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INSIGHTS FOR DESIGNING EFFECTIVE MEDICAID READMISSIONS POLICIES

Public payers, such as the Centers for Medicare & Medicaid Services (CMS) and State Medicaid agencies, have found that linking payment to healthcare outcomes can be an equitable and effective means to controlling costs. In particular, payment policies that create incentives for reducing avoidable readmissions can deliver substantial cost savings, while at the same time providing the administrative capacity to measure and regulate the quality of care delivered to highly-vulnerable patients in acute and post-acute care (PAC) settings.

Readmission-focused payment policies are generally consistent with the mission of Medicaid agencies to improve the efficiency and quality of care delivered to their beneficiaries. These policies also align with the Center for Medicare & Medicaid Innovation's assertion that "provider incentives for better outcomes and more efficient care align payment with performance and provide new incentives that encourage care coordination, high quality, and efficient care delivery.[1]" While readmission policies linking payment to outcomes are common in Medicaid programs nationwide, there remains substantial variation in the scope and structure of these policies. Generally, the most effective policies include:

- Well-defined methodologies for identifying and incentivizing reductions in potentially preventable readmissions, as opposed to planned or unrelated readmissions.
- Risk adjustment and benchmarking of hospital performance against standardized performance measures, such that the policy does not inequitably impact providers treating higher proportions of patients more prone to readmissions due to clinical acuity, co-morbidities, or socio-economic status.
- Use of analytic engines and algorithms to reduce the operational burden associated with administering the policy.
- Consideration for the role of managed care organizations and post-acute providers in reducing readmissions.

This Issue Brief provides a brief history of Medicare and Medicaid readmission policies, an analysis of current Medicaid program policies, and insights for designing highly effective readmission policies.

1. https://www.cms.gov/About-CMS/Agency-Information/CMS-Strategy/Downloads/CMS-Strategy.pdf

A BRIEF HISTORY OF MEDICARE AND MEDICAID READMISSION POLICIES

It has been nearly a decade since hospital readmissions took center stage as a part of CMS's efforts to improve the quality and efficiency of care delivered to its beneficiaries. In 2007, MedPAC submitted a report to Congress, "Promoting Greater Efficiency in Medicare," which identified hospital readmissions as a key area of opportunity for improving outcomes and containing Medicare costs. At that time, MedPAC estimated that 17.6 percent of Medicare admissions resulted in readmissions within 30 days of discharge, accounting for $15 billion in annual Medicare spend.

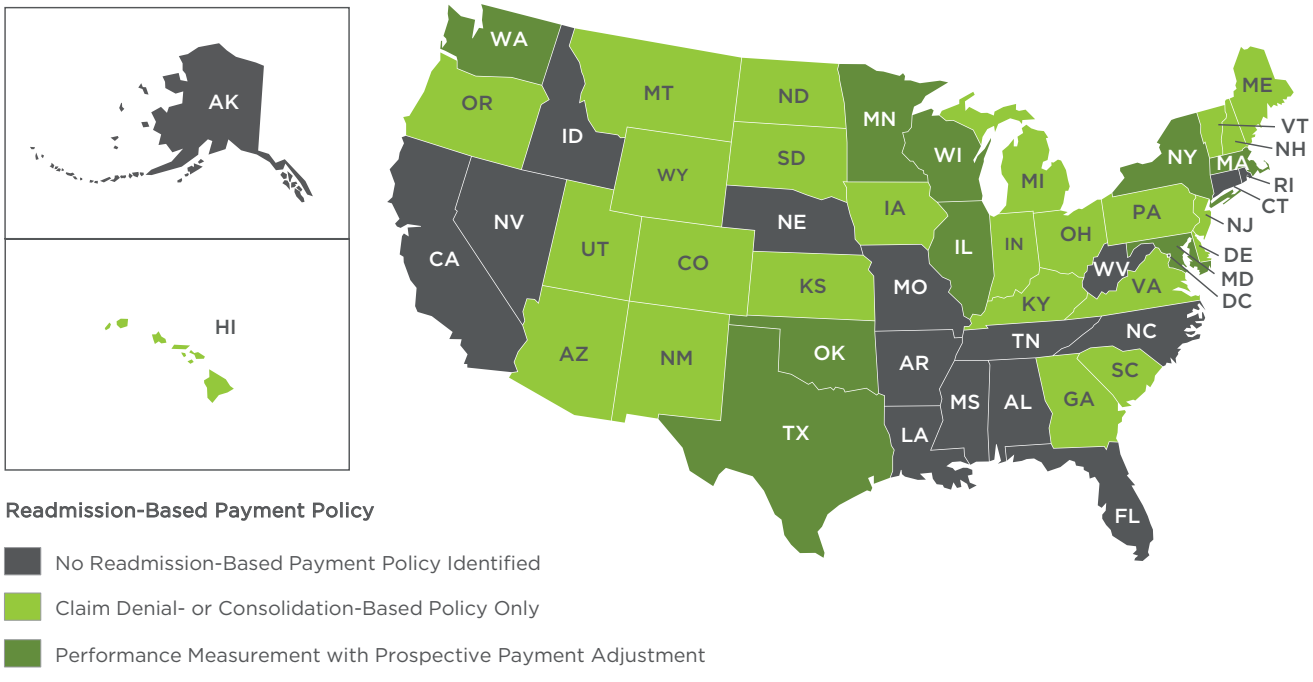
To address the issue, MedPAC recommended implementation of a phased-in policy that initially would measure and publicly report hospital readmission rates, and then adjust payments to hospitals in order to financially incentivize reductions in readmission rates.[2] CMS began measuring and publicly reporting readmission rates in 2009, and the Affordable Care Act of 2010 established the *Hospital Readmissions Reduction Program (HRRP)*, which required CMS to reduce payments to hospitals with comparatively high rates of readmissions beginning in 2012.[3,4]

