The Medicare Hospital Readmissions Reduction Program

Impact on Rural Hospitals

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Session Topics

- Overview of Medicare Hospital Readmissions Reduction Program (MHRRP)
- Program Changes for FY 2015
- Analysis of MHRRP Impact on Rural Hospitals
- MHRRP State Rural Hospital Profiles
- The Issue of Preventable Readmissions
- The Role of CAHS in Preventing ReadmissionS

CMS Readmissions Reduction Program: Authority

- Section 3025 of the Patient Protection and Affordable Care Act (PPACA) added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012.
- The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

Reassessment Penalty: Process

- In the FY 2012 IPPS final rule, CMS finalized the following policies with regard to the readmission measures under the Hospital Readmissions Reduction Program:
  - Defined readmission as an admission to a subsection(d) hospital within 30 days of a discharge from the same or another subsection(d) hospital;
  - Adopted readmission measures for the applicable conditions of Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN); established a methodology to calculate the excess readmission ratio for each applicable condition, which is used, in part, to calculate the readmission payment adjustment. Identified two additional factors for FY 2015.
  - A hospital's excess readmission ratio is a measure of a hospital's readmission performance compared to the national average for the hospital's set of patients with that applicable condition.
- Subsection(d) hospitals, per the Social Security Act, include short term inpatient acute care hospitals , but exclude critical access, psychiatric, rehabilitation, long term care, children's, and cancer hospitals.

Readmissions Penalties

- CMS expanded the applicable conditions for FY 2015 to include:
  - patients admitted for an acute exacerbation of chronic obstructive pulmonary disease (COPD); and
  - patients admitted for elective total hip arthroplasty (THA) and total knee arthroplasty (TKA).
- Maximum penalties will increase to the following maximums:
  - 1% in Year One: beginning October 1, 2012.
  - 2% in Year Two: beginning October 1, 2013.
  - 3% in Year Three: beginning October 1, 2014.

Typical Rural IPPS Hospital Impact

Penalty Percent	Medicare Revenue Reduction
0.25%	$ 25,000
0.50%	$ 50,000
1.00%	$ 100,000
1.50%	$ 150,000
2.00%	$ 200,000
2.50%	$ 250,000
3.00%	$ 300,000

47-Bed Hospital with $10 million Annual Medicare Revenues

PPACA Quality Improvement Initiatives

- The Readmissions Reduction Program is only one of several PPACA authorized initiatives designed to improve hospital quality.
- PPAC also authorizes a Hospital Value-Based Purchasing Program (HVBPP), which provides payment bonuses or assesses payment reductions based upon a broader set of operational measures.
- The impact of the HVBPP is in addition to that of the Readmissions Reduction Program, and has the potential of further reducing a hospital's Medicare revenue.

Detailed Data Analysis

Summary of FY 2015 Analytic Findings

- There are 953 rural IPPS hospitals, representing 28% of all IPPS hospitals.
- 748 (78%) of these rural IPPS hospitals have a readmission penalty.
- The average Medicare reduction for penalized rural hospitals is approximately 0.7%.
- The average penalized rural hospital reduction is more than 20% worse than penalties for penalized urban hospitals.
- This higher penalty reflects poorer performance on readmission targets.
- This average penalty rate for penalized hospitals would lead to a reduction of $70,000 per year for the typical rural hospital described earlier.

Adjustment Factor Distribution

Adjustment Factor Distribution All Hospitals - FY 2015			
	Number	PCT All	Cum PCT
2.5%< to 3%	58	2%	2%
2.0%< to 2.5%	51	1%	3%
1.5%< to 2.0%	124	4%	7%
1.0%< to 1.5%	299	9%	16%
.5%< to 1.0%	652	19%	35%
0%< to .5%	1,454	43%	77%
0%	780	23%	100%
Total	3,418	100%	

Penalized Hospitals – Rural/Urban

FFY 2015	Number of IPPS Hospitals	Percent of IPPS Hospitals	Number Penalized	Percent of All Penalized	Percent of Category
Rural	953	28%	748	28%	78%
Urban	2,465	72%	1,890	72%	77%
All Locations	3,418	100%	2,638	100%	77%

FFY 2014	Number of IPPS Hospitals	Percent of IPPS Hospitals	Number Penalized	Percent of All Penalized	Percent of Category
Rural	950	27%	613	28%	65%
Urban	2,533	73%	1,612	72%	64%
All Locations	3,483	100%	2,225	100%	64%

-- Many more rural hospitals are penalized in FFY 2015 than in FFY 2014.

-- A higher percentage of rural hospitals are penalized in FFY 2015 than in FFY 2014.

-- The increase likely reflects the addition of additional factors to the penalty formula.

