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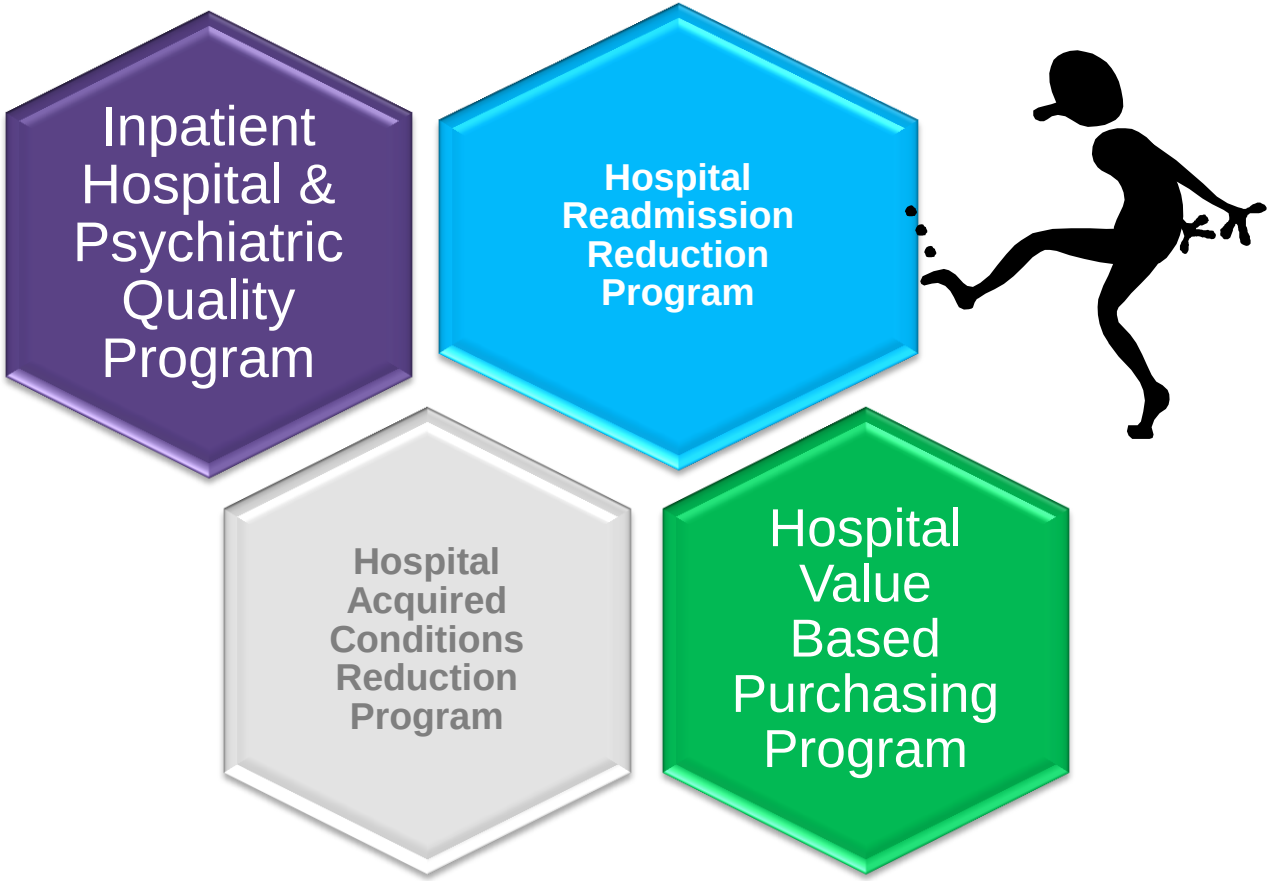
Overview of the FY 2014 IPPS Final Rule

Part 3 of 4: Hospital Readmission Reduction Program

Hospital Readmission Reduction Program

Part 3 of 4 of Review of the IPPS 2014 Final Rule



Hospital Readmission Reduction Program:

Part 3 of 4: A Detailed Review of the Final CMS FY 2014 IPPS Rule

Welcome and Introductions

Vicky Mahn DiNicola RN, MS, CPHQ
VP Research and Market Insights
Midas+ Xerox

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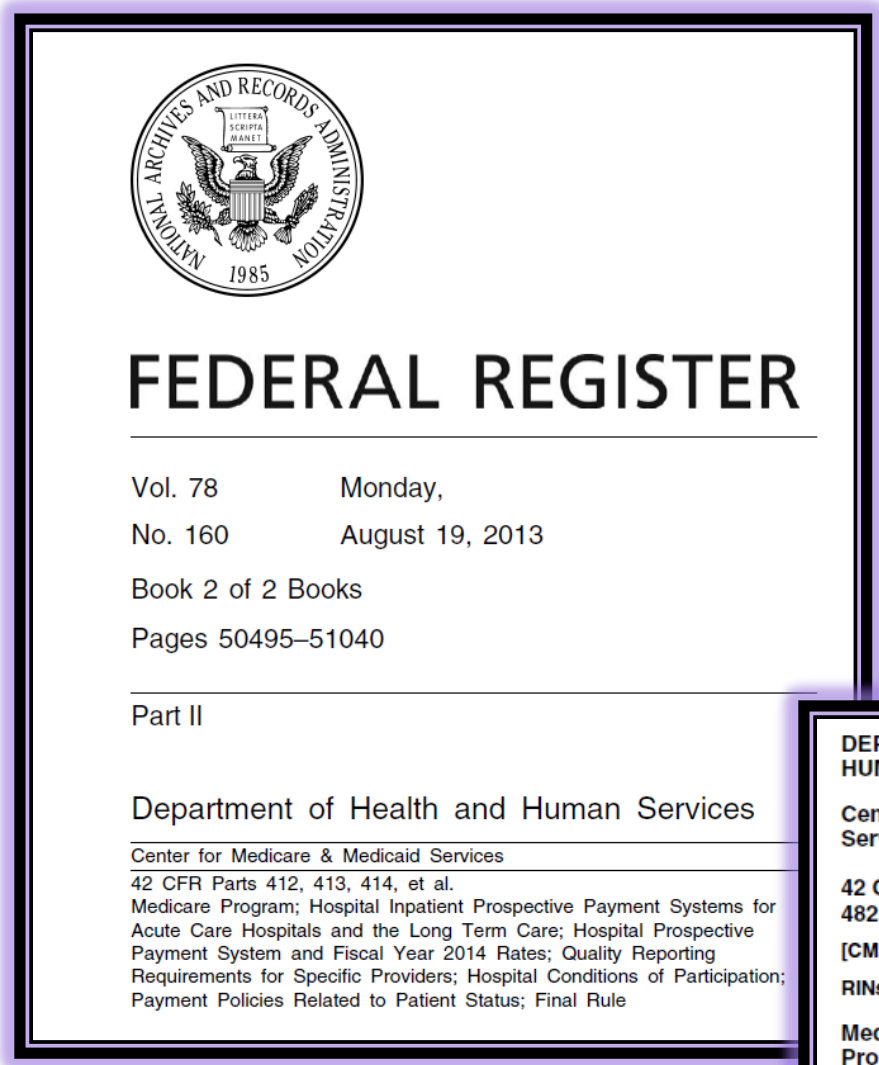
Questions regarding this briefing may be submitted directly to me in a private email simply by clicking on the comment bubble in the tool bar at the bottom right of your presentation screen, or you may contact me directly by sending me an email to vicky.mahn@xerox.com

Review of Final IPPS Rule for FY 2014 CMS-1599-F CMS-1455-F

Posted to Federal Registry August 19, 2013

http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf



FEDERAL REGISTER

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Book 2 of 2 Books
Pages 50495–51040

Part II

Department of Health and Human Services

Center for Medicare & Medicaid Services

42 CFR Parts 412, 413, 414, et al.
Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care; Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 414, 419, 424, 482, 485, and 489

[CMS–1599–F; CMS–1455–F]

RINs 0938–AR53 and 0938–AR73

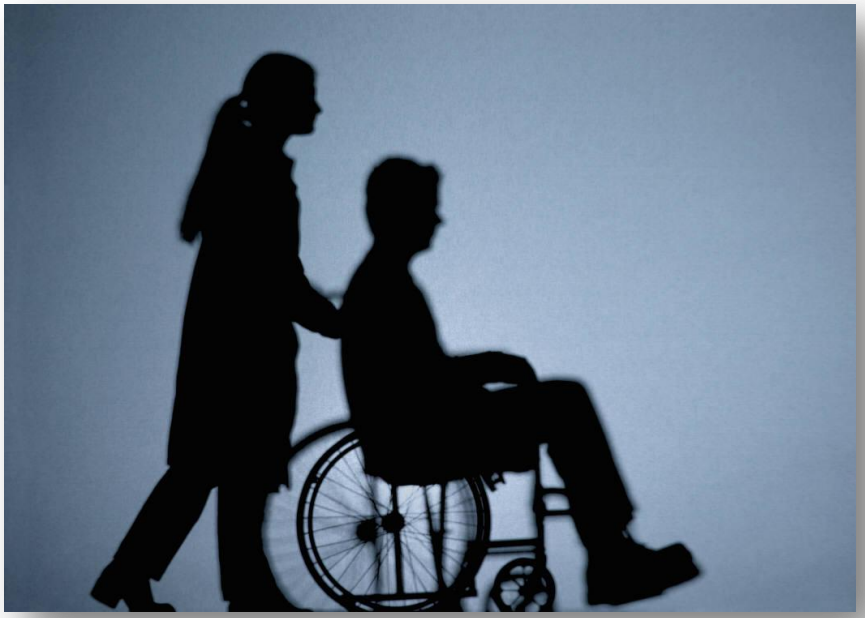
Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status

AGENCY: Centers for Medicare and Medicaid Services (CMS), HHS.

ACTION: Final rules.

Hospital Readmission Reduction Program

Began in FY 2013



- Began with payments for Medicare claims October 1, 2012
- Initial Populations of Acute MI, Pneumonia and Heart Failure
- 30-day Risk-standardized Readmissions (all cause)
- Based on excessive readmission ratios for discharges July 1, 2008 through June 30, 2012
- Hospitals financially penalized up to 1% of their Medicare Payments

COPD 30-day All Cause Risk Standardized Readmission Rate

HRR Program beginning with FY 2015
HIQR Program beginning with FY 2014

- ✓ *Acute exacerbation of COPD (4th largest Medicare diagnosis)*
- ✓ Median 30-day readmission rate among Medicare patients in 2008 was **22.0%**.
- ✓ NQF endorsed COPD 30-day All Cause Risk Standardized Readmission Rate (NQF #1891) in March, 2013
- ✓ Similar to Acute MI, Heart Failure and Pneumonia includes only patients ≥ 65, 30-day post discharge enrollment in Medicare FFS, excludes deaths, transfers to other acute care facilities, patients who leave AMA and planned readmissions
- ✓ Includes Acute Exacerbation of COPD as both a primary diagnosis and Acute Respiratory Failure with COPD as a secondary diagnosis

Elective Total Hip/Knee Arthroplasty 30-day All Cause Risk Standardize Readmission Rate

HRR Program beginning with FY 2015

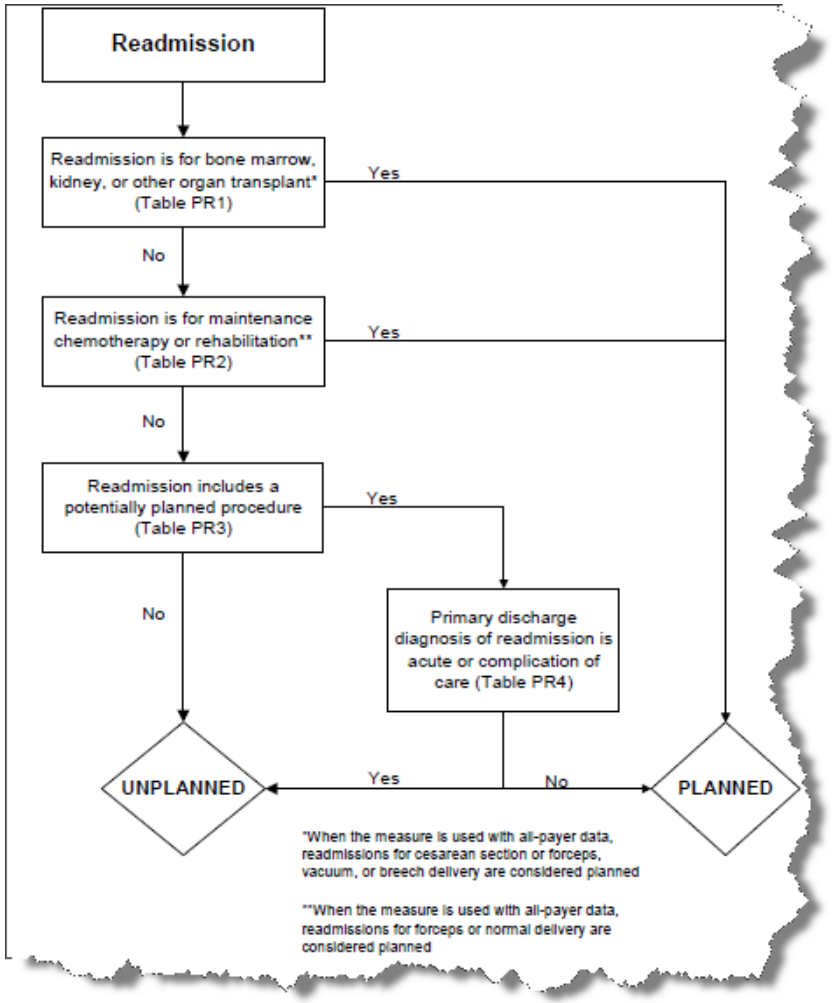
HIQR Program beginning with FY 2013

- ✓ *Elective total hip and knee arthroplasty (represents the largest procedural cost in the Medicare Budget).*
- ✓ Median 30-day readmission rate among Medicare patients between 2008 and 2010 was **5.7%**.
- ✓ NQF endorsed Elective Total Hip Arthroplasty/Total Knee Arthroplasty 30-day All Cause Risk Standardized Readmission Rate (NQF #1551) was approved for use in the Hospital Inpatient Quality Reporting Program in the FY 2013 IPPS/LTCH PPS Final Rule
- ✓ Similar to Acute MI, Heart Failure and Pneumonia includes only patients ≥ 65, 30-day post discharge enrollment in Medicare FFS, excludes deaths, transfers to other acute care facilities, patients who leave AMA and planned readmissions

