Quality Resource Brief

TRIPLE AIM ACHIEVEMENT • MAY 2015

The Strategic Quality Initiatives division of the Missouri Hospital Association will periodically release tips and tools to assist hospitals in achieving the Triple Aim – better health, better care, lower costs. These resources, and many more, can be accessed at www.mhanet.com/strategic-quality

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Readmissions

To encourage efforts to reduce readmissions, Congress created the Hospital Readmissions Reduction Program as part of the Affordable Care Act in 2010. Of the three penalty programs created by the ACA, the HRRP is the most significant for fiscal year 2015 inpatient payments.[i] Through the ACA, the Centers for Medicare & Medicaid Services is instructed to penalize hospitals with higher than expected readmissions for specific clinical conditions such as AMI, pneumonia and heart failure.[ii] In FFY 2015, chronic obstructive pulmonary disease and hip and knee replacements were added to the list of clinical conditions. The HRRP payment penalties took effect in FFY 2013, and hospitals can now incur a penalty of up to 3 percent of their base operating Medicare diagnosis-related group payments[ii] — the maximum penalty defined by the ACA.

Readmissions at a Glance	
Who?	Patients readmitted to the hospital within 30 days of discharge for certain clinical conditions and associated ICD-9 codes
What?	Acute care, inpatient prospective payment system hospitals are affected by the penalty. The HRRP currently excludes critical access hospitals and post-acute care providers. The law currently includes patients with a primary discharge diagnosis of: • acute myocardial infarction • pneumonia • congestive heart failure • chronic obstructive pulmonary disease • hip and knee replacements
When?	MS-DRGs and clinical conditions are updated with every new FFY; CMS may or may not delete and/or add clinical conditions and ICD-9 codes for relevant conditions with an evidence-based indication of ability to prevent recurring readmissions.
Why?	The HRRP was designed to: • require hospitals to engage providers in preventing readmissions • encourage providers to engage patients in their care • decrease health care spending
How?	A few recommended strategies to reduce readmissions and improve care coordination are: • health care-risk identification and stratification • reliable health care within the four walls of the hospital/health system • reliable health care outside the four walls of the hospital/health system • streamlined and reliable coordination of care both inside and outside the four walls of the hospital/health system • patients and families engaged in self-management of their health

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Federal fiscal year 2017 adds coronary artery bypass grafts.

CMS has the authority to include percutaneous transluminal coronary angioplasty in the future. It is unknown when PTCA will be included.

READMISSIONS RATIO METHODOLOGY

A hospital's excess readmission ratio is a measure of a hospital's readmission performance. The hospital's patient ratios are compared to the national average sampling of patients with the applicable condition. The ratios are risk-adjusted, which includes adjustment for factors that are clinically relevant, such as comorbidities and patient frailty. The risk-adjustment methodology is endorsed by the National Quality Forum and is based on a rolling, three-year period of discharge data with a minimum of 25 patient cases per clinical condition considered necessary for a hospital to be included and receive a readmissions ratio.

Beginning in FY 2015, the law allowed the Secretary of the U.S. Department of Health & Human Services to expand the list of conditions. Chronic obstructive pulmonary disorder and total hip and knee replacement now are included as measures eligible for reimbursement penalty.[iii] Due to the inclusion of these two additional conditions, approximately 12 percent of hospitals are now set to receive a readmissions penalty. A small subset of hospitals that have not previously had any reimbursement penalty now will incur the maximum 3 percent penalty in FY 2015.[i]

ADVOCATING FOR HRRP POLICY CHANGES

Now, three years into the HRRP, two issues are apparent and having a negative impact on Missouri hospitals.

- **Penalizing hospitals for unrelated admissions that occur within 30 days of the original hospitalization.**
  - While hospitals feasibly have the ability to mitigate readmissions due to the same or related clinical condition, penalizing them financially when patients are readmitted because of unrelated reasons should be excluded from the readmission measures. Interestingly, the ACA requires that unrelated readmissions be excluded from the program; however, CMS has not fully implemented this policy. For example, a patient may have an index admission for pneumonia and be readmitted within 30 days for a hip fracture. The diagnosis of hip fracture is not the same as the index admission, but the current methodology counts this event as part of the readmission penalty.[iii]
- **Key patient and community sociodemographics are not included in readmissions methodology.**
  - The policy does allow for risk-adjustment of readmission ratios, but excludes many pertinent sociodemographic and socioeconomic characteristics that have been linked to an increased risk for readmission. Excluding this information takes additional critical resources away from Missouri's most resource-constrained providers and further limits capability to meet policy demands.[iii]
  - MHA and the Hospital Industry Data Institute[iv] have contributed to research advocating for revised readmissions methodology to support member hospitals.[v]

