a new light: Strategies to drive value; Deloitte Center for Health Solutions, 2016
    https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-post-acute-care-innovation-report.pdf
13. CMS delays start of mandatory bundled-payment models
    http://www.modernhealthcare.com/section/search#stq=CMS delays start of mandatory bundled-payment models&stp=1
14. AMA praises CMS bundled-payments program
    http://www.modernhealthcare.com/article/20110824/MODERNPHYSICIAN/308249997
15. The Hospital Readmissions Reduction Program — Time for a Reboot. Rishi K. Wadhera, M.D., M.P.P., Robert W. Yeh, M.D., and Karen E. Joynt Maddox, M.D., M.P.H. June 13, 2019 N Engl J Med 2019; 380:2289-2291DOI: 10.1056/NEJMp1901225
    https://www.nejm.org/doi/full/10.1056/NEJMp1901225