Adding Planned Readmission Exclusions to CMS Readmission Methodology Starting in FY 2014

(October 1, 2013 discharges)

- **Planned readmission algorithm** added to all readmission measures to avoid penalizing hospitals for performing scheduled procedures within 30 days of discharge.
- This method also avoids counting unplanned readmissions that occur after a planned readmission, but within 30 days of discharge from the index admission.
- The Planned Readmission Algorithm uses a flow chart and four tables of procedures and conditions to classify readmissions as planned or unplanned.



http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HositalQualityInits/Measure-Methodology.html

Acute or Complication Categories Determined by Using AHRQ Diagnoses CCS Codes

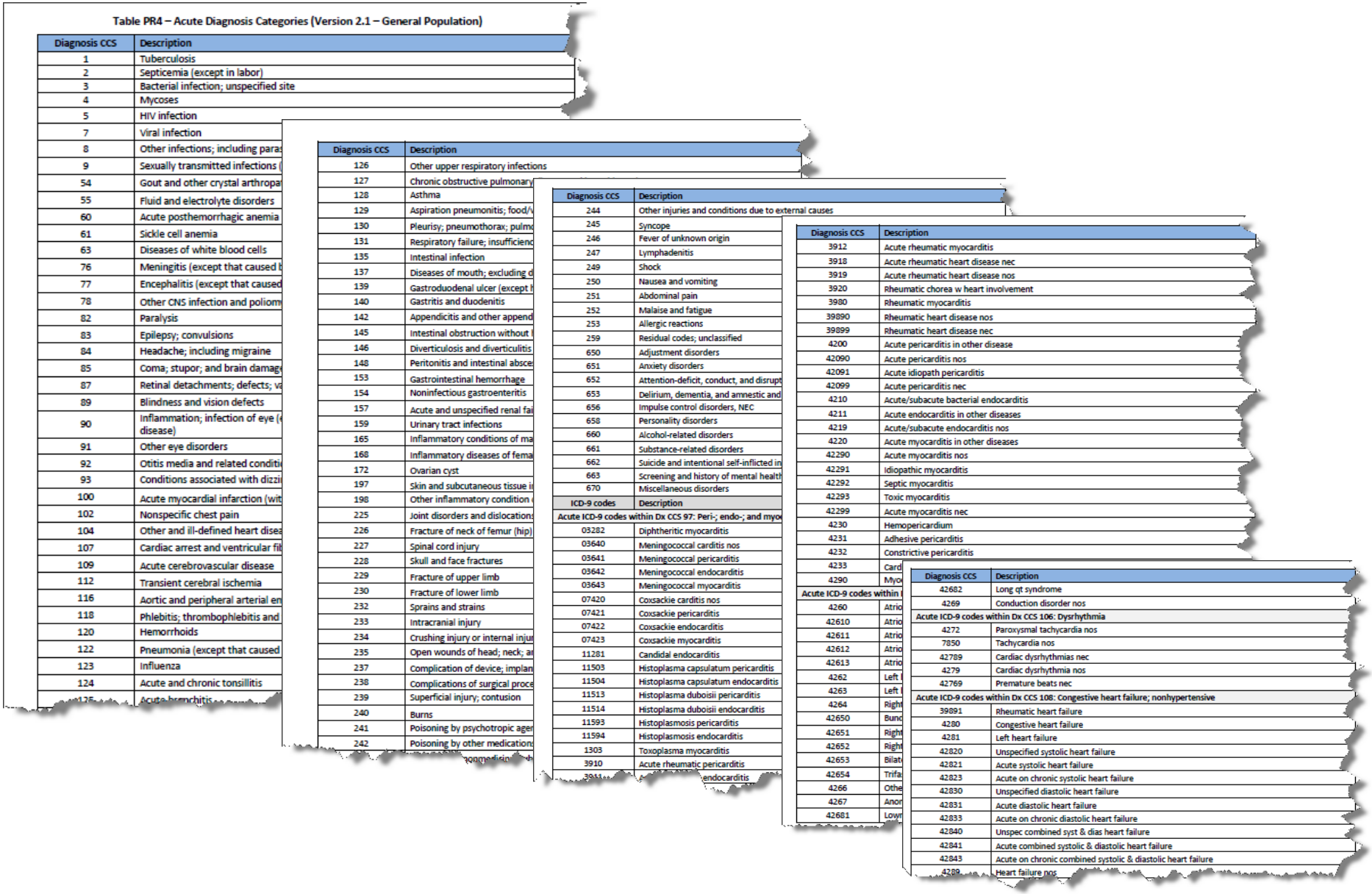


Table PR4 – Acute Diagnosis Categories (Version 2.1 – General Population)

Diagnosis CCS	Description
1	Tuberculosis
2	Septicemia (except in labor)
3	Bacterial infection; unspecified site
4	Mycoses
5	HIV infection
7	Viral infection
8	Other infections; including paras
9	Sexually transmitted infections (
54	Gout and other crystal arthropa
55	Fluid and electrolyte disorders
60	Acute posthemorrhagic anemia
61	Sickle cell anemia
63	Diseases of white blood cells
76	Meningitis (except that caused b
77	Encephalitis (except that caused
78	Other CNS infection and poliom
82	Paralysis
83	Epilepsy; convulsions
84	Headache; including migraine
85	Coma; stupor; and brain damag
87	Retinal detachments; defects; va
89	Blindness and vision defects
90	Inflammation; infection of eye (disease)
91	Other eye disorders
92	Otitis media and related conditi
93	Conditions associated with dizzi
100	Acute myocardial infarction (wit
102	Nonspecific chest pain
104	Other and ill-defined heart disea
107	Cardiac arrest and ventricular fib
109	Acute cerebrovascular disease
112	Transient cerebral ischemia
116	Aortic and peripheral arterial em
118	Phlebitis; thrombophlebitis and
120	Hemorrhoids
122	Pneumonia (except that caused
123	Influenza
124	Acute and chronic tonsillitis
125	Acute bronchitis

Diagnosis CCS	Description
126	Other upper respiratory infections
127	Chronic obstructive pulmonary
128	Asthma
129	Aspiration pneumonitis; food/v
130	Pleurisy; pneumothorax; pulmo
131	Respiratory failure; insufficienc
135	Intestinal infection
137	Diseases of mouth; excluding d
139	Gastroduodenal ulcer (except h
140	Gastritis and duodenitis
142	Appendicitis and other append
145	Intestinal obstruction without h
146	Diverticulosis and diverticulitis
148	Peritonitis and intestinal absce
153	Gastrointestinal hemorrhage
154	Noninfectious gastroenteritis
157	Acute and unspecified renal fai
159	Urinary tract infections
165	Inflammatory conditions of ma
168	Inflammatory diseases of fema
172	Ovarian cyst
197	Skin and subcutaneous tissue in
198	Other inflammatory condition (
225	Joint disorders and dislocations
226	Fracture of neck of femur (hip)
227	Spinal cord injury
228	Skull and face fractures
229	Fracture of upper limb
230	Fracture of lower limb
232	Sprains and strains
233	Intracranial injury
234	Crushing injury or internal injur
235	Open wounds of head; neck; an
237	Complication of device; implant
238	Complications of surgical proce
239	Superficial injury; contusion
240	Burns
241	Poisoning by psychotropic agen
242	Poisoning by other medications
	nonmedicin

Diagnosis CCS	Description
244	Other injuries and conditions due to external causes
245	Syncope
246	Fever of unknown origin
247	Lymphadenitis
249	Shock
250	Nausea and vomiting
251	Abdominal pain
252	Malaise and fatigue
253	Allergic reactions
259	Residual codes; unclassified
650	Adjustment disorders
651	Anxiety disorders
652	Attention-deficit, conduct, and disrupt
653	Delirium, dementia, and amnestic and
656	Impulse control disorders, NEC
658	Personality disorders
660	Alcohol-related disorders
661	Substance-related disorders
662	Suicide and intentional self-inflicted in
663	Screening and history of mental health
670	Miscellaneous disorders
ICD-9 codes	Description
Acute ICD-9 codes within Dx CCS 97: Peri-; endo-; and myo	
03282	Diphtheritic myocarditis
03640	Meningococcal carditis nos
03641	Meningococcal pericarditis
03642	Meningococcal endocarditis
03643	Meningococcal myocarditis
07420	Coxsackie carditis nos
07421	Coxsackie pericarditis
07422	Coxsackie endocarditis
07423	Coxsackie myocarditis
11281	Candidal endocarditis
11503	Histoplasma capsulatum pericarditis
11504	Histoplasma capsulatum endocarditis
11513	Histoplasma duboisii pericarditis
11514	Histoplasma duboisii endocarditis
11593	Histoplasmosis pericarditis
11594	Histoplasmosis endocarditis
1303	Toxoplasma myocarditis
3910	Acute rheumatic pericarditis
3911	endocarditis

Diagnosis CCS	Description
3912	Acute rheumatic myocarditis
3918	Acute rheumatic heart disease nec
3919	Acute rheumatic heart disease nos
3920	Rheumatic chorea w heart involvement
3980	Rheumatic myocarditis
39890	Rheumatic heart disease nos
39899	Rheumatic heart disease nec
4200	Acute pericarditis in other disease
42090	Acute pericarditis nos
42091	Acute idiopath pericarditis
42099	Acute pericarditis nec
4210	Acute/subacute bacterial endocarditis
4211	Acute endocarditis in other diseases
4219	Acute/subacute endocarditis nos
4220	Acute myocarditis in other diseases
42290	Acute myocarditis nos
42291	Idiopathic myocarditis
42292	Septic myocarditis
42293	Toxic myocarditis
42299	Acute myocarditis nec
4230	Hemopericardium
4231	Adhesive pericarditis
4232	Constrictive pericarditis
4233	Card
4290	Myo
Acute ICD-9 codes within	
4260	Atrio
42610	Atrio
42611	Atrio
42612	Atrio
42613	Atrio
4262	Left
4263	Left
4264	Right
42650	Bund
42651	Right
42652	Right
42653	Bilat
42654	Trifa
4266	Othe
4267	Anor
42681	Low

Diagnosis CCS	Description
42682	Long qt syndrome
4269	Conduction disorder nos
Acute ICD-9 codes within Dx CCS 106: Dysrhythmia	
4272	Paroxysmal tachycardia nos
7850	Tachycardia nos
42789	Cardiac dysrhythmias nec
4279	Cardiac dysrhythmia nos
42769	Premature beats nec
Acute ICD-9 codes within Dx CCS 108: Congestive heart failure; nonhypertensive	
39891	Rheumatic heart failure
4280	Congestive heart failure
4281	Left heart failure
42820	Unspecified systolic heart failure
42821	Acute systolic heart failure
42823	Acute on chronic systolic heart failure
42830	Unspecified diastolic heart failure
42831	Acute diastolic heart failure
42833	Acute on chronic diastolic heart failure
42840	Unspec combined syst & dias heart failure
42841	Acute combined systolic & diastolic heart failure
42843	Acute on chronic combined systolic & diastolic heart failure
4289	Heart failure nos

AHRQ Clinical Classification Software (CCS)

Table 2: Examples of single-level CCS procedure categories

Description	ICD-9-CM procedure Codes used to map	CCS category
Heart valve procedures	3500 3501 3502 3503 3504 3510 3511 3512 3513 3514 3520 3521 3522 3523 3524 3525 3526 3527 3528 3596 3599	43
Coronary artery bypass graft (CABG)	3610 3611 3612 3613 3614 3615 3616 3617 3619 362 363 3631	44

- Developed by AHRQ as part of the Healthcare Cost and Utilization Project (HCUP)
- Categorization scheme for ICD-9 diagnose and procedure codes
- Clusters over 14,000 diagnosis codes and 3,900 procedure codes into a manageable number of clinically meaningful categories
  - Single level diagnosis CCS: 285 mutually exclusive categories
  - Single level procedure CCS: 231 mutually exclusive categories
- Useful in research and statistical analysis
- Files downloaded and used with SAS or SPSS to convert ICD-9 codes to CCS codes
- Mental health populations have unique CCS-Mental Health and Substance Abuse (MHSA) tools
- See http://www.hcup-us.ahrq.gov/toolssoftware/ccs/CCSUsersGuide.pdf

Planned Readmission Exclusions

Always Planned

- Transplants (bone, kidney, organ)
- Cesarean section
- Normal pregnancy and/or delivery
- Forceps, vacuum and breech delivery
- Maintenance Chemotherapy
- Rehabilitation

Potentially Planned

When discharge diagnosis of readmission is NOT acute or a complication of care

- Laminectomy, spinal fusion
- Knee and hip replacement
- Limb amputation
- Thyroidectomy and endocrine surgery
- Lung resections
- Hernia repairs
- Oophorectomy, hysterectomy
- TURP, prostatectomy
- Colorectal and gastrectomy surgery
- Cardiac surgery (CABG, Valve Repair)
- Wound and burn debridement
- Laryngectomy, tracheostomy revisions
- **More!**

