Curing Medicare’s hospital readmissions penalties

Nestled within the 996 pages of the 21st Century Cures Act that President Barack Obama signed into law last week is a change to the way hospitals are judged when patients are unnecessarily readmitted.

The law requires Medicare to account for patients’ backgrounds when it calculates reductions in its payments to hospitals under the Hospital Readmissions Reduction Program.

Until the passage of the Cures Act—a bundle of legislation aimed at fostering biomedical innovation that, on its way to becoming law, turned into a smorgasbord of healthcare policies—thorny questions about adjusting for patient demographics had been raised and studied but not addressed in the structure of the readmissions reduction program.

Preventing readmissions can be complicated to manage for hospitals in impoverished areas, where patients might be unable to afford medication or healthy food, or they lack transportation to attend checkups with primary-care doctors.

Those hospitals nevertheless face financial penalties unless their readmission rate falls below the national average. They and their advocates have been arguing for years that the framework unfairly depletes the resources of hospitals that care for the most vulnerable patients.

The other side of the argument is that creating different rules for those hospitals allows facilities that serve low-income communities to provide lower-quality care. The program already risk-adjusts using clinical co-morbidities, which are more common in poor communities.

Policy experts say that the effectiveness of the risk adjustment called for in the Cures Act depends on the details of its implementation, which are scant in the legislation. They have also raised concerns that because sophisticated, reliable risk-adjustment methodologies are in their infancy, handicapping for patient demographics might foster complacency among some hospitals or even exacerbate health disparities, especially along racial lines.

“Nobody wants to give a blanket pass for hospitals to deliver poor care, and we certainly don’t want to further disadvantage any already disadvantaged population,” said Melony Sorbero, a senior policy researcher at the RAND Corp.

Created under the 2010 Affordable Care Act, the readmissions program requires Medicare to cut payments to hospitals with excess 30-day readmissions for certain conditions. That list of conditions has expanded from the original three—heart attack, heart failure and pneumonia—to include chronic obstructive pulmonary disease, hip and knee replacements and coronary artery bypass grafts.
The CMS estimated it would save $538 million in fiscal 2017 from payment cuts to 2,588 hospitals under the program. About 3,330 acute-care hospitals and 430 long-term care facilities are eligible. Penalties are capped at 3% of Medicare inpatient prospective payments.

The Cures Act requires the CMS to adjust penalties based on the proportion of a hospital’s patients identified as dual-eligible beneficiaries, or those who qualify for both Medicare and Medicaid.

Those patients are often expensive to serve, accounting for nearly a third of total Medicare fee-for-service spending in 2012 despite constituting only 18% of beneficiaries.

According to Dr. Helen Burstin, chief scientific officer at the National Quality Forum, the risk-adjustment approach may benefit safety net hospitals the most, since it would allow for “apples to apples” comparisons. Burstin said it might also encourage hospitals to admit the most vulnerable patients, while money saved from reduced penalties could be invested in community initiatives for preventive health.

But even as they praised the intent of the provision, several experts and hospital leaders raised questions about how it would work.

In specifying how the CMS should adjust for risk, the Cures Act states that the HHS secretary “shall assign hospitals to groups” and apply “a methodology in a manner that allows for separate comparison of hospitals within each group.” Those groups would be based on hospitals’ overall proportion of dual-eligible individuals.

The secretary “may consider” the Medicare Payment Advisory Commission’s June 2013 report, which found that hospitals with higher proportions of poor patients tended to have higher readmission rates and higher Medicare penalties.

The report suggested setting different target readmission rates for different hospitals, grouped according to patient profiles.

For instance, hospitals whose patient populations are 30% dual-eligible will not be compared to hospitals where dual-eligibles are just 2% of the patient mix, said Philip Alberti, senior director for health equity research and policy for the Association of American Medical Colleges.

Beyond that, not much is clear.

Dr. Michelle Schreiber, senior vice president and chief quality officer at Henry Ford Health System in Detroit, said it will require long-term research to identify the most equitable approach to risk adjustment.

“The variables that will probably need to be included are not only patient-specific but also community-level variables, such as how stressed is the community,” Schreiber said. “If you’re poor, it increases the risk of readmission, but if you’re also poor in a community with poor resources compared to a community with rich resources—that too is different.”
This complexity is one reason the CMS has long been wary of incorporating some form of risk adjustment for socio-economic factors. The agency and the NQF have been studying whether and how to do it.

Although strong evidence indicates that these factors play a role in health outcomes, researchers have yet to figure out how to reliably predict the effects of different variables.

“These data are difficult to capture,” said Francois de Brantes, executive director of the not-for-profit Health Care Incentives Improvement Initiative. When de Brantes collaborated on research to see whether sorting patients by ZIP codes in New York City could predict patient outcomes, for instance, he and his colleagues came up empty.

But now that the bill is law, de Brantes said, “it kind of forces the industry to come up with a solution.”

The CMS has been wary of creating a lower standard of care for hospitals serving higher proportions of low-income patients. In 2013 the agency wrote that making accommodations for economic and demographic factors would “suggest that hospitals with low SES (socio-economic status) patients are held to different standards for the risk of readmission than hospitals treating higher SES patient populations.”

Indeed, some safety net hospitals have proved they can perform as well as any hospital on readmissions. The readmissions penalties that Medicare will impose in 2017 on members of America’s Essential Hospitals, a trade group representing safety net providers, run the gamut, according to a Modern Healthcare analysis.

Six of 161 organizations (which operate more than 220 hospitals and campuses) will be penalized between 2% and 3% of their inpatient Medicare pay. But twice as many will see no penalty at all, and many of the AEH members have improved their performance over the course of the program.

**MH TAKEAWAYS**

There’s still little agreement about how to achieve fairness for hospitals in low-income communities without lowering the bar for the quality of care they provide.

###

Copyright 2016 Crain Communications