Overview of Readmissions Policy: Implications for Hospital Operations and Finance

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Presentation Outline - Premises

Hospital Readmissions are a significant issue

Policy-makers are considering readmissions as a central issue for budget and healthcare reform

There are very promising uses of technology-enabled innovation

Leading industry efforts at improving hospital readmissions performance have a relatively small technology component

Achieving major performance improvement will require a thorough understanding of technology issues, capabilities, and adoption strategies
Hospital Readmissions are a Significant Issue

Readmission rates and spending are significant

- Aggregate levels of readmissions and related cost are high
- Current measurement, especially at the local level, likely underestimates the scale of the problem
- The implications for hospital finance are high – particularly if there is any movement toward methodologies like bundling and penalties for poor performance.
- Readmissions are intimately tied to a wide range of operational issues

Reducing readmission rates is both important and feasible

- Many readmissions viewed as preventable
- Wide variation in readmission rates between different hospitals, plans and geographic areas suggests room for improvement
Readmissions Data: Medicare Claims 2003-2004 (Jencks, et al.)

Readmission rates are high

- 19.6% of Medicare beneficiaries discharged from a hospital were readmitted within 30 days

Institutional readmission rates significantly understate the size of the issue

- 24.4% of rehospitalized patients were admitted to another facility
- 44.2% of patients in hospitals with fewer than 1,000 discharges were admitted to another facility

Cost of readmissions is high

- The estimated cost to Medicare of unplanned rehospitalizations in 2004 was $17.4 Billion

Readmissions are intimately tied to a wide range of operational issues

- Roughly 90% of rehospitalizations within 30 days appear to be unplanned and the result of clinical deterioration
- 50.2% of rehospitalized patients had no evidence of a bill for a visit to a physician’s office
Readmission Data (cont’d)

Many readmissions are viewed as preventable

- AHRQ study found that ~20% of patients had at least one preventable readmission within 6 months

Wide variation in readmission rates between different hospitals, plans and geographic areas suggests room for improvement

- Jencks, et al. found that rehospitalization rate was 45% higher in the five states with the highest rates than in the five states with the lowest rates
- PacifiCare Health System found that readmission rates at hospitals ranged from 0-44% for its enrollees
Data Demonstrates Wide Variation in Readmissions Performance

Readmission rates correlate with increased overall spending on Medicare beneficiaries.

Large variation across states suggests opportunities for improvement.
The results of the Jencks, et al. study indicate continued wide variation in performance by state – from 13 to 25%.
## Potential Losses from CHF in a Typical Hospital

<table>
<thead>
<tr>
<th>Metric</th>
<th>Assumptions</th>
<th>Volume</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admits per year</td>
<td>250 bed hospital at 90% occupancy</td>
<td>21,000/yr</td>
<td></td>
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<tr>
<td>CHF admits per year</td>
<td>5.7% of admissions are for CHF</td>
<td>1,150/year</td>
<td>$575,000</td>
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<tr>
<td></td>
<td>The average reimbursement for CHF is -$500-$1000/admission average loss to</td>
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<tr>
<td></td>
<td>cost of care</td>
<td></td>
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<tr>
<td>CHF 30-day readmissions per year</td>
<td>CHF DRG-specific 23% readmission rate</td>
<td>265/year</td>
<td>$1,590,000</td>
</tr>
<tr>
<td></td>
<td>Median CMS reimbursement for CHF is $6,000/discharge</td>
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<tr>
<td></td>
<td>-with more than a 3 fold variation not attributable to clinical condition</td>
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<tr>
<td>Total Annual Loss</td>
<td></td>
<td></td>
<td>$2,165,000</td>
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Putting the Evidence in Context

Economic value of readmissions depends on the “risk” of payment reform

<table>
<thead>
<tr>
<th>Metric</th>
<th>Structure of Payment:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>FFS</td>
</tr>
<tr>
<td>Decrease in Readmits</td>
<td></td>
</tr>
<tr>
<td>Decrease in Bed Days</td>
<td></td>
</tr>
<tr>
<td>Decrease in HH Visits/Pt</td>
<td></td>
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</tbody>
</table>
Hospital Readmissions and Operations

"Rehospitalization may be the most powerful single example of the cost of fragmented, provider-centered care. I believe that a successful campaign to reduce rehospitalization will also make care more patient-centered."

Stephen Jencks, MD
Operating Issues Surrounding Readmissions

Care Team
- Complex Care Coordination
  - Timely medication
  - Reconciliation
  - Lack of skills in complex case management
  - Lack of Shared Care plan and Goals
  - Lack coordination with PCI
  - Lack coordination with other services

Patient
- Self Management
  - Deficits that prevent self management
    - Cognitive
    - Psych
    - Financial
    - Driving etc.
  - Lack of Shared Care Plan and Goals

Pop Management
- Unable to ID pop at risk
- Lack optimal care paths for Pts with complex chronic diseases
- Lack of cost metrics to understand change implications
- Lack of benchmarks of success

Information
- Accurate
- Timely
- Complete
- Standardized
- Timely Med Reconciliation
- Lack of Shared Care Plan
- Shared

No 30 Day Readmissions
Process Issues Surrounding Readmissions

1st Hospitalization
- Pt. Psych, Cog eval
- Shared DC plan goals
- Timely Med Rec.

