

(Re)Admissions
Payment & Policy:
CMS Perspective

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Financial Impact of Readmissions

- Department of HHS Estimates for healthcare cost savings from 2010 to 2019
 - \$1.211 billion with a hospital Value-Based Purchasing (VBP) Program payment framework implemented
 - \$8.43 billion if focus on readmissions included with VBP Program
 - \$16.1 billion if a bundled acute/post-acute care payment framework added

Hospital Readmissions

- Recent NEJM article once again documenting the problem
 - 1/5 Medicare patients are readmitted within 30 days following discharge from hospital
 - This finding has been known for years
 - Observed in commercial, Medicare, Medicaid and other payer settings
- Discussions often focus on excuses for findings
 - Risk adjustment of metrics isn't sufficiently comprehensive
 - Provider settings can't control many contributing factors
 - Causes are complex and there are many barriers to addressing
 - Not all readmissions are preventable
 - Improvement activities an unfunded mandate
 - Solutions lead to lost revenue for hospitals
 - No incentive to address the problem without payment reform

Hospital Readmissions

- Although addressing high hospital readmission rates has multiple challenges, the time for action is long overdue
 - Current CMS metrics are risk-adjusted
 - There are evidence-based interventions that:
 - Work, without having to address every barrier or challenge
 - Are arguably part of good discharge planning already
 - Required by hospital Conditions of Participation
 - Reimbursed under current IPPS payment systems
 - Address a significant number or preventable readmissions
 - Should be utilized while addressing larger healthcare reform
- Healthcare Reform begs for action on this issue

CMS Action Strategies

- Readmission Metrics Development
- Data Collection and Validation Design
- Evidence-Based Interventions
- Demonstrations
- Utilization of Readmission Metrics
 - “Traditional” Quality Improvement
 - Public Reporting and Transparency
 - Incentives (and/or Disincentives), Payment Reform
- Regulatory Oversight
 - Conditions of Participation and Conditions for Coverage
 - Contractor contractual requirements
 - Survey & Certification Process
 - Beneficiary Complaint Process

Readmission Metrics Development

- Risk-standardized 30-day readmission measures
 - Congestive Heart Failure
 - Acute Myocardial Infarction
 - Pneumonia
 - Represent about 46% of Medicare readmissions
- Developed by CMS under contract with Yale and Harvard Universities
- Methodology published in peer-reviewed literature
 - Also subjected to public comments in various venues, including public rulemaking

Readmission Metrics Development

- Comply with standards set by the American Heart Association and the American College of Cardiology
- Estimated with Medicare administrative data using models validated against medical record-based abstraction models
 - Results of the models with administrative claims and enrollment data were shown to be highly correlated with the results of models based on clinical data
- Endorsed by the National Quality Forum
- Adopted for reporting by the Hospital Quality Alliance
- Tested in advance of implementation
- Linked to Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) & Hospital Compare

Data Collection & Validation

- Claims and administrative data
- Chart abstraction
- Registries
- Electronic Health Records
- Many issues come up
 - Burden to providers, payers and other stakeholders
 - Accuracy and how to validate results
 - Review of results by provider
 - Attribution
 - Single provider
 - Chains, Accountable Care Organizations, ?other
 - How accurate must data be for various uses

Evidence-Based Interventions

- Pre-discharge education
- Discharge medication programs
- Comprehensive Discharge planning
- Post-discharge appointment, the sooner the better
 - Home visits by RNs and/or physicians
- Inconclusive
 - Telephone follow-up
 - Home telecare monitoring
 - Post-acute care tool across settings

CMS Demonstrations

- **Readmissions in Medicare Premier Hospital Quality Incentive Demonstration**
 - Provides bonuses for high quality care in 5 clinical areas.
 - Readmissions included as a quality measure for hip and knee replacement
 - Test measure for AMI, CABG, pneumonia, and CHF
- **Readmissions in the Acute Care Episode (ACE) Demonstration**
 - Bundled payment currently covers only hospital and physician services provided during hospitalization
 - 30-day readmission rate is one of the quality measures for monitoring both cardiovascular and orthopedic procedures
 - Demonstration may include readmissions in future

CMS Demonstrations

- Readmissions in Post Acute Care (PAC) Demonstration
 - Demonstration is assessing use of a single post acute care tool to identify, monitor and address conditions across settings of care after discharge from an acute care hospital admission
 - May lead to consolidation of multiple payment systems to pay for episodes of care in hospitals, nursing homes, and other settings
 - Readmission to hospitals, as well as other settings, a key metric

Utilization of Readmission Metrics

- “Traditional Quality Improvement”
- Public Reporting and Public Transparency
- Incentive (or Disincentive) Programs
 - VBP (formerly P4P)
 - Bundled payments with quality oversight
 - Gainsharing
 - Many others potentially, including hybrids
- Research for effective evidence-based programs

CMS Quality Improvement Organization (QIO) Program

- VALUE Project during 8th SOW
 - 4 sites
 - Most successful in Colorado by QIO and University of Colorado
 - Set stage for wider initiative in 9th SOW
- Care Transitions Theme in QIO 9th SOW
 - 3 years of planning
 - Implemented August 1, 2008
 - 14 states involved, hopefully nationwide in 10th SOW
 - Not a pilot or demo, contractual with deliverables

Regulatory Oversight

- Conditions of Participation for hospitals
 - Requires hospitals to provide comprehensive discharge evaluation and planning services to its patients under certain circumstances
 - Must identify patients at risk early in hospitalization
 - Patient/family request
 - Physician request in absence of hospital-generated plan
 - Must include evaluation of services needed and availability
 - Must be timely
 - Must be supervised by nurse, social worker or other appropriately trained personnel

Regulatory Oversight

- Conditions of Participation for hospitals
 - Hospital must arrange for initial implementation
 - Arrangement for post-hospital services and care
 - Educating patient, family, caregivers and community providers about the plan
 - Hospitals must transfer patient to appropriate facilities, agencies, or outpatient services as needed (with caveats)
 - Hospital must reassess discharge plan if there are factors that may affect the continuing care needs or appropriateness of the discharge plan
 - Discharge planning part of required QAPI requirements

Regulatory Oversight

- Survey & Certification Process
 - Routine and complaint-driven
 - Surveyor guidelines assess compliance with Conditions of Participation
 - If deficiencies found can result in
 - Corrective actions: Far most common
 - Termination from Medicare Program
 - Referral to Office of the Inspector General
 - We could target readmissions as a focus if a policy decision were made

Regulatory Oversight

- Beneficiary Complaint Process
 - Many venues to register a complaint
 - 1-800-MEDICARE
 - QIOs
 - State Survey Agencies
 - CMS Central Office and Regional Offices
 - Office of Ombudsman
 - Contractors: MA Health Plans, Prescription Drug Plans, MACs, etc.
 - Hospital CAHPS (HCAHPS) Survey

Summary

- Preventable readmissions reflect low quality (care that should be unacceptable for patients) and low value (waste of dollars) and must be addressed NOW
- There are interventions that can and should be implemented immediately, while simultaneously addressing larger barriers and policy issues
- Payment reform will be one of several key components to reduce preventable readmissions
- Payment reform, by itself, won't correct all the issues
 - Some form of integration of the healthcare delivery system addressing care transitions and coordination will also be needed

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