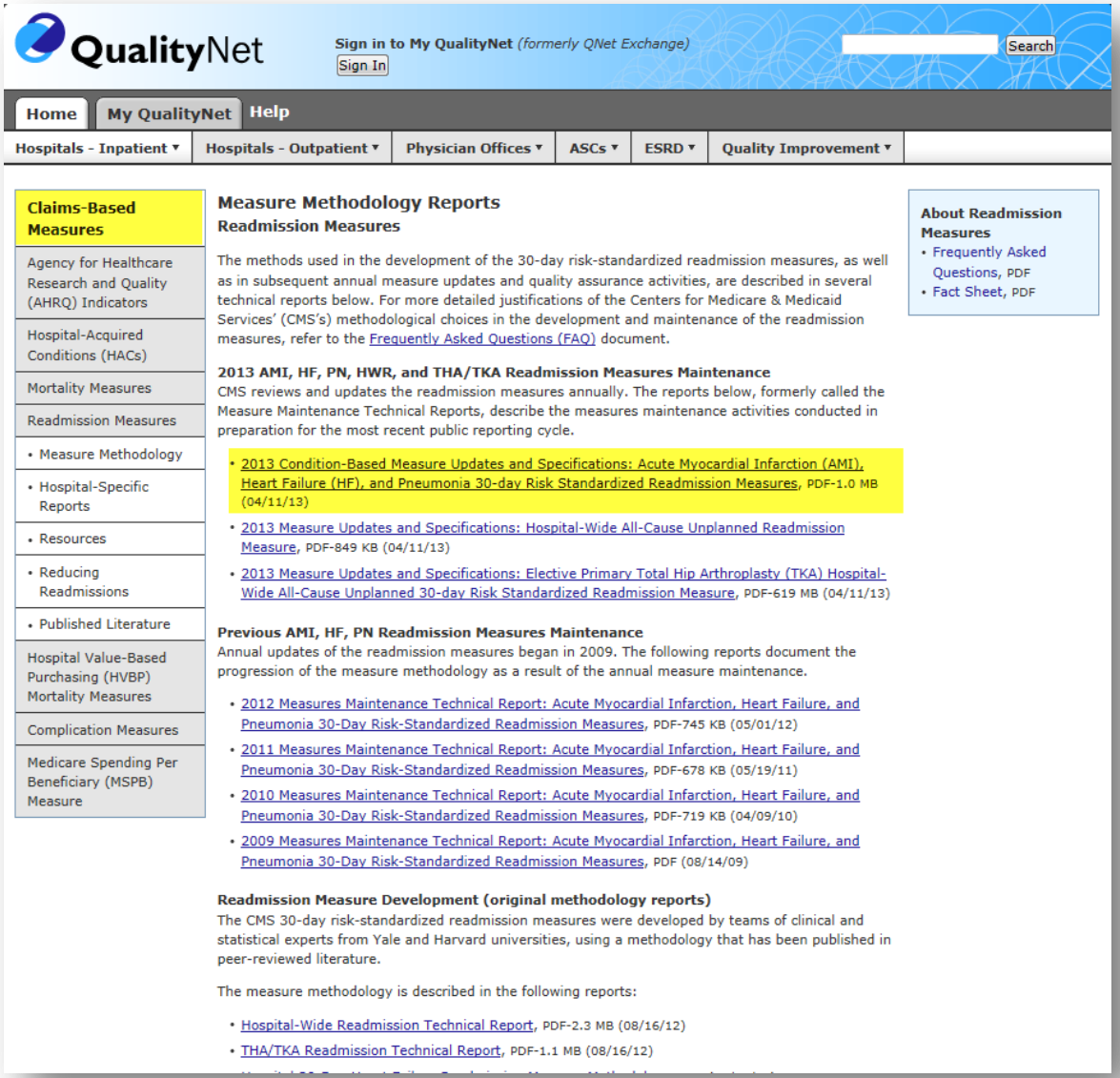
Impact on National Readmission Rates when Planned Readmissions are Excluded

This modified measurement technique reduced hospital wide 30-day all cause readmission rates from **16.5% to 16.0%** in the July 1, 2011 to June 30, 2012 data set

	Before	After
Acute MI	19.2%	18.2%
Heart Failure	24.6%	23.1%
Pneumonia	18.5%	17.8%

Table V.G.1. Comparison of Original AMI/HF/PN Measures Finalized in FY 2013 Relative to Proposed Revised AMI/HF/PN Measures for FY 2014
(Based on July 008 through June 2011 Discharges from 3,025 Hospitals – p. 478)

For More Information on Readmission Measure Methodology



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Claims-Based Measures

- Agency for Healthcare Research and Quality (AHRQ) Indicators
- Hospital-Acquired Conditions (HACs)
- Mortality Measures
- Readmission Measures
  - Measure Methodology
  - Hospital-Specific Reports
  - Resources
  - Reducing Readmissions
  - Published Literature
- Hospital Value-Based Purchasing (HVBP) Mortality Measures
- Complication Measures
- Medicare Spending Per Beneficiary (MSPB) Measure

Measure Methodology Reports

Readmission Measures

The methods used in the development of the 30-day risk-standardized readmission measures, as well as in subsequent annual measure updates and quality assurance activities, are described in several technical reports below. For more detailed justifications of the Centers for Medicare & Medicaid Services' (CMS's) methodological choices in the development and maintenance of the readmission measures, refer to the Frequently Asked Questions (FAQ) document.

2013 AMI, HF, PN, HWR, and THA/TKA Readmission Measures Maintenance

CMS reviews and updates the readmission measures annually. The reports below, formerly called the Measure Maintenance Technical Reports, describe the measures maintenance activities conducted in preparation for the most recent public reporting cycle.

- 2013 Condition-Based Measure Updates and Specifications: Acute Myocardial Infarction (AMI), Heart Failure (HF), and Pneumonia 30-day Risk Standardized Readmission Measures, PDF-1.0 MB (04/11/13)
- 2013 Measure Updates and Specifications: Hospital-Wide All-Cause Unplanned Readmission Measure, PDF-849 KB (04/11/13)
- 2013 Measure Updates and Specifications: Elective Primary Total Hip Arthroplasty (TKA) Hospital-Wide All-Cause Unplanned 30-day Risk Standardized Readmission Measure, PDF-619 MB (04/11/13)

Previous AMI, HF, PN Readmission Measures Maintenance

Annual updates of the readmission measures began in 2009. The following reports document the progression of the measure methodology as a result of the annual measure maintenance.

- 2012 Measures Maintenance Technical Report: Acute Myocardial Infarction, Heart Failure, and Pneumonia 30-Day Risk-Standardized Readmission Measures, PDF-745 KB (05/01/12)
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- 2009 Measures Maintenance Technical Report: Acute Myocardial Infarction, Heart Failure, and Pneumonia 30-Day Risk-Standardized Readmission Measures, PDF (08/14/09)

Readmission Measure Development (original methodology reports)

The CMS 30-day risk-standardized readmission measures were developed by teams of clinical and statistical experts from Yale and Harvard universities, using a methodology that has been published in peer-reviewed literature.

The measure methodology is described in the following reports:

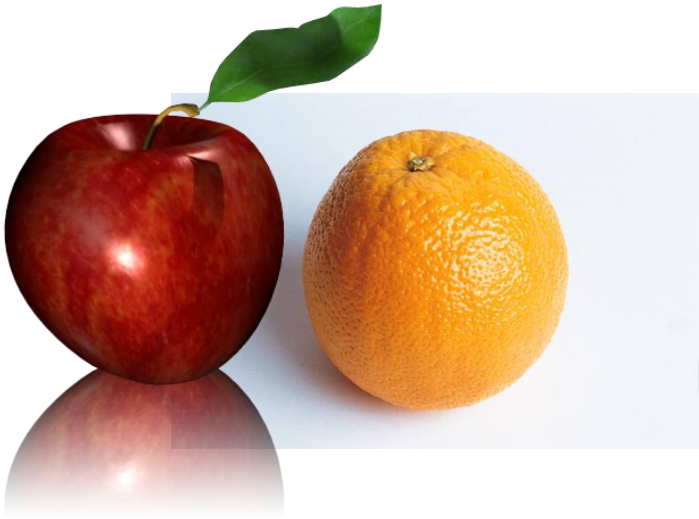
- Hospital-Wide Readmission Technical Report, PDF-2.3 MB (08/16/12)
- THA/TKA Readmission Technical Report, PDF-1.1 MB (08/16/12)

About Readmission Measures

- Frequently Asked Questions, PDF
- Fact Sheet, PDF

CMS Readmission Measures

- Calculated from Medicare Part A and B Claims Data
- Include readmissions back to ANY facility not jus YOUR facility
- Individual hospitals and vendors can't replicate exactly
- Complex risk model
- Getting more complex!



Note: *The Hospital Readmissions Reduction Program includes only subsection(d) hospitals and hospitals paid under section 1814(b)(3), while the IQR calculations include non-Inpatient Prospective Payment System (IPPS) hospitals such as critical access, territories, and cancer hospitals, as well as Veterans Health Administration (VA) hospitals. Consequently, your hospital's results for AMI, HF, and PN may differ from those calculated for IQR because they are calculated using a different set of hospitals.*

CMS Readmission Measures

All derived from Medicare Claims

Inclusions for Index Admissions

- Medicare FFS Part A and B for 12 months prior to index admission
- VA beneficiaries (no 12 month enrollment requirement applies)
- Aged 65 years or over
- Admissions that were discharged and readmitted to same hospital on the same day with DIFFERENT diagnoses

Exclusions for Index Admissions

- Patients discharged and readmitted to same hospital on the same day with SAME diagnoses *(the readmit will be combined with the previous index admission and considered to be one single encounter for measure purposes)*
- In-hospital death
- Discharged against medical advise
- Less than 30 days post-discharge enrollment in Medicare FFS program
- Transferred to another acute care facility *(admissions to another hospital within 1 day of discharge are considered transfers regardless of discharge disposition)*
- Acute MI patients admitted and discharged on same day

Multiple Readmissions

- If a patient has more than one admission within 30-days, only the first one is counted as a readmission.
- No hospitalization will be counted as both a readmission and an index admission within the same measure.
- However, because the cohorts for the various readmission measure populations are determined independently, a readmission in one measure may qualify as an index admission in another CMS readmission measure.

Variables Used to Adjust Data in CMS Risk Standardized Readmission Rates

Variables Used

- Age
- Gender
- Cardiovascular disease*
- Comorbidities*
  - Renal Disease
  - COPD, Asthma, Pneumonia
  - Fluid & electrolyte imbalance
  - Urinary Tract Infection
  - Psychiatric Disorders
  - Liver or biliary disease
  - Drug or alcohol abuse
  - Peptic Ulcer Disease
  - Decubitus Ulcers
  - Anemia
  - Infection
  - Cancer
  - Diabetes
  - Malnutrition
  - Dementia
  - Stroke
  - Paralysis
  - Sepsis
  - Shock

Variables NOT used

- Admission source
- Discharge disposition
- Socioeconomic status
- Language barriers
- Insurance status
- Post discharge support structure
- Functional and cognitive status
- Health literacy
- Access to primary care

** Each clinical population, including the hospital-wide 30-day all cause readmission measure has slightly different variables for cardiovascular disease and comorbidities*

Fractional Blobs Really??

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About Readmission Measures

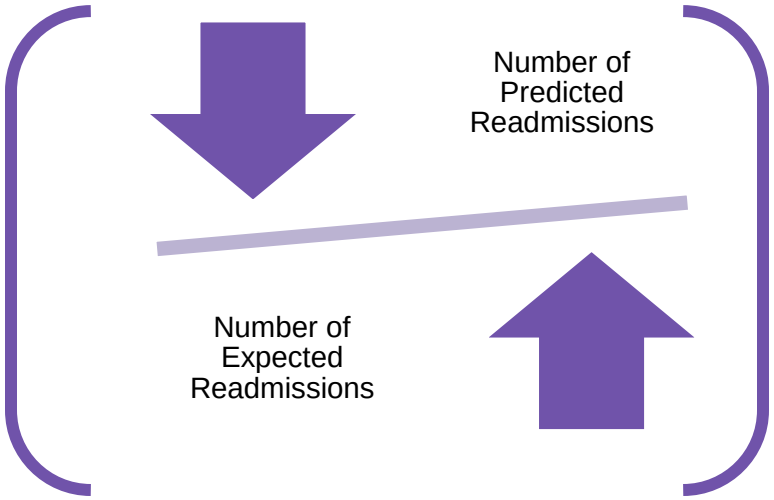
- Frequently Asked Questions, PDF
- Fact Sheet, PDF

The Statistical Methods used by CMS for risk adjustment are documented here:

www.hospitalcompare.hhs.gov/staticpages/for-professionals/ooc/statistcal-methods.aspx

Risk-Standardized Readmission Rates

Excess Readmission Ratio ✖ **National Unadjusted Readmission Rate**



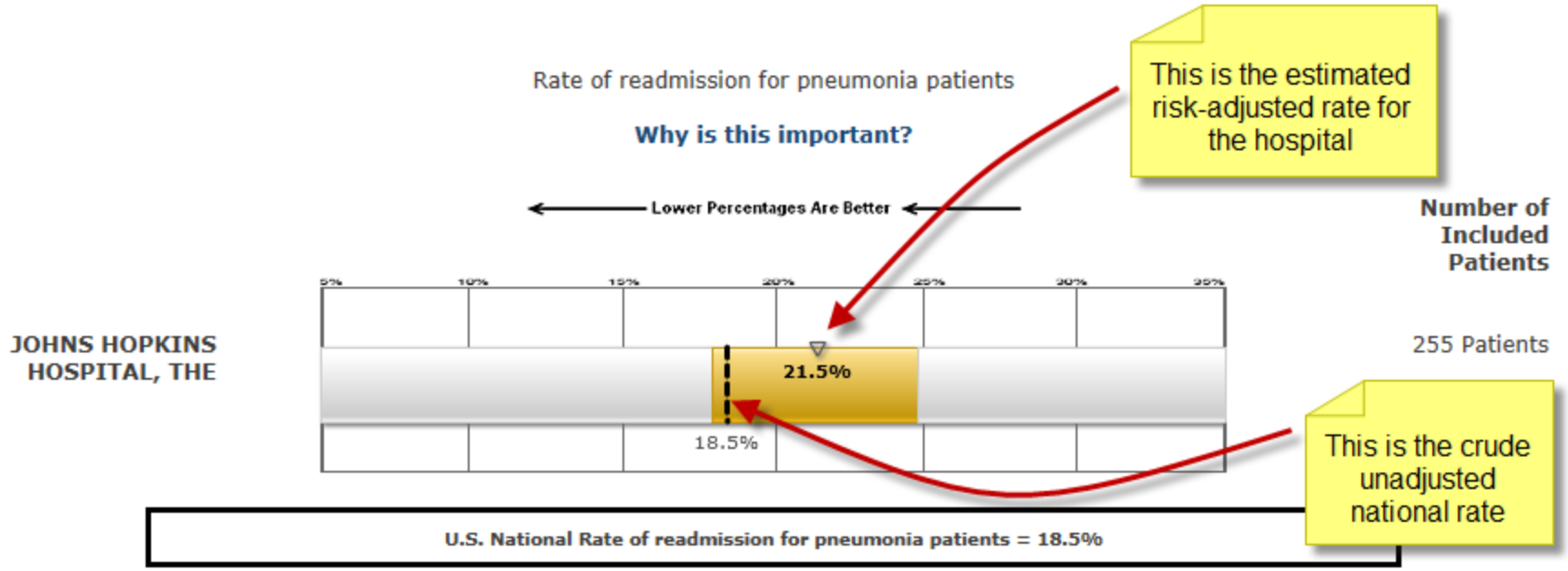
Excess Readmission Ratio < 1 = lower-than expected readmission rates (or better quality)

Predicted = The number of readmissions predicted based on the hospital's performance with its observed case mix. Predicted values are based on hierarchical logistic regression models that include variables about the patient, such as age, gender, comorbid diseases and indicators of patient frailty.