Average Rural Hospital Penalty Rate

MHRRP Penalty Amounts - FFY 2015				
	Number of IPPS Hospitals	Number Penalized	Average Penalty	Average of Penalized
Rural	953	748	0.56%	0.71%
Urban	2,465	1,890	0.45%	0.59%
Total	3,418	2,638	0.48%	0.63%

MHRRP Penalty Amounts - FFY 2014				
	Number of IPPS Hospitals	Number Penalized	Average Penalty	Average of Penalized
Rural	950	613	0.32%	0.49%
Metro	2,536	1,612	0.22%	0.34%
Total	3,486	2,225	0.25%	0.38%

-- The average Medicare reduction for penalized rural hospitals is approximately 0.7%.

-- This rate would represent a loss of $70,000 per year to a typical hospital .

-- Average rural hospital penalty rates have increased about 40-50%.

Rural/Urban Excess Readmission Ratios - 1

Pneumonia - Excess Readmission Ratio - FFY 2015 Basis								
	All	PCT of All	Pneumonia Ratio	PCT of Category	Ratio >1	PCT of Category	PCT of Ratio>1	Average for Ratio>1
Rural	953	28%	908	95%	371	41%	25%	1.0667
Urban	2,465	72%	2,188	89%	1,090	50%	75%	1.0626
Total	3,418	100%	3,096	91%	1,461	47%	100%	

Heart Failure - Excess Readmission Ratio - FFY 2015 Basis								
	All	PCT of All	Failure Ratio	PCT of Category	Ratio>1	PCT of Category	PCT of Ratio>1	Average for Ratio>1
Rural	953	28%	877	92%	444	51%	30%	1.0632
Urban	2,465	72%	2,173	88%	1,058	49%	70%	1.0663
Total	3,418	100%	3,050	89%	1,502	49%	100%	

Rural/Urban Excess Readmission Ratios - 2

AMI - Excess Readmission Ratio - FFY 2015 Basis								
	All	PCT of All	AMI Ratio	PCT of Category	Ratio>1	PCT of Category	PCT of Ratio>1	Average for Ratio>1
Rural	953	28%	424	44%	177	42%	16%	1.0503
Urban	2,465	72%	1,812	74%	931	51%	84%	1.0585
Total	3,418	100%	2,236	65%	1,108	50%	100%	

Arthroplasty - Excess Readmission Ratio - FFY 2015 Basis								
	All	PCT of All	Arthroplasty Ratio	PCT of Category	Ratio>1	PCT of Category	PCT of Ratio>1	Average for Ratio>1
Rural	953	28%	589	62%	278	47%	22%	1.1067
Urban	2,465	72%	1,967	80%	988	50%	78%	1.1244
Total	3,418	100%	2,556	75%	1,266	50%	100%	

Rural/Urban Excess Readmission Ratios - 3

COPD - Excess Readmission Ratio - FFY 2015 Basis								
	All	PCT of All	COPD Ratio	PCT of Category	Ratio>1	PCT of Category	PCT of Ratio>1	Average for Ratio>1
Rural	953	28%	877	92%	399	45%	27%	1.0535
Urban	2,465	72%	2,150	87%	1,054	49%	73%	1.0537
Total	3,418	100%	3,027	89%	1,453	48%	100%	

-- Rural hospitals with ratios>1 have, on average, lower ratios than urban hospitals, except for pneumonia readmissions.

-- Limited numbers of rural hospitals have readmissions ratios calculated for AMI and Arthroplasty. This can distort penalty calculations.

Rural/Urban Readmission Indicator Trends

Penalty and Readmission Trends - FFY 2014-5					
	Number of IPPS Hospitals	Average Penalty Trend	Average Pneumonia Trend	Average Heart Failure Trend	Average AMI Trend
Rural	953	0.25%	0.0041	0.0014	0.0608
Metro	2,465	0.23%	0.0074	0.0065	0.0171
Total	3,418	0.24%	0.0064	0.0050	0.0254

-- Rural IPPS hospitals have lower average increases in readmissions for Pneumonia and Heart Failure than do urban IPPS hospitals.

--Rural IPPS hospitals have higher average increases in readmissions for AMI than do urban IPPS hospitals.

Medicare Readmissions Reduction Program - State Profiles -

Readmissions Reduction Program- State Profiles

- Individual state profiles of rural hospitals affected by the Readmissions Reduction Program are available from NOSORH
- The number of affected rural hospitals varies widely. Some states have only one or two hospitals affected. Other states have several dozen.
- The amount of the penalty for hospitals in some states is fairly negligible, while in others there are multiple hospitals with penalties greater than one percent of total Medicare revenue. In some states no hospitals have been assessed a Medicare penalty.

