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Critical Readmissions Strategies for Hospital Leadership

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Agenda

- Background and Regulations
- Hospital Case Study
- Future and Section 3025
- Strategies for concurrent review and overall process evaluation

Why Readmissions?

- CMS reports 18% of Medicare Patients are readmitted within 30 days of discharge
- CMS believes many of these are either avoidable or unnecessary
- Estimates that $12B can be saved by reducing avoidable readmissions
- CMS also believes hospitals are financially rewarded for readmissions, and by eliminating this financial incentive, readmissions will be reduced
- Similar approach as to short stay admissions

The Medical Evidence of Medically Unnecessary Readmissions of Medicare Patients

- Stephen F. Jencks, MD., MPH et al., New England Journal of Medicine, April 2, 2009 360(14):1418–2:
- Key Findings:
  - Readmission Rates:
    - 19.6% readmitted within 30 days of discharge
    - 34% readmitted within 90 days
    - 56% readmitted within one year.
  - 50% of patients readmitted within 30 days had no bill for a physician visit during that time.
  - 70% of postsurgical patients were readmitted for a medical condition, such as pneumonia or a urinary tract infection.
  - Readmission rates varied greatly from state to state, with the highest five states seeing rates 45 percent higher than the lowest five.
  - The reason for the hospitalization and the length of stay contributed more to readmission than did demographic factors such as age, race, or presence of disability.

Who is Likely to Return?

Condition at Hospital Discharge	Readmission Rate*	CMS Target
Heart failure	26.9%	Current
Psychosis	24.6%	
Vascular surgery	23.9%	Future
COPD	22.6%	Future
Pneumonia	20.1%	Current
Gastrointestinal problem	19.2%	
Nonmajor hip or femur surgery	17.9%	Future
Major bowel surgery	16.6%	Future
Cardiac stent placement	14.5%	Current (AMI)

*Source: "Rehospitalizations among patients in the Medicare fee-for-service program," *The New England Journal of Medicine*, April 2, 2009

What Does This Tell You?

- This is a:
  - UR challenge
  - Quality Challenge
  - Case Management Challenge
  - Business Office Challenge
  - Finance Challenge
  - Physician Practice/Documentation Challenge
- There are specific areas CMS will focus on.

Regulations Governing Readmissions

- The Social Security (Medicare) Act: US Code Title 42 § 1395ww
- The Code of Federal Regulations: C.F.R. §476.71
- CMS Manual Guidance:
  - CMS Publication 100-04 (The Medicare Claims Processing Manual), Chapter 3, Section 40.2.5
  - CMS Publication 100-10 (The Medicare Quality Improvement Organization Manual), Chapter 4, Section 4240
- Other Applicable Guidance:
  - MedLearn Matters, MM3389
  - The Hospital Payment Monitoring Program (HPMP) Compliance Workbook, 2006 edition, revised 2008
  - Federal Register, Aug 2011

CMS Publication 100-04 (The Medicare Claims Processing Manual), Chapter 3, Section 40.2.5

- The QIOs may review acute care hospital admissions occurring within **30 days of discharge from an acute care hospital if both hospitals** are in the QIO's jurisdiction and if it appears that the two confinements could be related. Two separate payments would be made for these cases unless the readmission or preceding admission is denied.

- **NOTE:** The **QIO's authority to review and to deny readmissions when appropriate is not limited to readmissions within 30 days. The QIO has the authority to deny the second admission to the same or another acute PPS hospital,** no matter how many days elapsed since the patient's discharge.

- When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the **same day** for symptoms related to, or for evaluation and management of, the prior stay's medical condition, **hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.**

Is CMS Manual Guidance Consistent with the Law?

- The Social Security Act states that:
  - If the Secretary determines…that a **hospital**, in order to circumvent the payment method established under subsection (b) or (d) of this section, **has taken an action** that results in the admission of individuals entitled to benefits under part A unnecessarily, unnecessary multiple admissions of the same such individuals, or other inappropriate medical or other practices with respect to such individuals, the Secretary may…deny payment.
- But the CMS Manual Guidance calls for denial of readmissions which resulted from a premature discharge from the hospital.
- The language of the statute calls for denial of payment only when the hospital has "taken an action" to cause an unnecessary readmission.
- The Manual guidance punishes hospitals with denial of coverage even when the hospital does not take action to cause a premature discharge
  - such as when a physician orders discharge of a patient prematurely and the hospital faithfully carried out the physician orders.
- Are hospitals being penalized for the actions of a disinterested third party?

