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## Hospital Readmissions Reduction Program May Impact Post-Acute Providers

A new Medicare payment policy on readmissions may place more pressure on post-acute providers to coordinate care with the general acute-care hospitals in their community. The Centers for Medicare & Medicaid Services (“CMS”) is in the process of adopting a new policy for reducing payments under the inpatient prospective payment system (“IPPS”) to those hospitals with high readmission rates for patients with certain conditions. As a result, hospitals paid under the IPPS may incur a payment penalty if a skilled nursing facility (“SNF”), long-term acute care hospital (“LTCH”), inpatient rehabilitation facility (“IRF”) or other post-acute care provider transfers a patient or resident back to the hospital for additional inpatient services. This policy change provides a powerful incentive to coordinate care and standardize procedures across providers.

Beginning in fiscal year (“FY”) 2013, which commences October 1, 2012, an inpatient admission by a short-term acute care hospital (“STACH”) of a patient discharged from the same or different STACH within 30 days preceding the readmission may result in a reduction of Medicare payments to the STACH that initially treated the patient under the Hospital Readmissions Reduction Program (“HRRP”). CMS proposes to use a complex formula to determine the amount of the payment reduction to the original STACH for readmissions exceeding a hospital-specific, risk-adjusted ratio based on each applicable condition. CMS refers to readmissions exceeding the ratio as “excess readmissions.” For STACHs with excess readmissions, CMS will reduce the hospital’s base operating Diagnosis-Related Group (“DRG”) payment amount by an adjustment factor intended to account for the so-called excess readmissions. Initially, STACHs could be subject to a maximum potential reduction of 1 percent in FY 2013. CMS proposes to increase the payment penalties in subsequent fiscal years, increasing the importance of reducing unnecessary readmissions in the future.

Not every patient transferred by a post-acute provider to a STACH will result in a payment penalty to the STACH under the HRRP. For example, if a patient discharged from a STACH to a post-acute provider subsequently receives outpatient services from a STACH “under arrangements” (i.e., under an agreement between the post-acute provider and the STACH for provision of certain specialized services), the patient will not be considered to have been “readmitted” to the STACH for purposes of the HRRP, and will not create risk of reduced payment under the HRRP.

**Overview of the Hospital Readmissions Reduction Program** The Patient Protection and Affordable Care Act (“PPACA”) mandated the adoption of the HRRP for the purpose of reducing Medicare payments for services to patients who have been readmitted to a STACH within a short time after an initial hospital discharge.

Under the HRRP, any STACH that originally discharged a patient to a post-acute provider or to the patient’s home runs the risk of receiving a reduction in the payment it receives from Medicare if the patient:

- has a diagnosis of myocardial infarction (“AMI”), heart failure (“HF”) or pneumonia (“PN”) upon discharge from the STACH<sup>1</sup> ; *and*
- is readmitted as an inpatient to the same STACH, or to a different acute care facility, in 30 days or less with *any* acute condition (excluding planned readmissions).<sup>2</sup>

Patients who meet these conditions will be included in CMS’ calculation of the original STACH’s readmission rate. Hospitals with readmission rates that are higher than a specified threshold will experience decreased Medicare payments for all Medicare discharges.<sup>3</sup> The HRRP applies to those STACHs paid under the IPPS and certain demonstration programs.<sup>4</sup> LTCHs, SNFs, IRFs and inpatient psychiatric facilities are not subject to a reduction in Medicare payment under the HRRP.

Because the HRRP provisions set forth in the PPACA are not effective until FY 2013, CMS has chosen to implement the HRRP over a two year period. CMS addressed implementation of certain aspects of the HRRP in the FY 2012 IPPS/ LTCH PPS Final Rule (“2012 Final Rule”), which was published on August 18, 2011, while addressing other aspects of the program in the FY 2013 IPPS/ LTCH PPS Proposed Rule (“2013 Proposed Rule”), published on May 11, 2012. Comments will be accepted on the 2013 Proposed Rule until June 25, 2012. Final rules will be adopted in the annual update to the IPPS payment rates and policies for FY 2013 published this summer. Changes to the final rules may impact portions of the analysis set forth in this alert.