Around this same time, there was a growing sense of competitive and budgetary imperative to improve outcomes and reduce costs among health systems nationwide —perhaps best exemplified by the introduction of the Institute for Healthcare Improvement's Triple Aim initiative in 2007.[5] State Medicaid agencies were facing strained budgets and increasing Medicaid enrollment due to the Great Recession of 2008, and, following the establishment of HRRP for Medicare in 2010, there was some concern among Medicaid program leadership that federal policymakers could mandate a reduction in federal expenditures for avoidable readmissions in Medicaid. As a result, many Medicaid programs implemented readmission-focused hospital payment policies.[6,7]

ANALYSIS OF CURRENT MEDICAID POLICIES

Currently, there are at least 41 readmission-focused hospital payment policies in use by 34 different Medicaid programs.[8] However, there is substantial variation in the scope and design of these Medicaid policies, not only in relation to each other but also compared to Medicare policy. There are two basic types of readmission-focused hospital payment policies in use by Medicaid programs: policies that deny or consolidate payment for readmissions, and policies with prospective payment adjustments based on periodic performance measurement. Of the 41 identified Medicaid policies, 32 create financial incentives for reducing readmissions through claim denial or consolidation, while nine policies prospectively adjust payments based on periodic performance measurement, similar to Medicare's HRRP program.

CURRENT LANDSCAPE OF READMISSION-BASED PAYMENT POLICIES IN MEDICAID PROGRAMS



2. http://www.medpac.gov/documents/reports/Jun07_EntireReport.pdf
3. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2009-Fact-sheets-items/2009-07-09.html
4. https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html
5. http://content.healthaffairs.org/content/27/3/759.full.pdf+html
6. https://web.stanford.edu/group/recessiontrends/cgi-bin/web/sites/all/themes/barron/pdf/StateBudgets_fact_sheet.pdf
7. http://content.healthaffairs.org/content/33/8/1337.full.pdf+html

With respect to policy scope, most readmission policies define a fixed length of time following an initial hospital discharge—the "readmission window"— within which readmissions may result in payment penalties or otherwise impact financial incentive mechanisms. In addition, most policies employ some type of "relatedness or preventability test," such that they only apply to readmissions that are clinically related to a prior admission or that may have been prevented with improved care delivery or coordination. Readmission windows and relatedness or preventability tests have important implications for both the equitability of the policy and its potential impact on cost avoidance.

Among the 32 denial- and consolidation-based policies:

- Eight policies have one day readmission windows, six policies have 30 day readmission windows, five policies have windows of either 14 or 15 days, and eight policies have windows between two and ten days.
- 22 policies apply relatedness tests, eight policies apply preventability tests, and two policies have no defined relatedness or preventability test.

Relatedness and preventability tests are often performed via manual review of medical records by teams of clinically-trained staff, similar to medical necessity reviews. In some cases, relatedness tests are simplified by testing for same or similar diagnosis coding on the initial admission and readmission.

Among the nine policies that prospectively adjust payments based on periodic performance measurement:

- Six have 30 day readmission windows, one has a 14 day readmission window, and two do not specify a readmission window in publicly available information.
- All nine policies employ automated algorithms that test for "potential preventability" by excluding planned and unrelated readmissions. Seven policies employ 3M's Potentially Preventable Readmissions algorithm for identifying "potentially preventable" readmissions, and two policies employ the CMS Planned Readmission Algorithm.

Medicare's HRRP uses a 30-day readmission window and the CMS Planned Readmission Algorithm.

DESIGNING HIGHLY-EFFECTIVE READMISSION POLICIES

Based on decades of experience assisting Medicaid programs with the implementation of new and innovative payment policies for inpatient hospital services, and having recently assisted multiple states with the implementation of readmission-focused payment policies, Navigant has observed a number of benefits afforded by policies that prospectively adjust payments based on periodic performance measurement, including:

- Flexibility to phase-in, scale up, or scale down payment impacts;
- The ability to risk-adjust measured performance to account for variations in patient clinical acuity and socio-economic status;
- Standardization and automation of methodologies used to identify potentially preventable readmissions and to calculate hospital-level performance;
- Familiarity among hospital executive and clinical leadership, particularly given alignment with Medicare's HRRP program;
- Support for longitudinal tracking and evaluation of statewide and hospital-specific readmission rates; and
- The ability to analyze patterns in readmission outcomes at the hospital, patient, and episode level, and to share information and data with hospitals.

CONCLUSION

Government payers have found significant opportunities to achieve cost savings and improve patient outcomes through readmission-focused hospital payment policies. While policies that consolidate or deny payment for readmissions on a case-by-case basis can be a good first step toward reducing readmissions, the most efficient, equitable, and effective policies are those that prospectively adjust payments based on periodic, risk-adjusted performance measurement.

8. Based on a review of administrative rules, State Plan Amendments, provider manuals, and other official information made publically available by these Medicaid programs, which was performed by Navigant during the period of May 24th to June 15th, 2016.

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