Maryland Health Services Cost Review Commission

Readmission Targets for CY 2014 Performance Year

Performance Measurement Work Group
02/20/2014

HSCRC
Health Services Cost Review Commission

Recap from First Meeting

- Goal is to reach or exceed National Medicare Readmission rate by CY 2018
- CMS Measure of Readmissions, which is used by Partnership for Patients Program
- Short-term considerations for an implementation in CY2014 as the performance period

National Readmission Projections- Scenario 1

	National Medicare				Maryland Medicare			
	Admissions	Readmissions	% Readmissions	Percent Change	Admissions	Readmissions	% Readmissions	Percent Change
FY2010	11,043,196	2,049,473	18.56%		253,320	54,019	21.32%	
FY2011	11,129,694	2,070,250	18.60%	0.22%	248,731	52,032	20.92%	-1.88%
FY2012	10,857,862	1,991,886	18.35%	-1.34%	241,681	49,100	20.32%	-2.87%
FY2013	10,458,098	1,847,036	17.66%	-3.76%	235,532	45,244	19.21%	-5.46%
FY 2014			17.00%	-3.76%			18.15%	-5.52%
CY 2014			16.66%	-5.64%			17.62%	-8.27%

National Readmission Projections- Scenario 2

	National Medicare				Maryland Medicare			
	Admissions	Readmissions	% Readmissions	Percent Change	Admissions	Readmissions	% Readmissions	Percent Change
FY2010	11,043,196	2,049,473	18.56%		253,320	54,019	21.32%	
FY2011	11,129,694	2,070,250	18.60%	0.22%	248,731	52,032	20.92%	-1.88%
FY2012	10,857,862	1,991,886	18.35%	-1.34%	241,681	49,100	20.32%	-2.87%
FY2013	10,458,098	1,847,036	17.66%	-3.76%	235,532	45,244	19.21%	-5.46%
FY 2014			16.78%	-5.00%			17.91%	-6.76%
CY 2014			16.34%	-7.50%			17.26%	-10.13%

Issues for Consideration

- Adjustments
  - Planned Admission
  - Risk Adjustment
    - Admission APR-DRG vs. Discharge APR-DRG
- All Payer vs. Medicare Targets
- Options for setting improvement targets for hospitals
  - Segmented approach (ie. vary the target based on the readmission rate)
  - Uniform Approach (ie. same percent target for all hospitals)
- Cumulative target setting for Hospitals
  - Crediting high performers in later years
- Impact of observation stays in readmission rates

Planned Admission Definitions

- CMS Algorithm V2.1, published on March 2013 and developed by Yale New Haven Health Services Corporation Center for Outcomes Research & Evaluation (YNHHSC/CORE)
- Based on Clinical Classification Codes for primary diagnosis and procedures (CCS)
- Admissions for the following conditions are always planned
  - Bone marrow, kidney, or other organ transplants
  - Maintenance chemotherapy or rehabilitation
  - Vaginal and C-Section Deliveries (HSCRC modified the coding to include all deliveries using APR-DRGs)

Overall 23.5 % of Inpatient Admissions are Planned, Top Planned Admission DRGs

APR_DRG	DRGNAME	Total Discharges	Percent Planned within DRG	Percent of Total Planned Admissions
560	Vaginal delivery	42,515	100.0	28.1
540	Cesarean delivery	23,364	100.0	15.4
302	Knee joint replacement	11,612	91.1	7.0
860	Rehabilitation	6,939	100.0	4.6
301	Hip joint replacement	7,528	72.2	3.6
263	Laparoscopic cholecystectomy	4,473	98.3	2.9
304	Dorsal & lumbar fusion proc except for curvature of back	4,331	92.8	2.7
321	Cervical spinal fusion & other back/neck proc exc disc excis/decomp	3,638	94.8	2.3
221	Major small & large bowel procedures	5,842	48.3	1.9
693	Chemotherapy	2,741	100.0	1.8
513	Uterine & adnexa procedures for non-malignancy except leiomyoma	3,190	82.4	1.7

Setting Readmission Targets: Timing
Input from Collaborative Healthcare Strategies, Amy Boutwell, MD

- Set targets a year at a time-
  - The pressures on the rest of the US will remain constant, while the pressure in Maryland is distinctly different and the incentives distinctly unique.
  - Nationally, the "readmission penalty" may have stimulated as much activity as it is going to, and the technical assistance provided by the Partnership for Patients will end at year-end 2014.
  - Readmission penalties on SNFs and then on home health care agencies will likely create another phase of improvement for those transition types in 2017.
- It would be an over estimate to assume the same pace of improvement nationally for 2014-2018 compared with 2011-2013. The national pace of improvement will slow down, if one assumes the penalties have exerted their effect on the field and the technical assistance via partnership for patients and the QIO programs have essentially flooded the field will all the best practices.

Setting Readmission Targets: Front-Loading Inputs from Amy Boutwell, MD

- Should the annual targets be greater (front-loaded) in the first couple of years?
  - No. Readmission rates do not move quickly at first.
  - Trial-redesign-retrial and establishment of successful implementation occurs over 12-18 months when more substantive improvement is seen.
  - In some cases there will be improvement to goal and then a plateau, in other cases, continuous improvement may be achieved beyond the goal if a truly transformative approach has been implemented. Other hospitals may struggle to achieve improvements beyond isolated small pilots.

Readmission Measurement: Shifting Denominator Inputs from Amy Boutwell, MD

- Readmission Rate per Admission: The “shifting denominator”- when hospitals purposefully reduce 30-day readmissions, there is an effect on admissions >31 days as well as an effect on an orientation around acute utilization in general. This results in the denominator decreasing in non-linear manner as compared to the numerator.
- Readmission per 1,000 Beneficiaries: The readmissions/1000 beneficiaries does not reflect a strong downward trend, but rather a disproportionate increase in the beneficiary population for Maryland. The “system property” we are looking at is not a function of the beneficiary population, but rather a function of transitions between settings and acute care utilization patterns. Admissions per 1000 beneficiaries is interesting (as a measure of acute care utilization patterns), but readmissions is better examined as a function of the admissions (actually the discharges).

On Adjustments to Readmission Rate Measures: Inputs from, Amy Boutwell, MD

- On adjustments necessary for hospital specific readmission rates
  - From a **quality improvement** perspective at the hospital/community level, the small percentage of readmissions that are planned do not need to be accounted for when designing a strategy to improve transitions and reduce rates.
  - In the vast majority of cases, Maryland hospitals can stand to reduce their readmissions by 20-30% before they will encounter an asymptote on improvement that requires a consideration of planned readmissions.
  - Recommend using all cause, raw, unadjusted rates to calculate numeric targets for readmission reduction for each hospital that will result in the readmission % for the state by 2018.
  - Specifically recommend against risk adjusting as it is not helpful for system redesign and quality improvement.
- On Attainment versus improvement-
  - Recommendation for a segmented hospital-specific readmission reduction target is based on current performance (in other words, recognizes attainment). Even the best hospitals can improve by something as modest as 5%; this will at the least engage these hospitals on ensuring they hold their current performance with the expectation on expanding their efforts to achieve slightly further gains.