Expected = The number of readmissions expected on the basis of the nation's performance with that hospital's case mix.

Interpreting QNET Reports

http://www.medicare.gov/hospitalcompare/



- Interval performance with overlap on either side of the crude unadjusted national rate are reported as “same as” other hospitals

Interpreting QNET Reports

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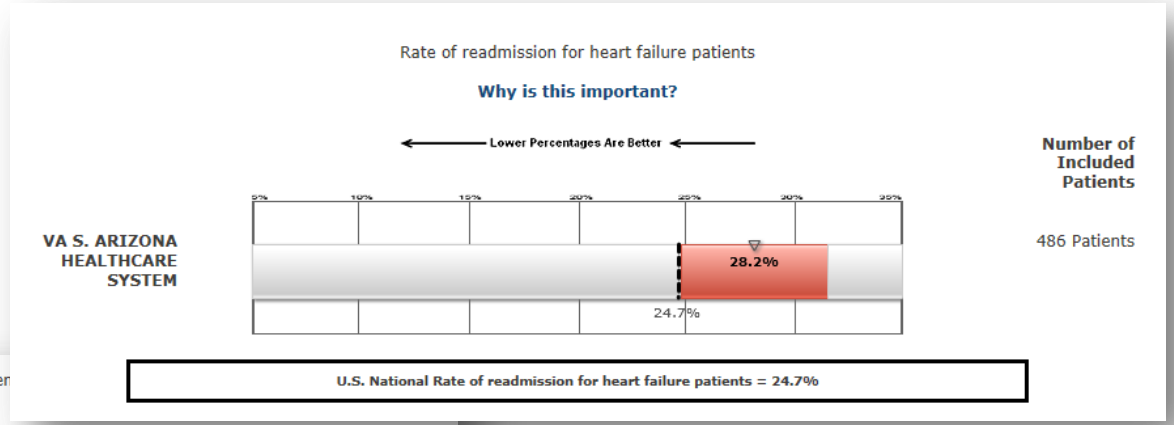

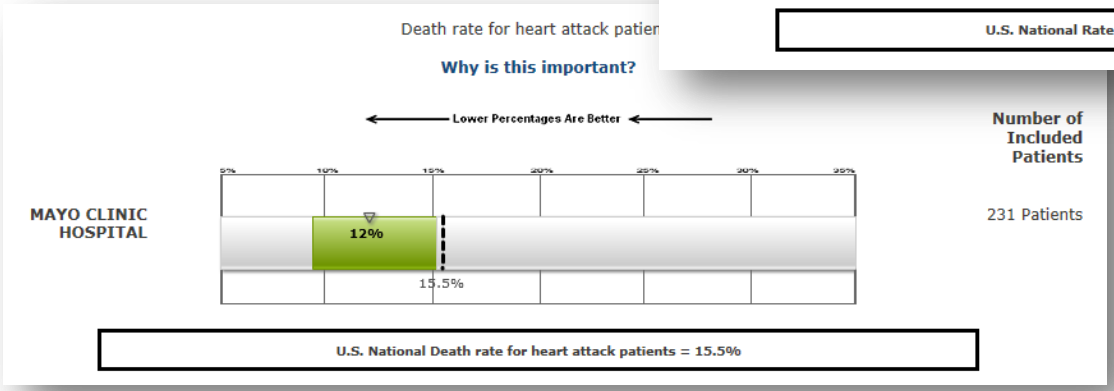

- Interval performance completely to the right of the national crude unadjusted national rate are "worse than" other hospitals
- Interval performance completely to the left of the national crude unadjusted national rate are "better than" other hospitals

Interpreting QNET Reports

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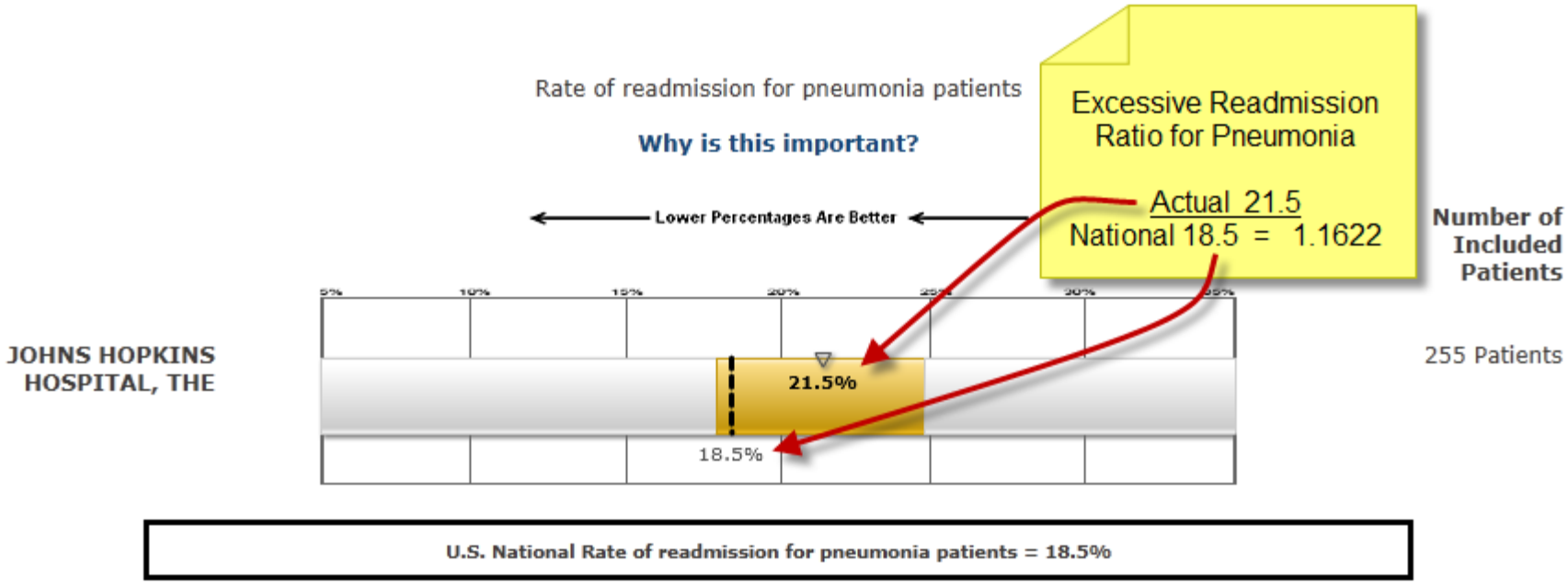

- Interval performance with overlap on either side of the crude unadjusted national rate are reported as “same as” other hospitals
- Excessive Readmission Ratio calculated for FY 2014 based on discharged July 1, 2009 to June 30, 2012

Excess Readmission Ratio Replication Instructions

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Readmissions Reduction

- Hospital-Specific Reports
- Resources
- Questions and Comments

Resources

Hospital Readmissions Reduction Program

Timeline, PDF-17 KB (06/20/12) – a general timeline for the implementation of the proposed FY 2013 Hospital Readmissions Reduction Program

Frequently Asked Questions, PDF-69 KB (06/20/12) – a list of questions and answers regarding the calculation and public reporting of the CMS 30-day Risk-Standardized Readmission measures for the Hospital Readmissions Reduction Program.

Excess Readmission Ratio Replication Instructions, PDF-60 KB (06/20/12) – instructions on how to replicate Excess Readmission Ratios. This document was included with each hospital's Hospital-Specific Report (HSR) and discharge-level data file along with an example of how to do the replication in Excel. If your hospital did not receive an HSR and would like the example of how to do the replication instructions, contact cms_readmissions_reduction@mathematica-mpr.com.

Fiscal Year 2013 Hospital Readmissions Reduction Program Measure Methodology Report, PDF-237 KB (6/20/12) – a detailed explanation of the methodology for the 30-day Risk-Standardized Readmission measures for the Hospital Readmissions Reduction Program.

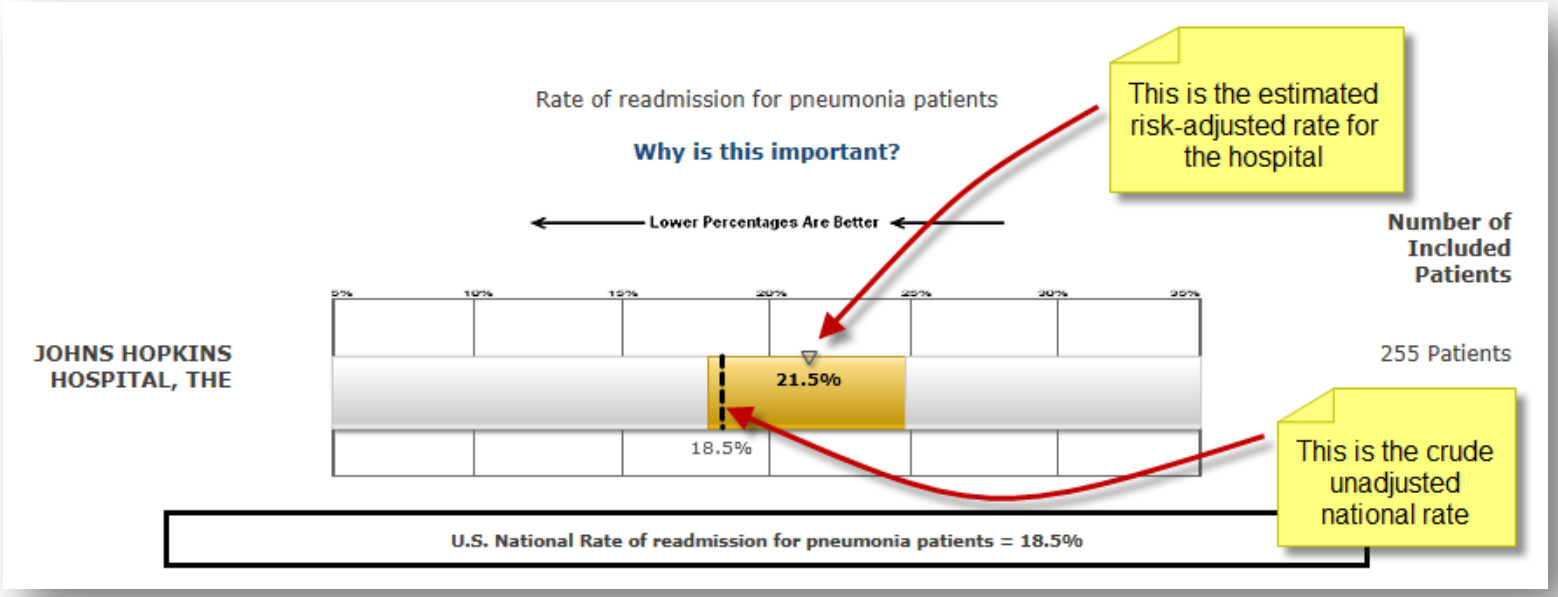
Use the Hospital General Information table to locate provider ID numbers (CMS Certification Numbers, or CCNs) and names of hospitals. With provider IDs from the discharge-level date file accompanying the hospital-specific report (HSR), this table can also be used to determine where a patient was readmitted.

Risk-standardized Readmission Rates

Excess Readmission Ratio

National Unadjusted Readmission Rate

1.162 ✖ **18.5** = **21.5**



Calculating Financial Impact of Hospital Readmission Reduction Program

- Hospital Readmission Reduction Program began with October 1, 2012 discharges for initial populations Acute MI, Heart Failure & Pneumonia
- 2,217 hospitals will be assessed a penalty ranging from 0.01 to 1 percent of their Medicare revenue in FY 2013 (cap is increasing to 2% in 2014 and 3% in 2015)
- CMS reports reduction of > 70,000 readmissions in 2012 (19% to 17.2%)
- FY 2013 projected savings of approximately $280 to 300 million (or 0.3 percent) of total Medicare IPPS operating payments
- FY 2014 projects approximately $175 million (0.2 percent) reduction in payment to hospitals

Calculating Financial Impact for Your Hospital's Performance in the Readmission Reduction Program

Hospital's Base Operating DRG Amount
(before any adjustments made by Value-based purchasing)

x

Adjustment Factor determined by the higher of Two Values

Hospital Specific Adjustment Factor

Floor Adjustment Factor

FY 2013 0.9900
FY 2014 0.9800
FY 2015 0.9700

The GREATER value of the two becomes your hospital's adjustment factor for any given fiscal year

Steps to Calculate Your Hospital's Adjustment Factor

Adjustment Factor = 1 − (Aggregate payments for excess readmissions / Aggregate payments for all discharges)

Step 1: Calculate aggregate payments for all discharges

(Current Base DRG payment x Medicare Part A Volume
(July 1, 2008 to June 30, 2011)