2nd Hospitalization
- Coordination in Transitions in Episodes of Care
- Self Management
- POP follow up

Discharged Patient
- Trained Staff in Complex Chronic care
- Homecare Coordination of DME, Logistics, Teaching

Unreliable Communications:
Timely, Accurate, Complete, Standardized

ID Pops at risk for Readmit
Optimal Pt. Cohort Care Paths
Benchmarks for Success, Quality, Financial, Customer Sat. Workforce
Shared Metrics for: Coding standard, Budget align, Risk share

Population Data
Policy-Makers, Readmissions and Healthcare Reform

Policy-makers are considering readmissions as a central issue for budget and healthcare reform. Among the groups participating in the discussion:

- CMS
- OMB – the Obama Administration proposed budget
- MedPAC
- Senate Finance Committee
CMS Measures Readmissions Performance on Key DRGS, Solicits Comments on Policy Alternatives

CMS has sought to track performance on three key DRGS - Congestive heart failure (CHF), Pneumonia, and Acute Myocardial Infarction (AMI) – and sought input on a series of policy alternatives.

- In 2010 three readmission measures may be calculated using Medicare administrative claims data: Heart failure (HF) 30-day risk standardized readmission measure, Pneumonia (PN) 30-day risk standardized readmission measure, Heart Attack (AMI) 30-day risk standardized readmission measure (for Medicare patients) (pg 23648).

- CMS is taking public comment on three potential policy options: public reporting of performance, payment incentives for superior performance, and payment reductions for inferior performance (pg 23674).
“… Hospitals will receive bundled payments that cover not just the hospitalization, but care from certain post-acute providers the 30 days after the hospitalization, and hospitals with high rates of readmission will be paid less if patients are readmitted to the hospital within the same 30-day period.”
A New Era of Responsibility

Table S-6: Mandatory and Receipt Proposals

- Encourage hospitals serving Medicare beneficiaries to reduce readmission rates (projected savings $8,430,000,000)
- Create Hospital quality incentive payments (projected savings $12,090,000,000)
- Promote efficient provision of acute care through bundled Medicare payments covering hospital and post-acute settings (projected savings $17,840,000)

Total expected savings by 2019 for these 3 initiatives = $38,360,000,000
The View of MedPAC

“The Commission recommends changing payment to hold providers financially accountable for service use around a hospitalization episode. Specifically, it would reduce payment to hospitals with relatively high readmission rates for select conditions. Conditions with high volume and high readmissions rates may be good candidates for selection. “

“The Commission recommends that this payment change be made in tandem with a previously recommended change in law (often referred to as gainsharing or shared accountability) to allow hospitals and physicians to share in the savings that result from reengineering inefficient care processes during the episode of care.”

Statement of Glenn M. Hackbarth, J.D.
Chairman, Medicare Payment Advisory Commission
Before the Committee on Energy and Commerce, U.S. House of Representatives
MedPAC Policy Recommendations

#1 Medicare should:

- Confidently report readmission rates and resource use around hospitalization episodes to hospitals and physicians.
- Beginning in the third year, providers’ relative resource use should be publicly disclosed.

#2 Medicare should

- Reduce payments to hospitals with relatively high readmission rates for select conditions
- Allow shared accountability (i.e., gainsharing) between physicians and hospitals.

Anne Mutti
Medicare Payment Advisory Commission Staff
April 2, 2009

“Reducing rehospitalizations: A national priority:” A Commonwealth Fund webinar
Senate Finance Committee: Withholds and Bundling

“Starting in fiscal year 2013, hospitals with readmissions above the 75th percentile for selected conditions would be subject to a payment withhold on a MS-DRG-by-MS-DRG basis. Such a withhold would be based on the prior year’s performance and would be equal to 20 percent of the MS-DRG payment amount...