During the 113th Congress, the American Hospital Association supported the Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2014 (H.R. 4188), which would have adjusted the HRRP to account for certain socioeconomic and health factors that can increase the risk

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of a patient's readmission, such as being dually-eligible under Medicaid and Medicare. The bill did not pass, and the 114th Congress continues to propose language to adjust for SES. The current bills in review are H.R. 1343 and S.688. The AHA and MHA continue to review and advocate for inclusion of socioeconomic and health factor indicators.

Coordinating the care and services for patients with clinical conditions requiring ongoing care and follow-up is a daunting task; however, not doing so contributes to health risks for the patient and financial risks for the hospital. While hospitals and health care systems have put forth considerable efforts to mitigate a patient's likelihood to be admitted, more can be done:

- streamline care pathways that extend beyond the four walls of the hospital
- ensure reliable and standardized communication pathways among responsible providers
- engage patients and families in care that meets their current needs with consideration to socioeconomic conditions, health literacy levels, access to resources, supportive networks and health motivating factors

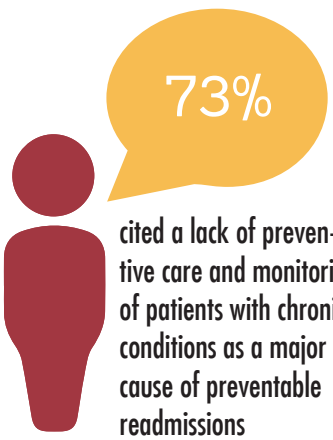
Historically, health care processes and strategies have been approached from the perspective of those providing the care, not those receiving it. Providers can design processes and systems of care, but if they don't work for the patient's lifestyle and needs, then they truly are of no value. So, how do hospitals reduce readmissions? A four-pronged strategy is recommended:

- coordination of care inside the four walls of the organization
- coordination of care outside the four walls of the organization
- data infrastructure and analytics for real-time solutions
- developing community and regional coalitions/partnerships to develop community resources and resiliency

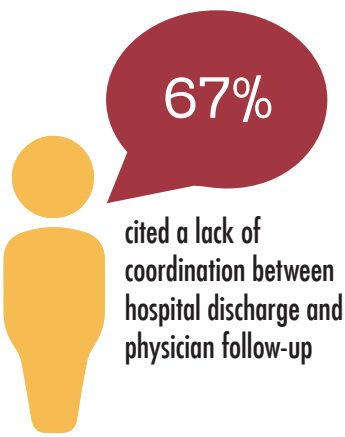
MHA recommends addressing patient, provider, and system reliability factors as they relate to each of the four strategy components as well.

MHA is producing a series of Quality Resource Briefs to further detail this four-pronged strategy. Share this information within your organization to educate staff and providers on addressing readmissions reduction. MHA also encourages members to strategize your capability to not only reduce the potential financial impact on your organization, but also to consider the Triple Aim of better care, better health and lower costs. Missouri hospitals can make a difference in the lives of those who live in our communities.

In 2013, a survey of 106 senior leaders at 44 U.S. health systems, conducted by HealthLeaders and Amedysis, Inc., noted the following.



cited a lack of preventive care and monitoring of patients with chronic conditions as a major cause of preventable readmissions



cited a lack of coordination between hospital discharge and physician follow-up

cited poor accountability for who is responsible for patient follow-up as major reasons driving readmissions[vi]

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REFERENCES

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[ii] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

[iii] American Hospital Association Factsheet. (2014, April). ***Hospital readmissions reduction program.***

[iv] Reidhead, M. (2014, October). Hospital quality spotlight on readmissions. ***HIDI HealthStats.*** Retrieved from http://web.mhanet.com/uploads/media/HIDI_HealthStats_October_Readmissions_1.pdf

[v] Nagasako, E., Reidhead, M., Waterman, B., & Dunagan, W. Adding socioeconomic data to hospital readmissions calculations may produce more useful results. ***Health Affairs, 33,*** no.5 (2014):786-791.

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