PEPPER Calculations

New Short-term acute care PEPPER definitions:

1. Count of index (first) admissions during the quarter for which a readmission occurred within 30 days to the **same hospital or to another short-term acute care PPS hospital** for the same beneficiary

2. Count of index (first) admissions during the quarter for which a readmission occurred within 30 days to **the same hospital for the same beneficiary.**

New Rehab Pepper includes readmission category

Admissions to short-term acute care hospitals after discharge from the IRF: TMF found that roughly 20% of patients discharged from an IRF are admitted to a short-term acute care hospital within 30 days.

After the Regs, Next Steps…..

- We need to decide what readmissions stand on their own and what readmissions are related to a prior claim
- We will need to watch the methodologies to make sure that “unrelated” is not just for expected readmission but truly means could not have been expected or prevented.

Related vs. Unrelated Readmission?

- “Related”
  - Readmission related to care delivered during previous admission
  - Represents a potentially avoidable readmission
  - Compliant Medicare billing means either a combined DRG payment or no bill
- “Unrelated”
  - Readmission not related to previous admission
  - Appropriate readmission despite the timeframe in which readmission has occurred
  - May be compliantly billed under Medicare as separate DRGs

Related vs. Unrelated Readmission?

- What differentiates Related vs. Unrelated diagnosis?
  - Different DRGs
    - Was the readmission DRG due to incomplete, incorrect or substandard care of secondary diagnosis during the prior admission?
    - Ex: Asthma and Diabetes
  - Same DRG
    - Was the patient's diagnosis at baseline at the time of or prior to the readmission?
    - Ex: CHF and CHF

The Future for Readmissions

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Section 3025: Hospital Readmissions Reduction Program

- Part of Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively known as the Affordable Care Act)
- Basically, this outlines how Medicare Payments will be affected to account for what is perceived as excess readmissions
- Updated in Aug 18, 2011 Federal Register

Payment Penalties for Readmissions

- ALL base DRG payment amounts in hospitals with excess readmissions are reduced by a factor determined by the level of "excess, preventable readmissions"
- Effective FY 2013
- Reduction is limited to 1% in 2013, 2% in 2014, and 3% in 2015 and beyond
- Initially applied to AMI, heart failure and pneumonia
- 30 day readmission window
- Excludes admissions unrelated to prior discharge Expanded in 2015 to 4 additional conditions (COPD, CABG, PTCA, and "other vascular surgery")
  - Secretary of HHS will seek NQF endorsement for additional conditions, although such endorsement is not required.

Calculations

- Excess Readmissions = Actual Readmission/Expected readmissions
- Total Excess Readmission = CHF + AMI + Pneumonia
- Excess Readmissions for CHF = CHF DRG payment for hospital * number of admissions for CHF * (excess readmission ratio -1)
- Adjustment Factor = 1 – (Payments for excess readmissions / Payment for all discharges)
- Payment Cut = DRG payment * Adjustment factor
  - Max Cut is 1%, 2% and 3%

And What is an Applicable Condition?

APPLICABLE CONDITION.—The term 'applicable condition' means, subject to subparagraph (B), a **condition or procedure selected by the Secretary** among conditions and procedures for which—

"(i) readmissions (as defined in subparagraph (E)) that represent **conditions or procedures that are high volume or high expenditures** under this title (or other criteria specified by the Secretary); and

"(ii) measures of such readmissions—

"(I) have been endorsed by the entity with a contract under section 1890(a); and

"(II) such endorsed measures have **exclusions for readmissions that are unrelated to the prior discharge**

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Process Evaluation and Change

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Next Steps

- High level
  - Ensure appropriate coordinated care to avoid the potentially preventable “linked” readmission
- Tactics:
  - Understand what readmission means to your organization
  - Based upon that understanding, create a daily process that:
    1. Identifies whether a patient hospital stay is a readmission
    2. Ensures the compliant certification of a readmission as “linked” or “unlinked” for purposes of compliance with the regs and achieving revenue integrity
    3. Gathers the data necessary to meet the high level strategic goal over time.