State Profiles - Description

- **Each State Profile table includes the following data for IPPS rural hospitals**
  - **Hospital Name,**
  - **Hospital Provider Identification Number,**
  - **Hospital County,**
  - **Percent of Medicare Penalty for FY 2015, and**
  - **Quartile ranking of the facility for each of the five readmissions factors.**
- **Hospitals are ranked by the Percent of Medicare Penalty, from high to low.**
- **The table includes hospitals identified by CMS as being in a rural location. The CMS definition may not entirely coincide with other definitions of rural hospital.**

State Profiles – Quartile Information

- **Quartile rankings are provided for the penalty amount and the five readmissions factors considered by the Program.**
- **The rankings range from 1 to 4, with 1 being the quartile of all hospitals, rural and urban, with the highest readmissions rate for a specific factor. Quartile 1 rankings flagged with an asterisk (*) denote hospitals with very high scores more than 1 standard deviation above national average.**
- **Any hospital identified as being in Quartile 1 or 2 on a readmissions measure is above the national median for readmissions.**
- **While a particular hospital may have no readmissions penalty, if any measure is above the national median it may suggest a potential focus for quality improvement efforts.**

Sample State Profile Table - 2015

Hospital Name	2015 Penalty Amount	Penalty Quartile	Pneumonia Quartile	Heart Failure Quartile	AMI Quartile	Arthroplasty Quartile	COPD Quartile
Hospital One	0.71%	2	2	4	1*	1	1*
Hospital Two	0.65%	2	4	4	1*	2	1*
Hospital Three	0.49%	2	3	4	4	4	1*
Hospital Four	0.40%	2	3	3	3	2	1*
Hospital Five	0.00%	4	4	3	3	4	3

Sample State Trend Table – 2014-5

Hospital Name	Penalty Trend	Pneumonia Readmission Trend	Heart Failure Readmission Trend	AMI Readmission Trend
Hospital One	0.67%	0.0048	-0.0285	0.0716
Hospital Two	0.60%	0.0089	-0.0020	0.0145
Hospital Three	0.49%	-0.0073	-0.0747	-0.0175
Hospital Four	0.36%	0.0037	0.0063	-0.0335
Hospital Five	0.00%	-0.0702	-0.0003	NA

The Issue of Preventable Readmissions

The Larger Issue of Preventable Admissions

- **MHRRP readmissions are a subset of all *preventable admissions*.**
- **There are multiple *unnecessary costs* associated with preventable readmissions:**
  - **Unnecessary hospital admissions**
  - **Extended hospital stays**
  - **Unnecessary tests – laboratory and imaging**
  - **Unnecessary services/procedures – medical, surgical, pharmacy**
  - **Transport costs**
- **The elimination of unnecessary costs is a major aim of health care reform.**

Additional Diagnoses With Impact on Preventable Admissions

- **The diagnoses considered in the MHRRP are significant with respect to preventable admissions.**
- **Other diagnoses/medical issues are important.**
  - **Diabetes**
  - **Asthma**
  - **Influenza**
  - **Hypertension**
  - **Wound care**
- **Behavioral health issues, including alcohol and substance abuse issues, are of particular importance.**

Service System Improvements to Reduce Preventable Readmissions

- **Service systems – both hospital and community-based – can be improved with an impact on preventable readmissions:**
  - **Hospital-Based Services:**
    - **Discharge Planning and Patient Counseling**
    - **Care Transition Services**
  - **Community-Based Services (outpatient, local facility and home-based):**
    - **Chronic Care Management Services**
    - **Acute Care Services**
    - **Local step-down services**

The Role of CAHs in Readmission Reduction

Role for CAHs in Readmission Reduction

- For rural communities served by CAHs, including those in Frontier Health System demonstration communities, Readmission Reduction requires improved coordination between CAHS and upstream referral hospitals.
- Improved coordination can include:
  - Improvements in discharge planning and care transition services;
  - Improvements and support of community-based services, such as chronic care management.
- Improved coordination can be reflected in a significantly revised Network Agreement between CAHs and upstream referral hospitals – expanded to specifically cover discharge and follow-up services.

FLEX Program Requirements for Rural Health Network Agreements

- The members of the network must entered into agreements regarding—
  - Patient referral and transfer;
  - The development and use of communications systems, including, where feasible, telemetry systems and systems for electronic sharing of patient data; and
  - The provision of emergency and nonemergency transportation among members.
- In addition, each CAH must have an agreement with respect to credentialing and quality assurance.
- These are largely ***upstream referral*** requirements. The requirements are less clear about discharge and downstream arrangements.

References

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