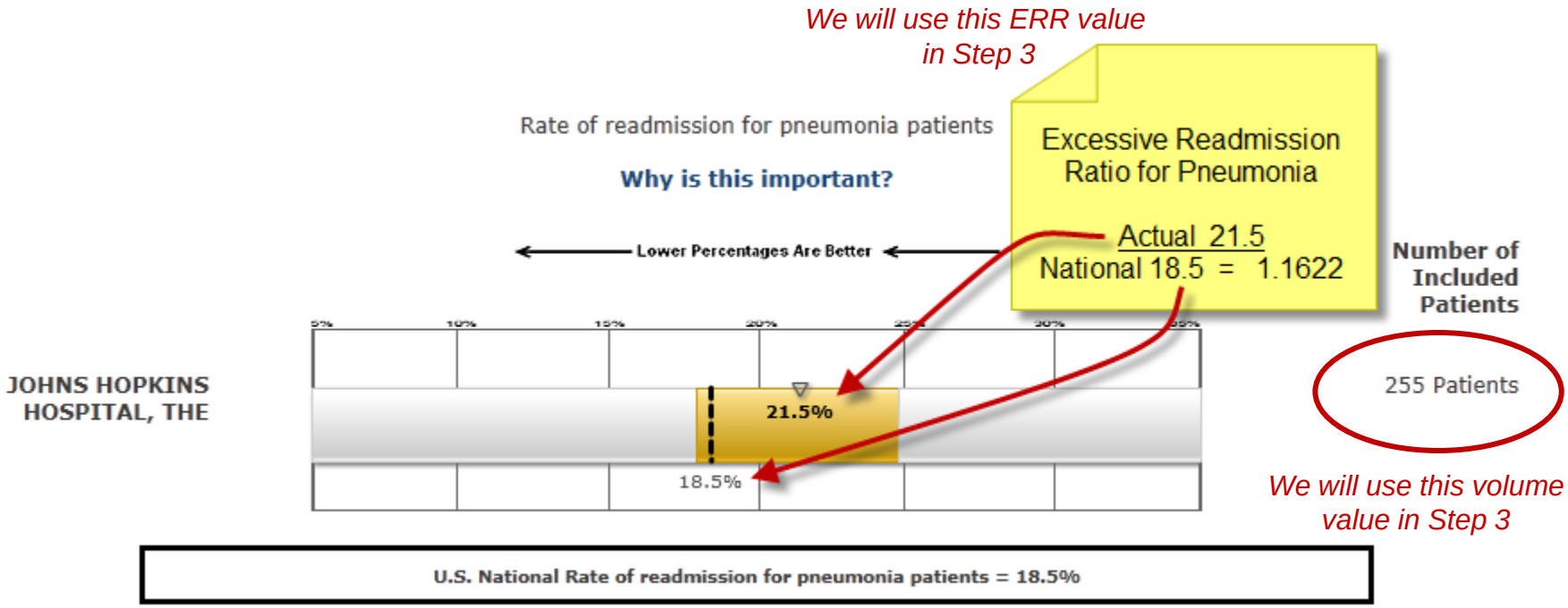
…keep in mind this volume represents over 3 years July 1, 2008 to June 30, 2011 and is applicable to FY 2013 Payment determination

$7830 x 27,601 = $216,115,830

Steps to Calculate Your Hospital's Adjustment Factor

$$\text{Adjustment Factor} = 1 - \left(\frac{\text{Aggregate payments for excess readmissions}}{\text{Aggregate payments for all discharges}} \right)$$

Step 2: Go to Hospital Compare to obtain population volumes and calculate your hospital's excessive readmission ratio (ERR) for Acute MI, Heart Failure and Pneumonia



Steps to Calculate Your Hospital's Adjustment Factor

$$\text{Adjustment Factor} = 1 - \left(\frac{\text{Aggregate payments for excess readmissions}}{\text{Aggregate payments for all discharges}} \right)$$

Step 3: Calculate aggregate payments for excessive readmissions

We got the ERR values in Step 2

(Base DRG payment x Acute MI volume) x (ERR – 1) =
($7830 x 415) x [(20.6 Hospital /19.7 National) – 1] = $148,500 in Excess Payments

(Base DRG payment x Heart Failure volume) x (ERR – 1) =
($7830 x 673) x [(25.6 Hospital /24.7 National) – 1] = $191,813 in Excess Payments

(Base DRG payment x Pneumonia volume) x (ERR -1) =
($7830 x 255) x [(21.5 Hospital /18.5 National) – 1] = $323,857 in Excess Payments

< 1 = NO EXCESS PAYMENTS

Only include Populations with Excess Payments in Total Calculation

---

Aggregate payments for excess readmissions = $664,170 Total Excess Payment

*You have to have zero excess payments in **all three** populations in order to avoid a reduction in your hospital's adjustment factor*

Revised Step 3 to Calculate Your Hospital's Adjustment Factor for FY 2015

$$\text{Adjustment Factor} = 1 - \left(\frac{\text{Aggregate payments for excess readmissions}}{\text{Aggregate payments for all discharges}} \right)$$

Step 3: Calculate aggregate payments for excessive readmissions

(Base DRG payment x Acute MI volume) x (ERR – 1) =
($7830 x 415) x [(20.6 Hospital /19.7 National) – 1] = $148,500 in Excess Payments

(Base DRG payment x Heart Failure volume) x (ERR – 1) =
($7830 x 673) x [(25.6 Hospital /24.7 National) – 1] = $191,813 in Excess Payments

(Base DRG payment x Pneumonia volume) x (ERR -1) =
($7830 x 255) x [(21.5 Hospital /18.5 National) – 1] = $323,857 in Excess Payments

(Base DRG payment x COPD volume) x (ERR – 1) =
($7830 x ___) x [(___ Hospital /22.0 National) – 1] = $_____ in Excess Payments

(Base DRG payment x TKA/THA volume) x (ERR -1) =
($7830 x ____) x [(____ Hospital /5.7 National) – 1] = $_____ in Excess Payments

< 1 = NO EXCESS PAYMENTS

*You have to have zero in all **FIVE** populations in order to avoid a reduction in your adjustment factor*

Steps to Calculate Your Hospital's Adjustment Factor

Step 4: Plug in your numbers

$$\text{Adjustment Factor} = 1 - \left(\frac{\text{Aggregate payments for excess readmissions}}{\text{Aggregate payments for all discharges}} \right)$$

$$\text{Adjustment Factor} = 1 - \left(\frac{\$\ 664{,}170 \textit{ from step 3}}{\$\ 216{,}115{,}830 \textit{ from step 1}} \right)$$

Adjustment Factor = 0.9693

Final Step to Calculating Your Hospital's Adjustment Factor for the Hospital Readmission Reduction Program

Step 5: Compare your hospital's adjustment factor to the floor adjustment factor for the selected fiscal year. The larger value becomes your hospital's adjustment value!

Floor adjustment set at 0.9900 for FY 2013, 0.9800 for FY 2014, and 0.9700 for FY 2015 and subsequent fiscal years

Hospital's Base Operating DRG Amount
(before any adjustments made by Value-based purchasing)

x

Adjustment Factor determined by Hospital's Readmission Rates

Ratio = 0.9693
Floor Adjustment = .9900

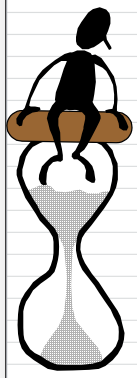
Use the largest of the two values

$7830 x .9900 = Reduced Base DRG Payment to $7752 in FY 2013
$7830 x .9800 = Reduced Base DRG Payment to $7673 in FY 2014

Meaning an overall payment reduction of $78 in FY 2013 for each Medicare claim.
In FY 2014 this same performance would result in an overall payment reduction of $157

Readmission Penalties for FY 2013 Payments are Publicly Available at

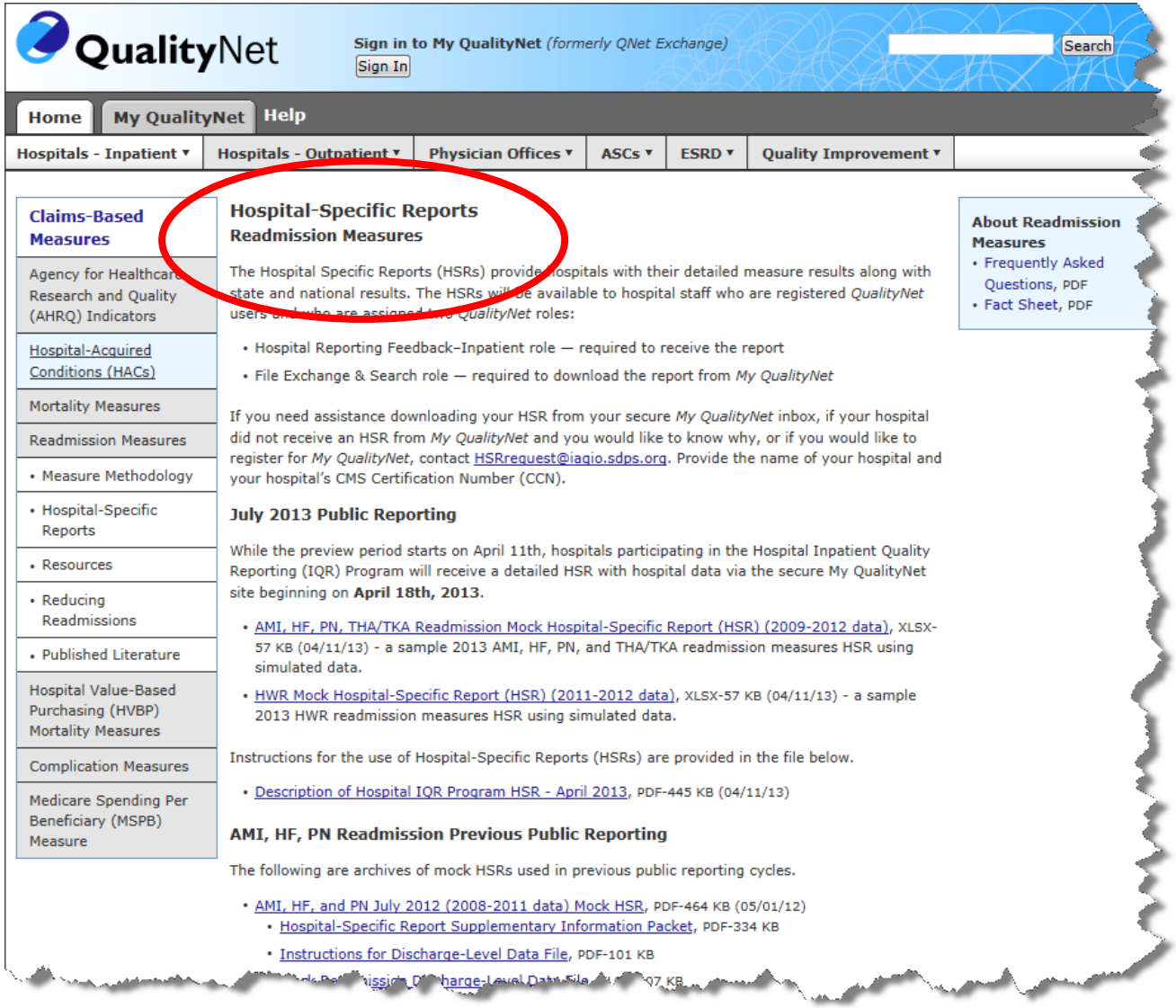
http://www.kaiserhealthnews.org/Stories/2013/August/02/readmission-penalties-medicare-hospitals-year-two.aspx



Source: Kaiser Health News analysis of data from the Centers for Medicare & Medicaid Services

CMS Certification Number (CCN)	FY 2014 Readmissions Adjustment Factor	Name	City	State	County	FY2013 Readmission Penalty	FY 2014 Readmission Penalty	Change 2013-4	2014 Pe
10036	0.9967	ANDALUSIA REGIONAL HOSPITAL	ANDALUSIA	ALABAMA	COVINGTON	0.59%	0.33%	-0.26%	Penalty
10079	1	ATHENS-LIMESTONE HOSPITAL	ATHENS	ALABAMA	LIMESTONE	0.04%	0.00%	-0.04%	No Pen
10169	0.9892	ATMORE COMMUNITY HOSPITAL	ATMORE	ALABAMA	ESCAMBIA	0.95%	1.08%	0.13%	Penalty
10149	0.9988	BAPTIST MEDICAL CENTER EAST	MONTGOMERY	ALABAMA	MONTGOMERY	0.36%	0.12%	-0.24%	Penalty
10023	0.9973	BAPTIST MEDICAL CENTER SOUTH	MONTGOMERY	ALABAMA	MONTGOMERY	0.75%	0.27%	-0.48%	Penalty
10058	0.9995	BIBB MEDICAL CENTER	CENTREVILLE	ALABAMA	BIBB	0.00%	0.05%	0.05%	Penalty
10139	0.9996	BROOKWOOD MEDICAL CENTER	BIRMINGHAM	ALABAMA	JEFFERSON	0.00%	0.04%	0.04%	Penalty
10112	0.9968	BRYAN W WHITFIELD MEM HOSP INC	DEMOPOLIS	ALABAMA	MARENGO	0.28%	0.32%	0.04%	Penalty
10110	0.9979	BULLOCK COUNTY HOSPITAL	UNION SPRINGS	ALABAMA	BULLOCK	0.23%	0.21%	-0.02%	Penalty
10018	1	CALLAHAN EYE FOUNDATION HOSPITAL	BIRMINGHAM	ALABAMA	JEFFERSON	0.00%	0.00%	0.00%	No Penal
10022	0.9986	CHEROKEE MEDICAL CENTER	CENTRE	ALABAMA	CHEROKEE	0.31%	0.14%	-0.17%	Penalty
10043	0.9961	CHILTON MEDICAL CENTER	CLANTON	ALABAMA	CHILTON	0.07%	0.39%	0.32%	Penalty
10101	0.9999	CITIZENS BAPTIST MEDICAL CENTER	TALLADEGA	ALABAMA	TALLADEGA	0.00%	0.01%	0.01%	Penalty
10073	0.996	CLAY COUNTY HOSPITAL	ASHLAND	ALABAMA	CLAY	0.26%	0.40%	0.14%	Penalty
10034	0.9944	COMMUNITY HOSPITAL INC	TALLASSEE	ALABAMA	ELMORE	0.04%	0.56%	0.52%	Penalty
10137	1	COOPER GREEN MERCY HOSPITAL	BIRMINGHAM	ALABAMA	JEFFERSON	0.00%	0.00%	0.00%	No Pen
10164	0.9978	COOSA VALLEY MEDICAL CENTER	SYLACAUGA	ALABAMA	TALLADEGA	0.58%	0.22%	-0.36%	Penalty
10008	1	CRENSHAW COMMUNITY HOSPITAL	LUVERNE	ALABAMA	CRENSHAW	0.00%	0.00%	0.00%	No Penal
10131	0.9996	CRESTWOOD MEDICAL CENTER	HUNTSVILLE	ALABAMA	MADISON	0.02%	0.04%	0.02%	Penalty
10035	0.9984	CULLMAN REGIONAL MEDICAL CENTER	CULLMAN	ALABAMA	CULLMAN	0.03%	0.16%	0.13%	Penalty
10092	0.9957	D C H REGIONAL MEDICAL CENTER	TUSCALOOSA	ALABAMA	TUSCALOOSA	0.30%	0.43%	0.13%	Penalty
10099	0.9939	D W MCMILLAN MEMORIAL HOSPITAL	BREWTON	ALABAMA	ESCAMBIA	0.29%	0.61%	0.32%	Penalty
10021	1	DALE MEDICAL CENTER	OZARK	ALABAMA	DALE	0.00%	0.00%	0.00%	No Pen
10085	0.9999	DECATUR GENERAL HOSPITAL	DECATUR	ALABAMA	MORGAN	0.31%	0.01%	-0.30%	Penalty
10012	0.9969	DEKALB REGIONAL MEDICAL CENTER	FORT PAYNE	ALABAMA	DE KALB	0.28%	0.31%	0.03%	Penalt