Beginning in fiscal year (FY) 2015, acute IPPS hospital services and post-acute care services occurring or initiated within 30 days of discharge from a hospital would be paid through a bundled payment. Under this policy, post-acute payments would include home health, skilled nursing facility, rehabilitation hospitals, and long-term care hospital services. “

Description of Policy Options
“Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs”
April 29, 2009
## Proposed Timeline for Implementation of Readmissions and Bundling Policy

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Readmission Policy</th>
<th>Bundled Payment Policy</th>
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</thead>
<tbody>
<tr>
<td>2010</td>
<td>CMS would develop readmissions policy and data parameters</td>
<td>CMS would develop bundling policy</td>
</tr>
<tr>
<td>2011 - 2012</td>
<td>CMS would provide readmission rate information to hospitals and compare that to national readmissions benchmarks for selected conditions</td>
<td>CMS would develop bundling policy</td>
</tr>
<tr>
<td>2012</td>
<td>April-August: CMS would issue proposed and final rules</td>
<td>CMS would develop bundling policy</td>
</tr>
<tr>
<td></td>
<td>FY 2013: Readmissions policy would start in October</td>
<td></td>
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<tr>
<td></td>
<td>CMS would publicly report readmission rates</td>
<td></td>
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<tr>
<td>2013</td>
<td>Readmissions policy would continue for those hospitals not paid under the new bundled rates</td>
<td>CMS would develop policy</td>
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<tr>
<td>2014</td>
<td>Policy would continue for those hospitals not paid under the new bundled rates</td>
<td>April-August: CMS would release proposed and final rule</td>
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<tr>
<td></td>
<td></td>
<td>FY 2015: 1st phase would start in October (would apply to first 20% of post-acute spending)</td>
</tr>
<tr>
<td>2015</td>
<td>Readmissions policy would continue for those hospitals not paid under the bundled rates</td>
<td>1st phase continues</td>
</tr>
<tr>
<td>2016</td>
<td>Readmissions policy would continue for those hospitals not paid under the bundled rates</td>
<td>April-August: CMS would release proposed and final rules</td>
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<td>FY 2017: 2nd phase would start in October (would apply to next 30% of post-acute spending)</td>
</tr>
<tr>
<td>2017</td>
<td>Readmissions policy would continue for those hospitals not paid under the bundled rates</td>
<td>1st and 2nd phases would continue</td>
</tr>
<tr>
<td>2018</td>
<td>FY 2019: Readmissions policy would end in October</td>
<td>April-August: CMS would release proposed rule on final phase of bundling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FY 2019: final phase would start in October (would apply to remaining 50% of post-acute spending)</td>
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Technology Enabled Innovation: Disruptive and Transformative

Transformative technologies enable a wide range of disruptive and positive changes in clinical care and administrative processes, **reducing net expenditures and improving the value of health care.**

- IOM Annual Meeting 2007
Hospital-Led Deployment of Remote Patient Management

72% reduction in HF hospitalizations
63% reduction in cardiac-related hospitalizations

Intervention = Remote Patient Management
Control

Heart Failure
All Cardiac
All

SPAN-CHF II: Tufts-New England Medical Center; Lahey Clinic; Beth Israel-Deaconess Medical Center; Rhode Island Hospital. Weintraub et al AHA 2005
The Early Adopter Experience: Veterans Health Administration

Findings from comparative studies conducted on patients enrolled in the VA’s Care Coordination/Home Telehealth program in 2006 and 2007 show:

• 25% reduction in bed days of care
• 20% reduction in numbers of admissions
• 86% mean satisfaction score rating
Medication Adherence: Significant Economic Opportunity

• Medication non-adherence results in approximately **$177 billion** annually in direct and indirect costs to the U.S. economy.

  • **$47 billion** each year is spent for drug-related hospitalizations.

• Not taking medications as prescribed has been associated with as many as **40%** of admissions to nursing homes with an additional **$2,000 a year per patient** in medical costs for visits to physician’s offices.
Medication Adherence – Broad Range of Enabling Technologies

“Smart” Pill Bottles

- Rex Talking Pill Bottle - offered at over 140 Northern California Kaiser Permanente pharmacies and health care facilities

Remote Medication Dispensing

- Med-eMonitor – improved adherence rates in diverse chronic illnesses from baseline levels of 35-55% to levels in excess of 90%

VA Experience Demonstrates Value of Segmenting Population

- First level – patient, peer-led coaching and problem solving
- Second level – medication management technologies
- Third level – in-home remote patient management
Technology-Enabled Innovation Exists – But Not Widely…

Leading industry efforts at improving hospital readmissions performance have a relatively small technology component

- Of the “15 Promising Interventions” identified by IHI, only one is technology-based (home health telemedicine), and there is little explicit use of advanced technology

The scarcity of technology-enabled solutions comes from a number of reasons:

- Little focus on finding technology solutions for specific issues
- Lack of clinical evidence supporting technology use
- Poor alignment with current business models

Two key questions:

- Are there promising technology-based, disruptive solutions?
- How can technology augment performance of other initiatives?
Successful Execution Builds on Three Elements

Understanding Issues

- What is the impact of this issue?
- What is the likely impact on my organization?

Choosing Solutions

- What solutions are available?
- Which solutions fit best with my organization?

Managing Adoption

- How do I manage a successful test?
- How do I manage broad diffusion?
Flow of the Pre-Conference Presentations

Understanding Issues
- What is the impact of this issue?
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Managing Adoption
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Overview
Innovations & Techs/Case Studies
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