**Definition of Readmission** Under the 2012 Final Rule, a “readmission” occurs when a patient is discharged from a STACH paid under IPPS and is then admitted as an inpatient for any reason to the same or another acute care hospital at

least once within 30 days from the time of discharge from the original acute care hospital.<sup>5</sup> The PPACA provides that only the original acute care facility will be charged with the readmission for purposes of the HRRP.<sup>6</sup> Planned readmissions or transfers to another hospital are not subject to the payment reduction under HRRP. Neither are readmissions for which there are fewer than 25 discharges during the three-year period used to calculate excess readmissions, as discussed below.<sup>7</sup> To implement the HRRP, CMS adopted, in the 2012 Final Rule, the 30-day Risk Standardized Readmission Measures for AMI, HF and PN which are endorsed by the National Quality Forum (“NQF”).<sup>8</sup> Under these three measures, the term “readmission” does not include transfers to other acute care facilities. Such transfers are instead considered to be a single acute episode of care.<sup>9</sup> Where a patient is transferred between two or more acute care facilities, any subsequent readmission is charged to the hospital that ultimately discharged the patient to a non-acute facility.

**Applicable Conditions** The HRRP will initially apply to inpatients that are diagnosed upon their initial discharge from an acute care facility with at least one of the following three conditions involving high volume and/or high expenditure readmissions: AMI, HF or PN.<sup>10</sup> According to the PPACA, starting in FY 2015, CMS has the authority to expand the list of applicable conditions to include chronic obstructive pulmonary disorder and several cardiac and vascular surgical procedures, among other conditions.<sup>11</sup>

**Formula for Reducing Payments** A complex formula will be utilized to determine the amount of the payment reduction to the original STACH for excess readmissions. As described in Chart A, the formula will apply an “adjustment factor” set forth in the PPACA to the otherwise applicable DRG payment amount.<sup>12</sup> The adjustment factor is one minus the ratio of Aggregate Payments for Excess Readmissions to Aggregate Payments for All Discharges over a three-year period.<sup>13</sup> Aggregate Payments for Excess Readmissions is calculated based on the product, for each applicable condition, of: (1) the base operating DRG payment amount for such condition; (2) the number of admissions for each such condition; and (3) the Excess Readmissions Ratio minus one.<sup>14</sup> The Excess Readmissions Ratio is, for each applicable condition, the ratio of the risk adjusted readmissions based on actual readmissions for such condition to the risk adjusted expected readmissions for such condition.<sup>15</sup> Aggregate Payments for All Discharges is calculated based on the sum of the base operating DRG payment amounts for all discharges for all conditions.<sup>16</sup> However, the PPACA states that the adjustment factor may not exceed 0.99 in FY 2013, 0.98 in FY 2014, or 0.97 in FY 2015 and beyond.<sup>17</sup> In other words, the largest potential reduction amount for a hospital would be 1 percent in FY 2013, 2 percent in FY 2014, and 3 percent in FY 2015 and beyond. Based on the formula set forth in the PPACA, the amount of a hospital’s payment reduction for its excess readmissions will increase as the proportion of the hospital’s excess readmissions increase.<sup>18</sup>

The 2012 Final Rule implemented a methodology for calculating the Excess Readmission Ratio.<sup>19</sup> The 2013 Proposed Rule addresses, among other things: (1) definition of base operating DRG payment amount; (2) refinement of the adjustment factor; and (3) definition of aggregate payments for excess readmissions and aggregate payments for all discharges, including methodologies for calculating each.<sup>20</sup>

**Reporting Requirements** The PPACA requires STACH facilities to submit data necessary for CMS to calculate readmission rates for all patients treated on an inpatient basis.<sup>21</sup> Under the 2012 Final Rule, CMS must make readmission rates of all hospitals subject to the HRRP publicly available on the Medicare Hospital Compare website.<sup>22</sup> The 2013 Proposed Rule also addresses reporting of hospital-specific information in greater detail, including hospitals' opportunity to review and submit corrections within thirty days of receipt of a confidential report and accompanying confidential discharge-level information containing the hospitals' excess readmission ratios for the applicable conditions.<sup>23</sup>