Hospital-Specific Reports



- Go to qualitynet.org for your hospital's HSR workbook
- Preview period started April 18, 2013
- Must be a QNET administrator to download into your secure inbox

Hospital-Specific Reports

Your hospital's performance

Table I.1: Your Hospital's Performance on 30-Day Risk-Standardized Readmission for AMI, HF, PN, and THA/TKA

Table I.1: Your Hospital's Performance on 30-Day Risk-Standardized Readmission for AMI, HF, PN, and THA/TKA
HOSPITAL NAME
July 2009 through June 2012

Items Available on Hospital Compare	AMI 30-Day Readmission	HF 30-Day Readmission	PN 30-Day Readmission	THA/TKA 30-Day Readmission
Your Hospital's Comparative Performance	Number of Cases Too Small*	No Different than U.S. National Rate	Worse than U.S. National Rate	No Different than U.S. National Rate
Total Number of Eligible Discharges (Denominator) at Your Hospital	23	26	25	27
RSRR at Your Hospital	19.8%	24.3%	22.0%	6.3%
Lower Limit of 95% Interval Estimate	15.8%	20.0%	18.5%	4.0%
Upper Limit of 95% Interval Estimate	23.8%	28.6%	25.5%	8.6%
Crude Readmission Rate (Numerator/ Denominator) in the U.S.	18.3%	23.0%	17.6%	5.4%
Additional Performance Information	**AMI 30-Day Readmission**	**HF 30-Day Readmission**	**PN 30-Day Readmission**	**THA/TKA 30-Day Readmission**
Total Number of Unplanned 30-Day Readmissions (Numerator) at Your Hospital	4	6	5	2
Crude Readmission Rate (Numerator/ Denominator) at Your Hospital	17.4%	23.1%		
Average RSRR in Your State	20.5%	25.1%		
Total Number of Unplanned 30-Day Readmissions (Numerator) in Your State	95	405		
Number of Eligible Discharges (Denominator) in Your State	527	1,632		
Crude Readmission Rate (Numerator/ Denominator) in Your State	18.0%	24.8%		
Total Number of Unplanned 30-Day Readmissions (Numerator) in the U.S.	93,966	291,063		
Number of Eligible Discharges (Denominator) in the U.S.	513,331	1,262,826	1	

*Number of cases too small (fewer than 25) to reliably tell how well the hospital is performing. Rate
RSRR = Risk-Standardized Readmission Rate. The RSRR presented for the state is the weighted
hospitals' RSRRs in the state.
N/A = No data are available from the hospital for this measure.

Workbook I Readmission | I.1 30-Day R Perf | I.2 Distrib of 30-Day R Perf | I.3 30-Day R Discharges | I.4 AMI

National and State Comparison

Table II.2: National and State Performance Categories for the HWR Measure

Table II.2: National and State Performance Categories for the HWR Measure
July 2011 through June 2012

Of the Total Number of U.S. Hospitals:	**4,809**
Number that Performed Better than U.S. National Rate	304
Number that Performed No Different than U.S. National Rat	3,983
Number that Performed Worse than U.S. National Rate	364
Number of Cases Too Small	158
Of the Total Number of Hospitals in Your State:	**20**
Number that Performed Better	
Number that Performed No Dif	
Number that Performed Worse	
Number of Cases Too Small	

Patient Detail for Readmissions

Table II.3: Discharge-Level Information for the Hospital-Wide Readmission Measure

Table II.3: Discharge-Level Information for the Hospital-Wide Readmission Measure
HOSPITAL NAME
July 2011 through June 2012
This file contains MOCK data except for national results. In your hospital's own HSR
EMAIL THE REAL HSR FILES OR ANY OF THEIR CONTENTS BECAUSE THEY C
IDENTIFIABLE INFORMATION. When referring to these documents, use ID Numbe

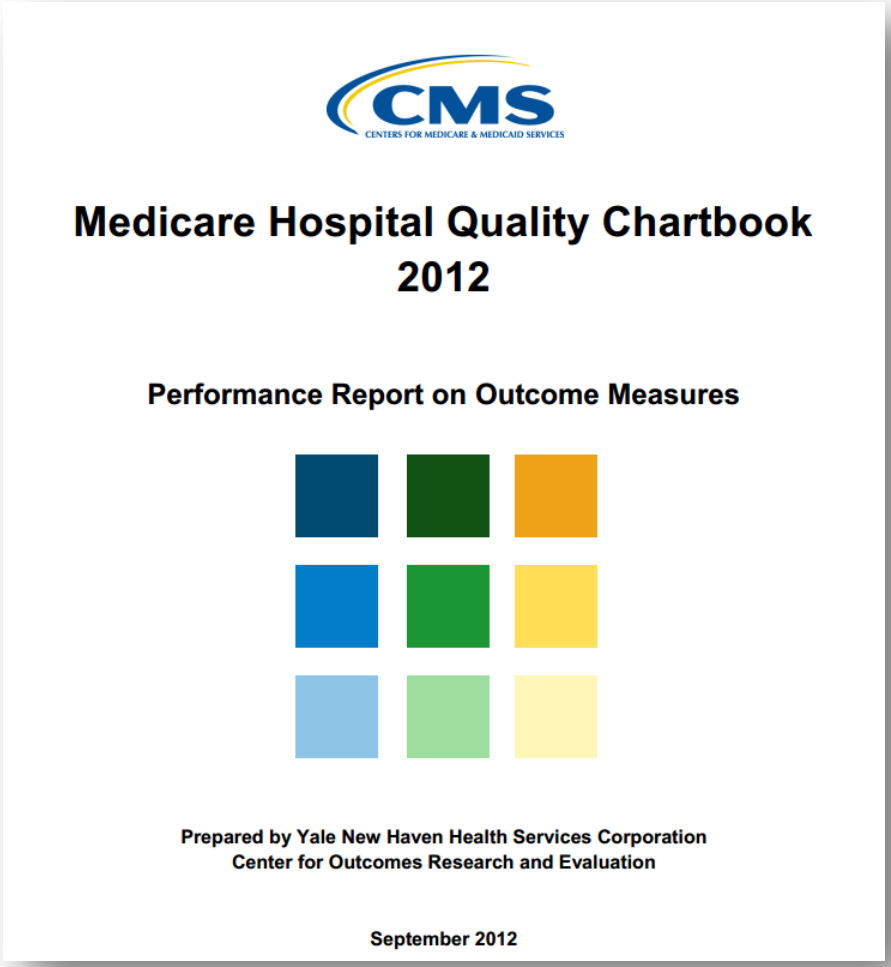
ID Number	Provider ID	Measure	Specialty Cohort	HICNO	Medical Record Number	Beneficiary DOB
1	999999	HWR	Medicine	123456789A	A001	07/07/1921
2	999999	HWR	Medicine	123456789B	A002	03/26/1935
3	999999	HWR	Medicine	123456789C	A003	09/30/1941
4	999999	HWR	Cardiovascular	123456789D	A004	02/10/1934
5	999999	HWR	Cardiovascular	123456789E	A005	12/10/1924
6	999999	HWR	Medicine	123456789F	A006	05/03/1943
7	999999	HWR	Medicine	123456789G	A007	08/28/1933

*To locate provider ID numbers (CMS Certification Numbers, or CCNs) and names
Information table, which can be found here: https://data.medicare.gov/dataset/Hospi

Medicare Hospital Quality Chartbooks

Available to public at
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/MedicareHospitalQualityChartbook2012.pdf

- ✓ Regional variation
- ✓ Racial disparities
- ✓ Reasons for readmissions
- ✓ Proportion by Medicare
- ✓ Small hospital data
- ✓ Large hospital data
- ✓ Measure methodology



Are Readmission Rates Associated with Public Reporting?

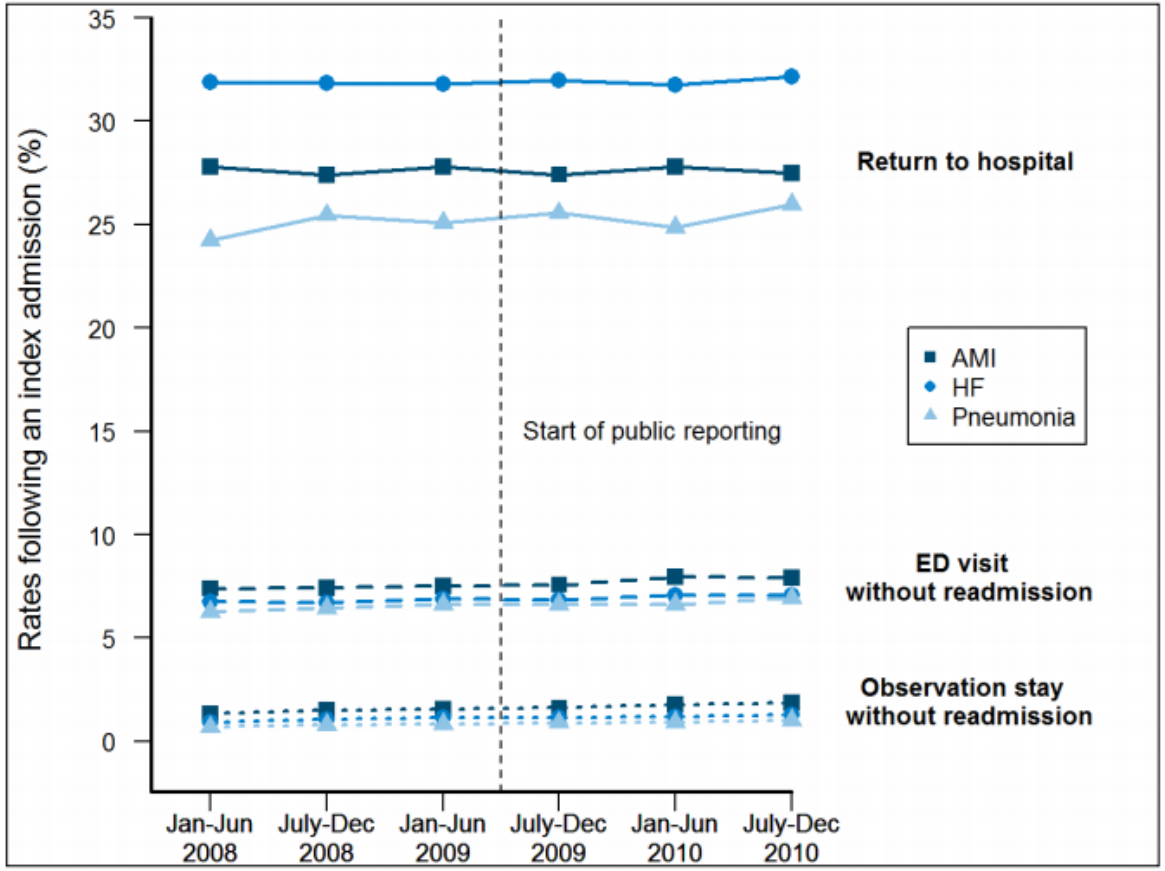
Public reporting is not associated with a reduction in readmission rates…

RETURNS TO THE HOSPITAL

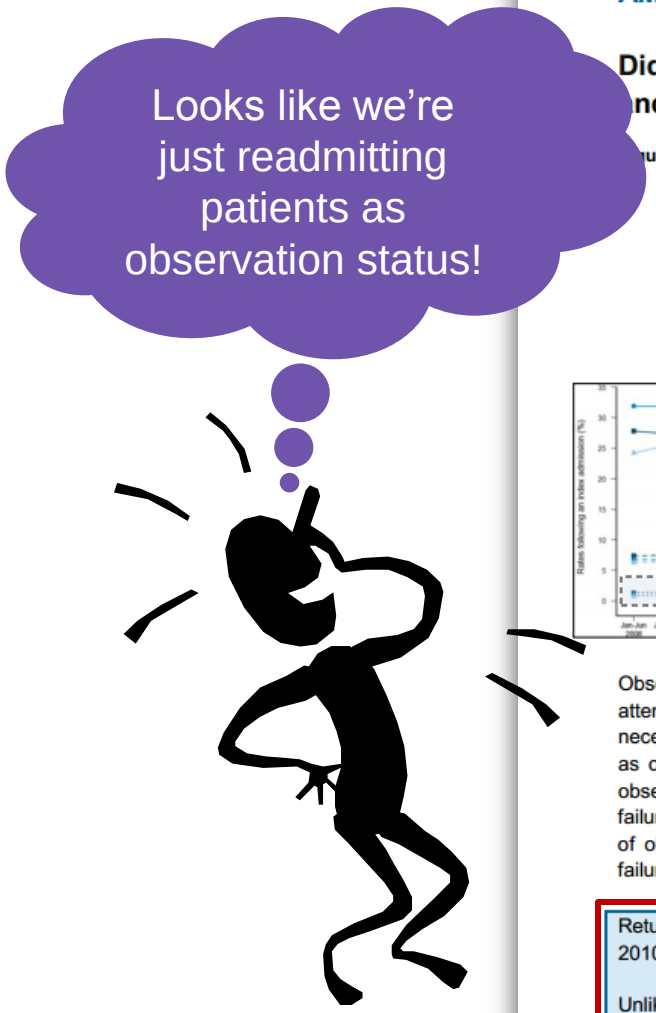
AMI, Heart Failure, and Pneumonia

Did the start of public reporting impact return-to-hospital rates after hospitalizations for AMI, heart failure, and pneumonia?

