

Whitepaper

# Hospital Readmissions: What Health Plans and Providers Need to Know

## Executive Summary

Headlines about the skyrocketing costs of healthcare are a constant refrain. So too are consumer demands for better quality and value from their healthcare spending. In response, the health care system is shifting to delivery models that focus on keeping patients healthy and rewarding providers for actual outcomes. These efforts accelerated with the passage of the Affordable Care Act in 2010. Since then, the Centers for Medicare and Medicaid Services (CMS) established several value-based programs, including the Hospital Readmission Reduction Program (HRRP), that link reimbursement or payment to the quality of care provided.

CMS estimates it spends \$17 billion dollars a year on avoidable readmissions.<sup>1</sup> To encourage hospitals to reduce preventable readmissions, CMS began publicly reporting hospital-level admission rates for select conditions in 2009. With the enactment of ACA, Medicare, as the largest purchaser of hospital care, implemented an aggressive HRRP, creating a value-based reimbursement program that penalizes hospitals with relatively high readmission rates for certain conditions. In 2018, 81% of hospitals had payments reduced because of HRRP. The average penalty was \$217,000. About 6% of penalized hospitals received the maximum penalty of 3% of total base Medicare inpatient operating payments.<sup>2</sup>

ACA also included funding for the creation of the Community-Based Care Transitions Program that tested models for improving patient transitions from the in-patient hospital setting to other care settings, increasing quality of care, reducing readmissions, and documenting measurable savings. Leading health plans have followed CMS's lead by implementing care coordination strategies, bundled payments, and other value-based programs using data and sophisticated predictive analytics for risk stratification of their member population, in order to identify and design care management for those at highest risk.

Beyond the cost factor, virtually every major quality measurement and incentive program evaluates readmission rates, recognizing that the reduction of preventable readmissions is one of the most important opportunities for reducing waste and improving outcomes for payers, plans, providers, and patients.

## The critical 30 days following hospitalization

Medicare defines a hospital readmission as a patient admitted to any hospital within 30 days after being discharged from an initial hospitalization. Planned readmissions for some patients may actually be a bolster to their quality of care. For example, patients being treated for oncology care are often given a schedule of planned treatments, whether it's surgical intervention or chemotherapy treatments, that require frequent admissions. The goal of HRRP is not to measure planned treatments or interventions but rather to focus on the unplanned, repeat admissions. HRRP focuses on preventable unplanned readmissions, using an "all-cause" definition, meaning that, with the exception of planned hospitalizations, hospital stays for any reason within 30 days of a discharge from an initial hospitalization are considered readmissions. The national average readmission rate and each hospital's specific readmission rate are calculated based on this all-cause definition.

Moreover, payers across the industry have followed Medicare in combatting waste and improving quality of care by adding hospital readmission quality measures to their value-based payment programs. For hospitals in any care model, enabling their providers to reduce hospital readmission rates is critical.

### Key Risk Factors For Patients Experiencing Readmissions

Understanding which patients might be at risk for readmissions and why is crucial to developing a robust care management plan aimed at preventing re-hospitalizations.

Patient and clinical factors play a significant role in the risk for hospital readmissions. A member's medical factors and health status will strongly determine whether he/she is more likely to return to the hospital within 30 days. Age, gender, demographics, and other social determinants of health can also contribute to a patient's risk of developing complications of treatment, such as post-operative infections, of falling, or of adverse consequences from medication non-adherence. When patients are discharged from the hospital, they can be especially vulnerable if they:

- Lack family or other caregiver support
- Live in an unsafe environment that has not been modified for required stairs
- Have inadequate access to healthy food or a poor understanding of their new dietary restrictions
- Have little knowledge/are unable to execute aftercare requirements such as wound dressing
- Have difficulty with and/or are unable to afford their medication regime
- Are reluctant/unable (due to language barriers) to provide relevant important information to their outpatient care providers

The root causes for medical readmissions can stem from the patient's treatment during the first hospitalization, or a secondary condition suggesting potential quality problems in the hospital care received, or breakdowns in transition care from discharge to outpatient care setting. Identifying the members at risk and putting in place appropriate resources for discharge planning and ongoing care coordination are key to reducing readmissions.

## Managing readmission risk from admissions through 30+ days post discharge

Reducing avoidable readmissions requires a proactive approach to patient care. For leading plans and providers, it starts with applying analytics to identify patients at risk. And because the days and weeks after hospital discharge are when patients are most vulnerable, health providers and plans must work together to engage patients in coordinating and managing care in order to mitigate readmission risk.

