Refining the Hospital Readmissions Reduction Program

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MEDPAC

Medicare Payment Advisory Commission

- Independent, nonpartisan, Congressional support agency
- 17 national experts selected for expertise, not representation
- Appointed by Comptroller General for 3-year terms (can be reappointed)
- Make recommendations to the Congress and the Secretary of HHS
- Vote on recommendations in public

Reducing hospital readmissions is an important problem in Medicare

- Previously, Medicare payments discouraged care coordination and avoiding readmissions
- Wide variation in hospital performance on readmission rates and spending – shows that high rates of readmission are not unavoidable
- When MedPAC began research (2005), 13.3% of Medicare beneficiaries had a potentially preventable admission within 30 days and Medicare spent $12 billion on these readmissions
- Discussions with providers revealed strategies to reduce readmissions

PPACA created financial incentives to increase readmission reduction efforts

- Hospital readmission reduction program enacted in 2010
- Payment penalty started in October 2012
  - Penalty based on 2009 – 2011 performance
  - Policy uses three conditions and requires NQF approved measures (AMI, heart failure, pneumonia)
  - In aggregate penalties equal about 0.3 percent of total base inpatient hospital payments in FY2013
  - Average penalty for hospitals with penalty about $125,000
- Penalty capped as 1% of base operating payment in 2013, 2%—2014, 3%—2015 and thereafter

Hospitals taking variety of measures to reduce readmissions

- Improve care in the hospital
  - Identify patient population at increased risk of readmission
  - Reduce central line infections and general infection rates
- Improve transitions
  - Provide patient education (such as teach-back) and self management
  - Schedule follow-up visits and medication reconciliation before discharge
  - Call or visit with patients after discharge
  - Communicate better with providers outside hospital

Policy may be having an effect

- Policy gave hospitals an incentive to reduce readmissions in 2010 and 2011
- MedPAC found a 0.7 percentage point decline in risk adjusted all-condition potentially preventable readmissions from 2009 to 2011
- CMS has reported that all-condition readmission rates declined from 2011 to the second half of 2012

Source: MedPAC analysis of 2009 through 2011 Medicare claims files.
CMS: Testimony of Jonathan Blum 2/28/2013 fact sheet

Four issues requiring policy refinements

- Penalty does not change as industry performance improves
- Random variation makes detection of differences in individual conditions difficult
- Socio-economic status related to readmission rates
- Connection between mortality rates and readmission rates

Issue: Computation of penalty

- Current policy
  - Penalty constant as industry readmission rates decrease
  - Penalty multiplier differs for each condition
  - Over half of hospitals always penalized
- Policy refinement
  - Use a fixed readmission-rate target that is below historical average (e.g., 40th percentile) – create clear targets for hospitals
  - Fixed penalty amount – More likely Medicare benefits from reduced readmissions, rather than penalties

Issue: Random variation and small numbers of observations

- Policy refinement
  - Use all-condition readmissions to increase number of observations (continue to use 3 years of data)
  - Allow hospitals to aggregate performance within a system for penalty purposes (continue to publicly report individual hospital performance)

Issue: Patient socio-economic status affects readmissions

- Hospitals serving low-income patients have higher readmission rates
  - Lower-income individuals may have fewer resources for self-care outside of the hospital
  - Hospitals may have to expend more resources to get equal outcomes for low-income patients
- Income is the dominant effect; effect of race is smaller and variable

Refinement: Compare hospitals with similar shares of low-income patients

- Arrange hospitals decile ranked by share of Medicare patients on SSI (peer group)
- Set target readmission rate for each hospital equal to the 40th percentile of hospitals in its peer group (i.e., low income hospitals less likely to experience penalty relative to current policy)
- No hospital that meets the peer-group prospective target would be penalized
- Outside the readmissions program: revise QIO policy

Maintain focus on quality of care for poor patients, while creating a fair penalty system

- Readmissions policy should not tolerate higher rates of poor care and coordination for poor patients
- Readmission measure would not adjust for income (disparities would continue to be observed in data)
- Penalty is adjusted for income to be more fair to hospitals
- Peer group approach maintains incentive to improve readmissions for poor

Summary

- Recommendations from MedPAC and others catalyzed national focus on readmissions
- PPACA provision moved payment policy in the right direction, but can be improved
- Early results encouraging: decline in readmissions, more coordinated care
- Commonwealth Fund Expert Panel:

"While the current readmissions metric is undoubtedly an imperfect proxy for broader health system failures, it also provides a valuable foundation on which to build a better policy—one that is useful for improvement, fair for accountability, and above all, relevant to patients."