Figure A.26. Trend in Median Overall Return-to-Hospital Rates, ED Visit Rates, and Observation Stay Rates, 2008-2010



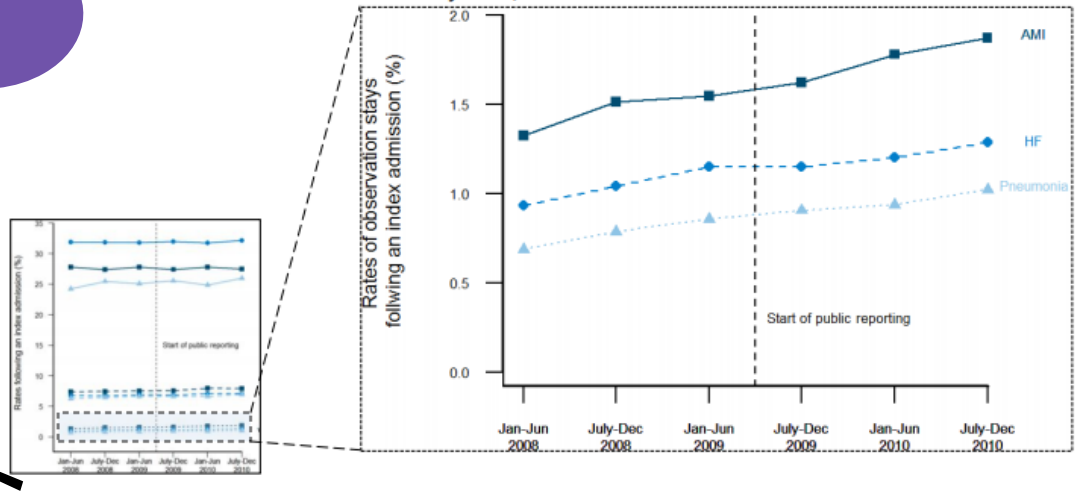
Observation Stays On The Rise



AMI, Heart Failure, and Pneumonia

Did the use of observation stays after hospitalization for AMI, heart failure, and pneumonia change with the start of public reporting?

ure A.27. Trend in Median Observation Stay Rates, 2008-2010



Observation stays are a subset of return-to-hospital events that have recently garnered significant media attention.[5] CMS defines observation stays as services furnished by a hospital which are reasonable and necessary to determine the need for a possible inpatient admission.[6] CMS currently does not count these events as outcomes in the publicly reported readmission measures. Although CMS has noted an overall increase in observation stay utilization in recent years,[7] observation stay trends related to hospitalization for AMI, heart failure, and pneumonia have not been specifically examined. There appears to be a slight increase in the number of observation stays without readmission over the past three years following a hospitalization for AMI, heart failure, or pneumonia. However, this increase seems to have begun prior to public reporting.

Return-to-hospital rates after hospitalizations for AMI, heart failure, and pneumonia were stable from 2008 to 2010. Public reporting is not associated with a change in return-to-hospital rates.

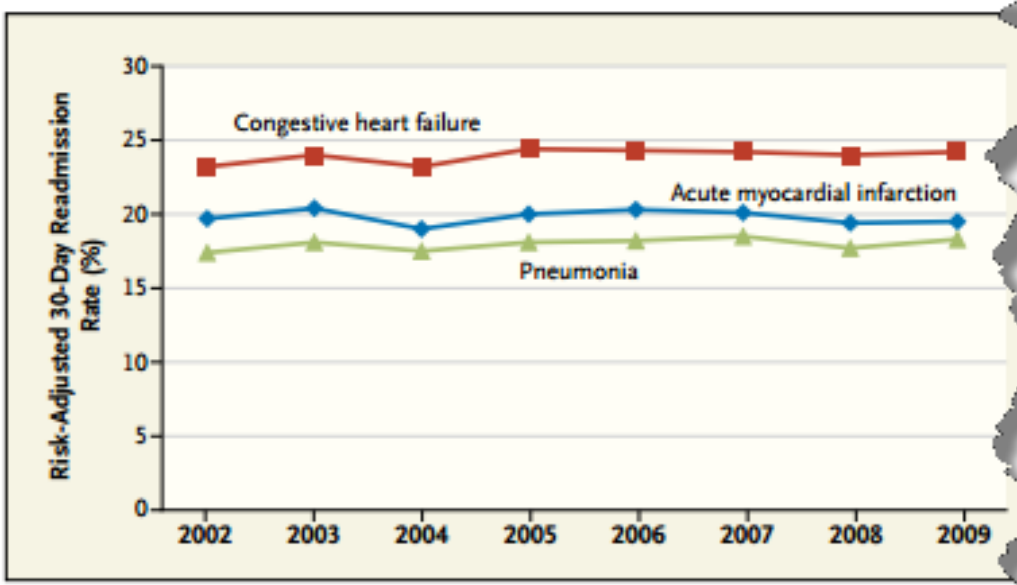
Unlike return-to-hospital rates, rates of observation stays after hospitalizations for AMI, heart failure, and pneumonia increased by 0.5%, 0.4%, and 0.3% respectively between 2008 and 2010. The start of public reporting in July 2009 is not associated with a change in observation stay utilization.

Thirty-Day Readmissions — Truth and Consequences

Karen E. Joynt, M.D., M.P.H., and Ashish K. Jha, M.D., M.P.H.

Reducing hospital readmission rates has captured the imagination of U.S. policymakers because readmissions are common and costly and their rates vary — and at least in theory, a reasonable fraction of readmissions should be preventable. Policymakers therefore believe that reducing readmission rates represents a unique opportunity to simultaneously improve care and reduce costs. As part of the Affordable Care Act (ACA), Congress directed the Centers for Medicare and Medicaid Services (CMS) to penalize hospitals with "worse than expected" 30-day readmission rates. This part of the law has stimulated hospitals, professional societies, and independent orga-

First, the metric itself is problematic: only a small proportion of readmissions at 30 days after initial discharge are probably preventable, and much of what drives hospital readmission rates are



National Trends in 30-Day Readmission Rates, 2002–2009.

Rates are authors' calculations based on Medicare data.

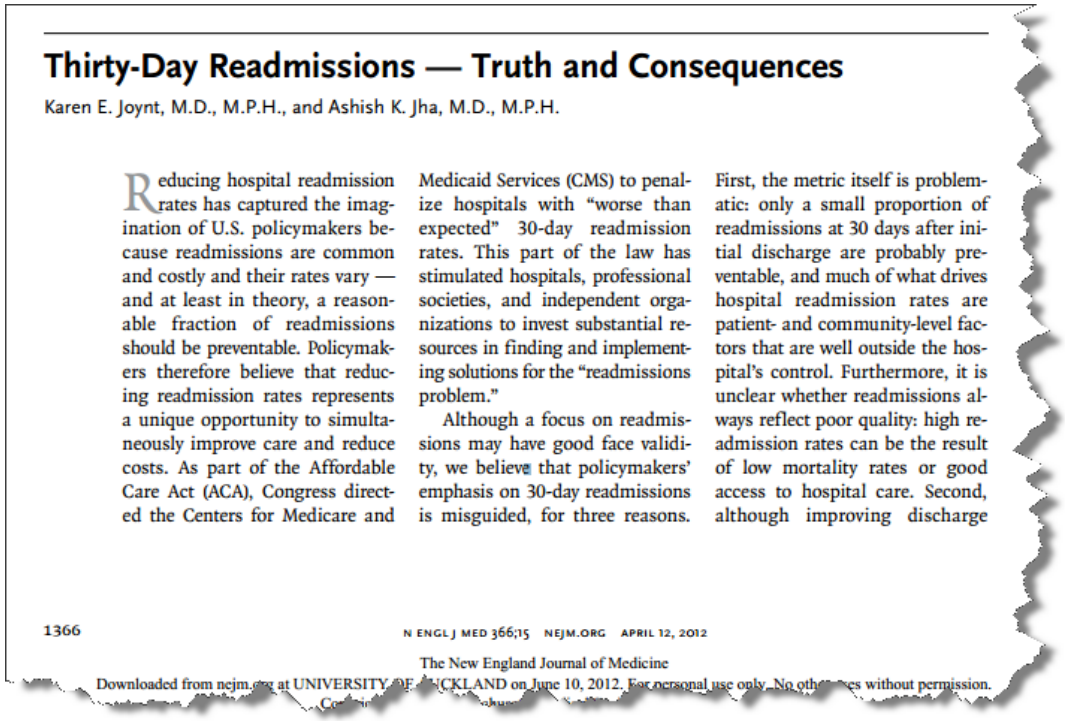
Source: Joynt, K. and Jha, A. (2012). Thirty-Day Readmissions – Truth and Consequences. New England Journal of Medicine, Vol. 366:15, 1366-1368.

Critics to CMS 30-Day Readmission Reduction Initiatives

1. Only a small proportion of 30-day readmissions are probably preventable
2. Much of what drives hospital readmission rates are patient and community-level factors outside of the hospital's control e.g. mental illness, poor social support and poverty
3. Readmission rates have weak signaling value for identifying high-quality hospitals
   - No clear link between readmission rates and quality of care
   - Higher readmission rates can be the result of low mortality rates or good access to hospital care
4. Hospitals are expending so much energy on readmissions they may forgo other important quality improvement efforts
5. Readmissions 3 to 7 days after discharge are much more under the hospital's control than 30-day readmissions
6. Financial penalties for high readmission rates dwarf the penalties for higher mortality rates and unsafe care

Source: Joynt, K. and Jha, A. (2012). Thirty-Day Readmissions – Truth and Consequences. New England Journal of Medicine, Vol. 366:15, 1366-1368.

Readmission Methodology Matters



Thirty-Day Readmissions — Truth and Consequences

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Although a focus on readmissions may have good face validity, we believe that policymakers' emphasis on 30-day readmissions is misguided, for three reasons. First, the metric itself is problematic: only a small proportion of readmissions at 30 days after initial discharge are probably preventable, and much of what drives hospital readmission rates are patient- and community-level factors that are well outside the hospital's control. Furthermore, it is unclear whether readmissions always reflect poor quality: high readmission rates can be the result of low mortality rates or good access to hospital care. Second, although improving discharge

1366 N ENGL J MED 366;15 NEJM.ORG APRIL 12, 2012

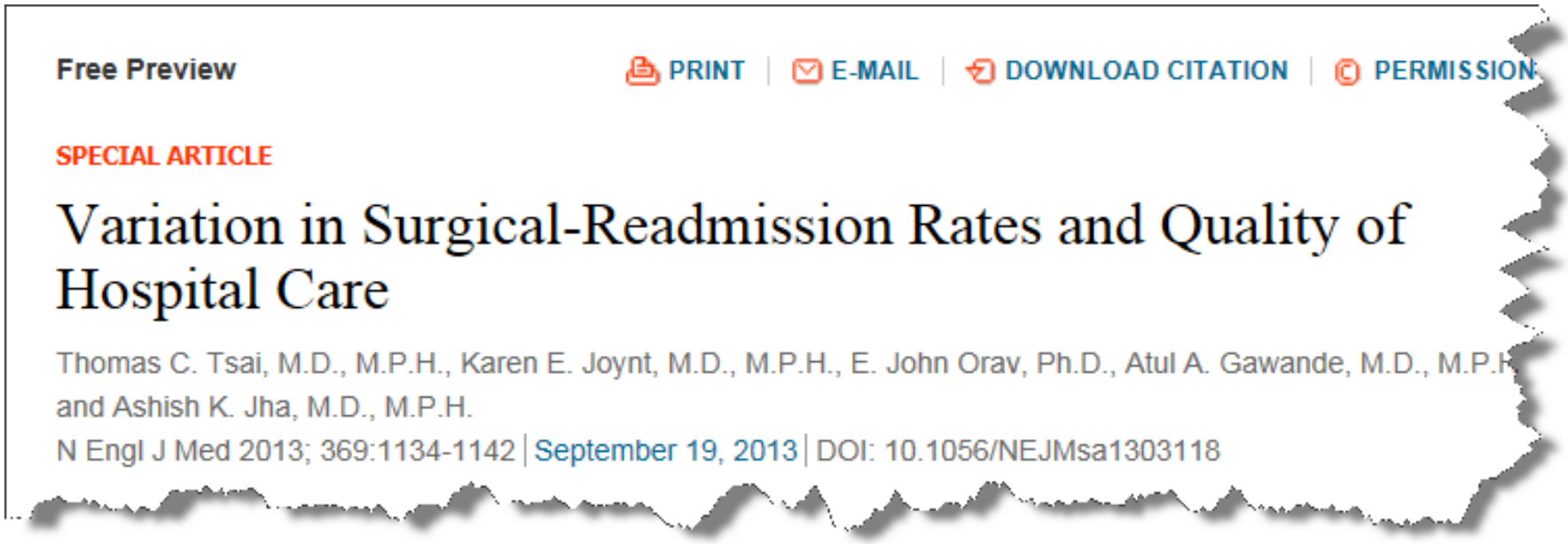
The New England Journal of Medicine

27% of readmission are preventable

- **12%** were deemed preventable in studies that used **clinical data**
- **59%** were deemed preventable in studies that used only **administrative data**

Total number of readmissions vary substantially among hospitals, but the rate of preventable readmissions does not