Readmission Review is Admission Review X 2

Recognize that this is about daily tactics:

1. Case Management *strictly* applies *current acceptable IP* admission screening criteria to 100% of medical and selected surgical cases placed in a hospital bed and documents this review in an auditable format
2. *ALL* cases that do not pass criteria (regardless of admission order status) are referred to a Physician Advisor who is an expert in CMS rules and regulations and evidence-based clinical standards of risk stratification and care.
3. A Physician Advisor reviews the case, speaks with treating physician as required, renders final recommendation for claim status (IP vs. OBS) based upon UR Standards and documents in auditable format on chart or in UR documentation
4. Treating physician changes order as appropriate
5. Must run 7 days a week/365 days a year

Questions for Readmission Reviews

- Ask “Were both cases appropriate for IP admission?”
- Ask “Could the second admission have been “anticipated” at the time of discharge?”
- Ask “Could the second admission have been “avoided” by some action at the time of discharge?”
- Ask “Is the second admission a scheduled admission, and if so, could the procedure have been performed during the first admission?”

Tactics

- First, it is important to look at denials from two perspectives:
  - Same Day
    - Clear guidance to combine claims
    - RAC approved target for HDI
  - Different day - guidance varies regionally
    - QIO's clearly may deny, but when we have seen denials, the recommended remedy is to combine episodes into a single claim
    - But some MAC's do not seem to be able to process this type of claim, and recommend complete denial of second claim, even if care was medically necessary
- As a hospital, you want to focus on areas you can improve

Focus Areas

Items to consider when designing a review process:

- Time frame between admissions
  - 7, 14 or 30 days
- Diagnosis Group
  - AMI, Pneumonia, CHF
- Physician
- Admit source (rehab, SNF, home)
- Patient
  - LACE index Scoring tool
  - Project Red
  - BOOST 8P
- High Risk Groups (Oncology, Trauma, etc)
- Comorbidities/chronic conditions
  - Every condition over 3 increase risk for readmission in linear relationship

Bring Process Suggestions to the UM Committee

Audit

- Consider audit of 30-40 readmissions – use NEJM and CMS targets as guidance
- We recommend looking at 7-14 day readmits first
- Identify sources of issues (are stays related or not, are there documentation issues, quality concerns, process issues, etc)
- If discharge documentation is a concern, consider discharge planning prompts to ensure co-morbid conditions are addressed in common problem areas

Audit

- Did discharge documentation contain:
  - Follow up physician appointment
  - Prescriptions for Medications
  - RN phone follow up
  - DC Documentation (over 2 pages?)
  - Clinical parameters when to call
  - other
- Consider concurrent/retro review process
  - Review all readmissions for 1. Med Necessity and 2. Relatedness
    - Can be done by CM and Physician Advisor
    - Can be done at point of admission, or put in place notification process in business office

Dashboard/Scorecard

- Daily Readmission Review Process will create Hospital specific data that can be used to: corroborate/explain/refute/act upon trend analysis and comparative Medicare Administrative Data (eg PEPPER, CERT)
- Use for early identification system
- Tactically useful in identifying and repaying past erroneous reimbursement
- Tactically useful in successfully appealing inappropriate CMS Intermediary denials

Resources for Clinical Change

- Project RED Re-Engineered Discharge www.bu.edu/fammed/projectred/
- Transitional Care Model www.innovativecaremodels.com/care_models/21/overview
- Society of Hospital Medicine BOOSTing Care Transitions http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/project_boost_background.cfm
- The Care Transitions Program http://www.caretransitions.org/
- LACE Index Scoring Tool Van Walraven, MD, Carl, et al. "Derivation and validation of an index to predict early death or unplanned readmission after discharge from hospital to the community"
- Teach Back www.nchealthliteracy.org/teachingaids.html
- http://www.ihi.org/explore/ADEsMedicationReconciliation/Pages/default.aspx
- Medication Reconciliation http://www.ihi.org/explore/ADEsMedicationReconciliation/Pages/default.aspx\
- Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. *How to Guide: Improving Transitions from the Hospital to Post Acute Care Settings to Reduce Avoidable Rehospitalizations.* Cambridge, MA: Institute for Healthcare Improvement; June 2011. Available at www.IHI.org

Questions?

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Finally…

- Readmission is not an easy topic
- Operations process is determined by individual facility and practice patterns
- Differentiate claims processes from operations processes
- Do not forget about commercial payors. They are becoming more aggressive and using readmissions as another reason to deny.

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EHR received the elite Peer Reviewed designation from the Healthcare Financial Management Association (HFMA) for its suite of medical necessity compliance solutions, including: Medicare and Medicaid Medical Necessity Compliance Management; Medicare and Medicaid DRG Coding and Medical Necessity Denials and Appeals Management; Managed Care/Commercial Payor Admission Review and Denials Management; and Expert Advisory Services.

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