### Pinpointing, Predicting, and Preventing

Healthcare organizations have more data than ever to generate insights. Forward-looking providers and plans are using sophisticated population-based, case-mix models that leverage predictive analytics at initial admission in order to better triage patients and allocate resources for care management. For example, the Johns Hopkins ACG<sup>®</sup> System, the most extensively used population health analytics system on the market today, will identify readmission risk by looking at:

- **Morbidity of the member.** Patients with high medical needs can be identified by measuring multi-morbidity. Further examination of the patient profile includes individual conditions and medications.
- **Prior utilization, including previous hospitalizations and/or multiple previous emergency department visits.** These are often indicators of illness level and strong risk factors for readmission.
- **Markers of clinical frailty.** Markers are derived from diagnosis and may indicate a patient has limitations related to their ability to perform self-care, such as dementia, malnutrition, difficulty walking, incontinence, vision impairment, histories of falls, etc.
- **The care setting to which a patient is discharged.** Patients requiring skilled nursing care, for example, tend to have a higher risk of re-admission than those that go home.
- **Overall medication use.** Medication non-adherence is a large contributor to hospital readmission, and multiple medications will likely indicate a higher risk of re-hospitalization.

Predictive modeling looks at all of those risk factors to assess the likelihood of the patient experiencing an unplanned readmission within 30 days of discharge. By scoring individuals with a probability of their experiencing an unplanned re-admission within 30 days, care managers will be able to determine those patients most at risk so they can best plan appropriate follow-up care and other interventions.

## Looking Across the Continuum of Care

Leading plans are beginning to adopt a population health approach, which focuses on coordinated, collaborative care. Rather than looking at the hospital as the center of care, this approach encompasses primary care and home care visitors, as well as case managers. Because it is critical that members go home after their hospitalization to a safe environment with the appropriate level of care, risk mitigation starts with appropriate discharge planning. It extends to other care managers that may be a part of the health plan's network or of provider-centered medical homes.

Moreover, whether care is rendered by a family member or a visiting nurse, coordination among the patient's health care team – from the hospital to the primary care physicians (PCPs) to specialists – is crucial. PCPs need to be alerted when their patient has been admitted to the hospital, and when the member is discharged. Coordinated, collaborative care facilitates an appropriate transition of care and adequate follow up. Follow up must include things like medication reconciliation and, where possible, engaging community resources to ensure the patient has the proper support system for their ongoing care needs.

## Aligning Incentives to Quality and Performance

Since CMS implemented HRRP in 2012, hospital readmissions have become a widely accepted measure of a hospital's quality of care among payers. Readmission rates are evaluated as part of the Merit Based Incentive Payment Systems (MIPS) quality measures, CMS's alternative payment model that introduces value-based payments to Medicare providers. The innovation centers, shared savings, and comprehensive Primary Care Plus programs also factor in readmission rates as part of their overall quality ratings.

From a health plan perspective, the National Committee for Quality Assurance (NCQA), health plan accreditation, Medicare Advantage Star Ratings, the quality rating system or the marketplace plans, and various State Medicaid agencies all consider all-cause readmissions in their quality rating. Many of these have positive incentives associated with reducing overall readmission rates – either in the form of an enhanced accreditation rating in the case of NCQA or a quality bonus payment in the case of Star Ratings. By adopting measures such as readmission rates into their value-based payment models to their

entire provider network, plans are able to incentivize the coordination and collaboration of care, with the goal of reducing readmissions and ultimately their total cost of care.

## Evolving prevention of avoidable readmissions in a value-based care world

As the shift to value-based care continues to accelerate throughout the U.S. healthcare system, plans and providers remain focused on reducing hospital readmissions with the triple aim in mind of improving care quality, lowering costs and waste, and increasing patient satisfaction. To best serve patients, innovative providers and plans are rapidly adopting data analytics and predictive modeling to identify patients at risk at initial hospitalization. And they are applying data-informed analytics to design comprehensive care coordination that involves all stakeholders, including the patients, to provide more seamless transitions and enhanced support to drive better outcomes.

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To learn more about our solutions and the Johns Hopkins ACG System, [contact us](#).

## Sources

1 RevCycle Intelligence, "Preventable Readmissions Cause CMS \$17 Billion," <https://revcycleintelligence.com/news/preventable-readmissions-cost-cms-17-billion>

2 MedPAC, Report to the Congress: Medicare and the Health Care Delivery System, [http://www.medpac.gov/docs/default-source/reports/jun18\\_ch1\\_medpacreport\\_sec.pdf](http://www.medpac.gov/docs/default-source/reports/jun18_ch1_medpacreport_sec.pdf)