Readmission Rates Show Positive Correlation to Volume and Mortality Rates



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SPECIAL ARTICLE

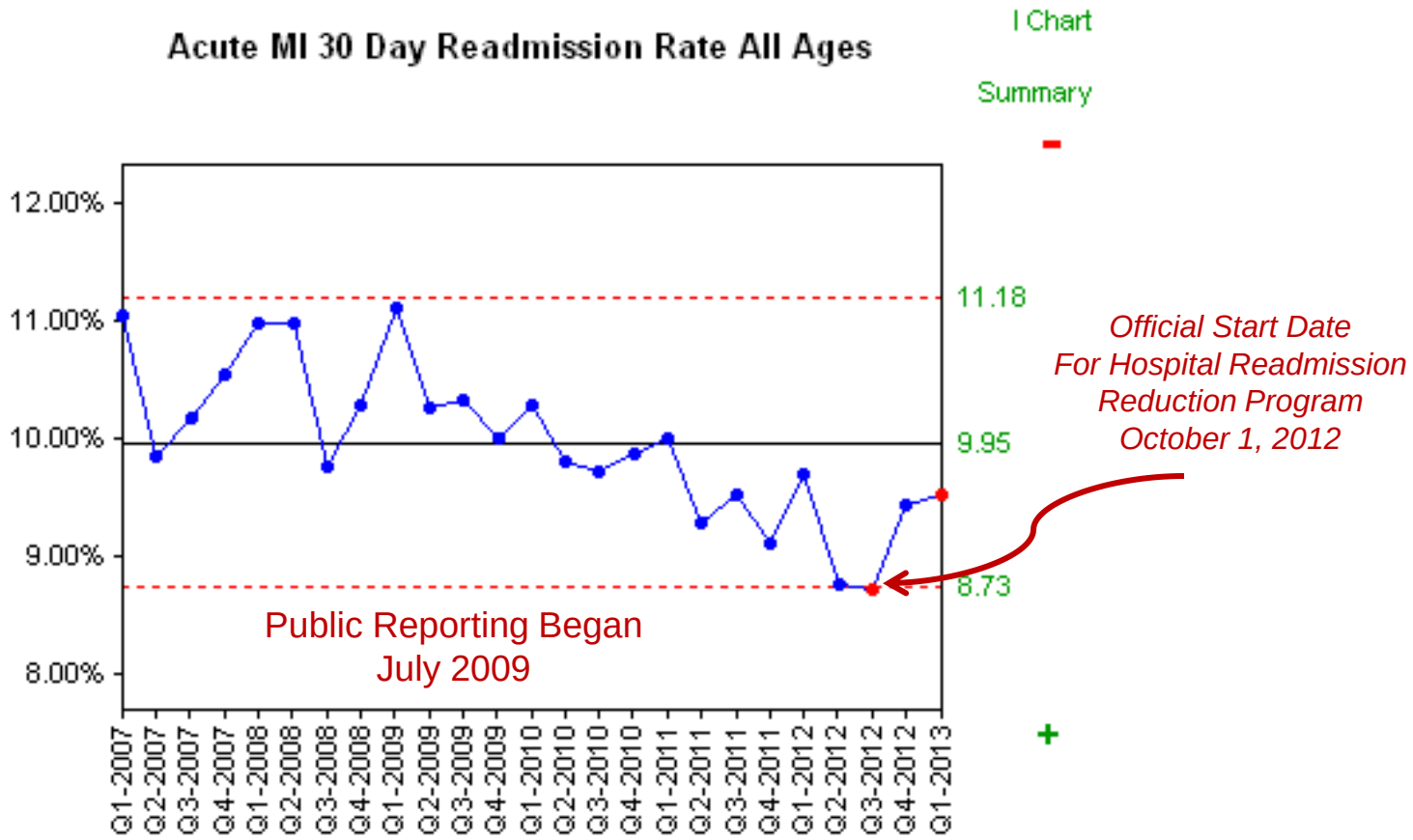
Variation in Surgical-Readmission Rates and Quality of Hospital Care

Thomas C. Tsai, M.D., M.P.H., Karen E. Joynt, M.D., M.P.H., E. John Orav, Ph.D., Atul A. Gawande, M.D., M.P.H., and Ashish K. Jha, M.D., M.P.H.

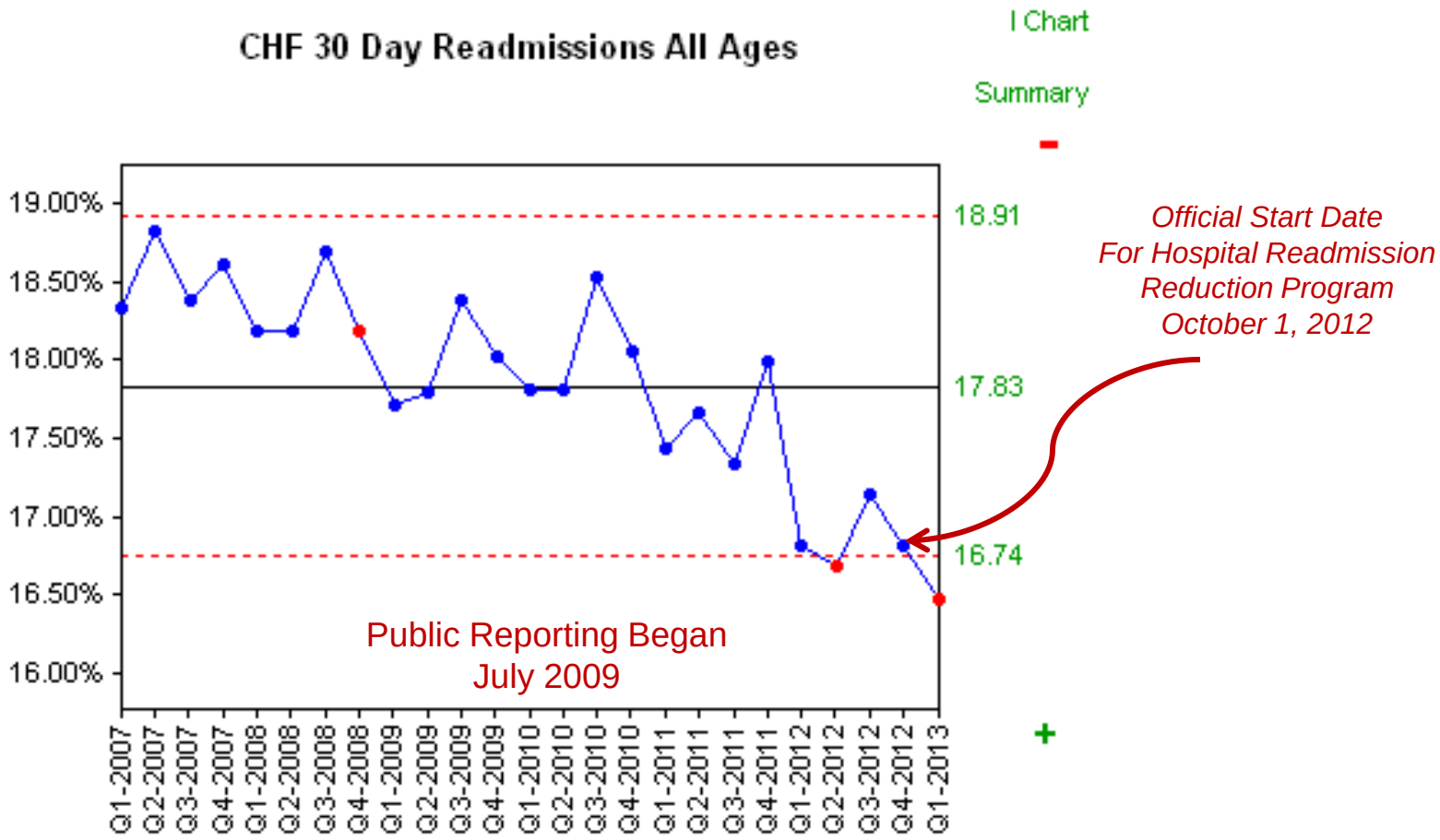
N Engl J Med 2013; 369:1134-1142 | September 19, 2013 | DOI: 10.1056/NEJMsa1303118

One in seven patients undergoing CABG, Pulmonary Lobectomy, endovascular and open AAA Repair, Total Hip Replacement, or Colectomy will be readmitted within 30 days

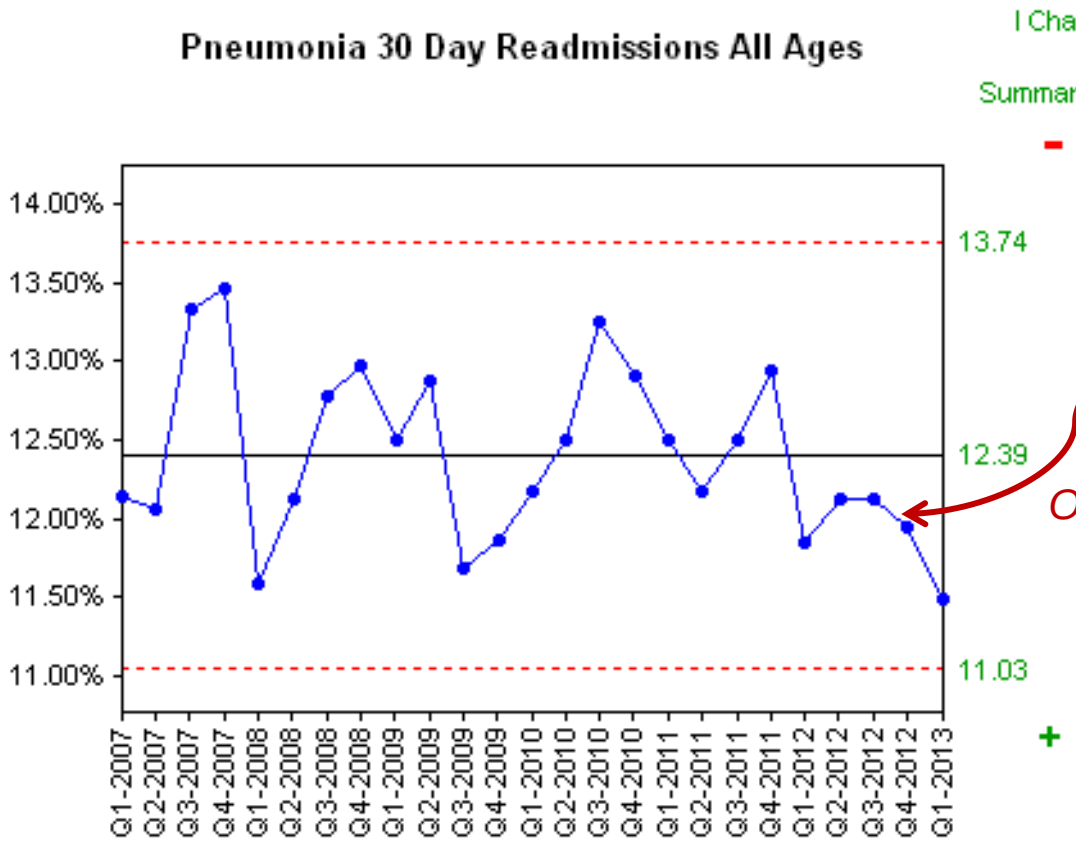
Downward Trends in Acute MI 30-day Readmissions Reflected in Midas+ Comparison Pool



Downward Trends in CHF 30-day Readmissions Reflected in Midas+ Comparison Pool



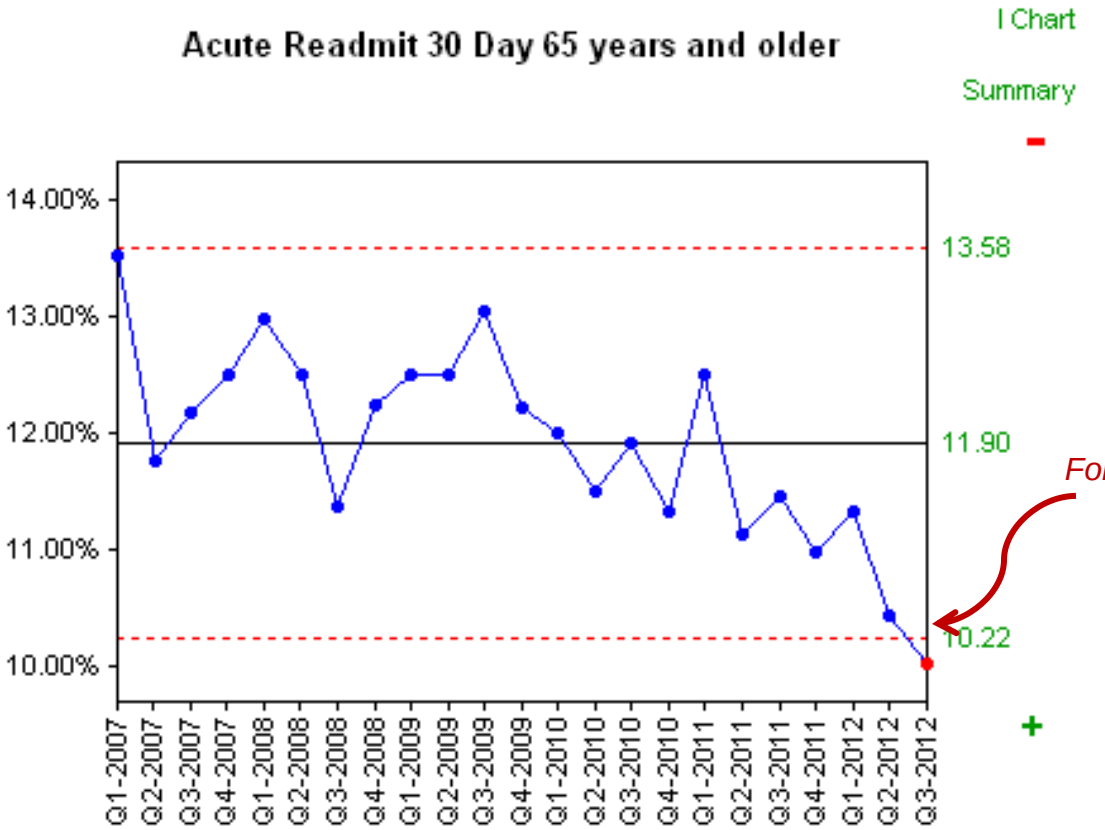
Stable Trend in Pneumonia 30-day Readmissions Reflected in Midas+ Comparison Pool



Official Start Date For Hospital Readmission Reduction Program October 1, 2012

One more quarter below the center line could indicate a statistical change in process!

Downward Trends in National Readmission Rates for Acute Care Inpatients ≥ 65 years of age Reflected in Midas+ Comparison Pool

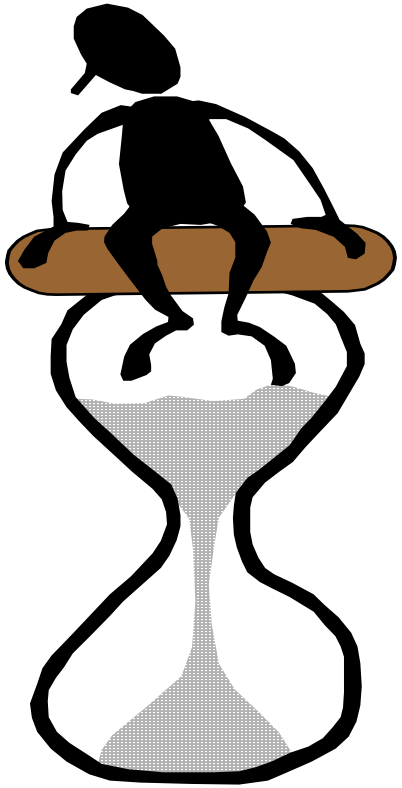


Official Start Date For Hospital Readmission Reduction Program October 1, 2012

Recommended Reading

http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf404178

Follow me at https://twitter.com/MidasXerox to keep up with regulatory changes impacting quality reporting requirements!

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