**Obligation for Services Provided "Under Arrangements"** The Medicare prospective payment systems for LTCHs ("LTCH-PPS") and IRFs ("IRF-PPS") require these facilities to furnish all necessary covered services to the Medicare beneficiary "either directly or under arrangements." Similarly, the majority of services provided to beneficiaries in a Medicare Part A covered SNF stay are included in the SNF's bundled prospective payment system ("SNF-PPS").<sup>24</sup> In general, Medicare does not pay any provider or supplier other than the LTCH, IRF or SNF for inpatient or outpatient services furnished to a Medicare beneficiary who is an inpatient of the facility (or an SNF resident), except as expressly provided by regulation. In order to provide the full set of covered services to an LTCH or IRF inpatient or an SNF resident, Medicare regulations permit these facilities to obtain specialized services "under arrangements" with another health care provider. For example, an LTCH may contract with a STACH to provide specialized services the LTCH cannot provide to its patients, such as general surgery or diagnostic tests.

Outpatient services a STACH provides under arrangement to an LTCH or IRF patient or an SNF resident, such as surgical services or diagnostic tests, generally have no impact on Medicare payment to the STACH.<sup>25</sup> The STACH receives payment for such services from the LTCH, IRF or SNF and is not penalized under the HRRP. Conversely, if a Medicare patient is discharged from a STACH with a diagnosis of AMI, HF or PN, admitted to an LTCH, IRF or SNF, and then subsequently readmitted as an inpatient to an acute care hospital paid under IPPS within 30 days, the STACH that initially treated the patient will be subject to a payment reduction under the HRRP.

**Questions Remain Regarding Interrupted Stay Regulations for LTCHs and IRFs** Whether the HRRP payment reduction applies to a particular inpatient service may also depend, in part, upon whether or not the inpatient stay qualifies as a so-called “interrupted stay” of a certain duration under the LTCH-PPS or the IRF-PPS. An “interrupted stay” occurs when an inpatient is discharged from an LTCH or an IRF for treatment and services not available at the LTCH or IRF and, after a specified number of hours or days, is readmitted to the same LTCH or IRF for further treatment.<sup>26</sup> Relevant to this alert is the impact of the interrupted stay regulations on an LTCH’s or IRF’s discharge of an inpatient to a STACH. Financial responsibility for the patient depends upon the length of the patient’s stay at the STACH. For example, where a patient discharged from a STACH to an LTCH leaves the LTCH for three days or less, or where a patient discharged from a STACH to an IRF leaves the IRF and returns the same day to obtain inpatient services at a STACH, the LTCH or IRF is responsible for paying the STACH under arrangements for those services.

While LTCHs and IRFs are responsible for the cost of care during these short “interrupted stays,” whether inpatient services provided by a STACH during the interrupted stay would be subject to a payment reduction under the HRRP is unclear from the PPACA, the 2012 Final Rule and the 2013 Proposed Rule. There was no discussion in any of these sources regarding interrupted stays or whether an admission to a STACH during an interrupted stay “counts” toward the STACH’s readmission numbers, even though the STACH would receive payment from the LTCH or IRF. The 2013 Proposed Rule at 42 C.F.R. § 412.152 defines “readmission” as including “in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period of 30 days from the date of such discharge.”<sup>27</sup> Because this definition does not expressly exclude admissions that are part of interrupted stays, these admissions could potentially be included in the readmission numbers unless and until regulations are issued excluding such admissions. Arguably, if CMS’ goal is to reduce the cost associated with unnecessary readmissions, it seems CMS would not be as concerned with admissions for services covered under a single payment to an LTCH or IRF. On the other hand, in the preamble to the 2012 Final Rule, CMS focused not only on the cost-cutting purpose of the HRRP, but also on the negative impact on patients who are subject to multiple (potentially unnecessary) admissions to acute care facilities. From that perspective, CMS might include admissions to STACHs during interrupted stays from LTCHs or IRFs in their calculation of readmission rates under the HRRP.

**New Challenge to Medicare Payment Rates** Beyond the lack of clarity regarding interrupted stays, the HRRP raises many other potential issues. For example, CMS’ definition of “readmission” includes readmissions that are unrelated to the initial discharge from the STACH and over which the STACH has

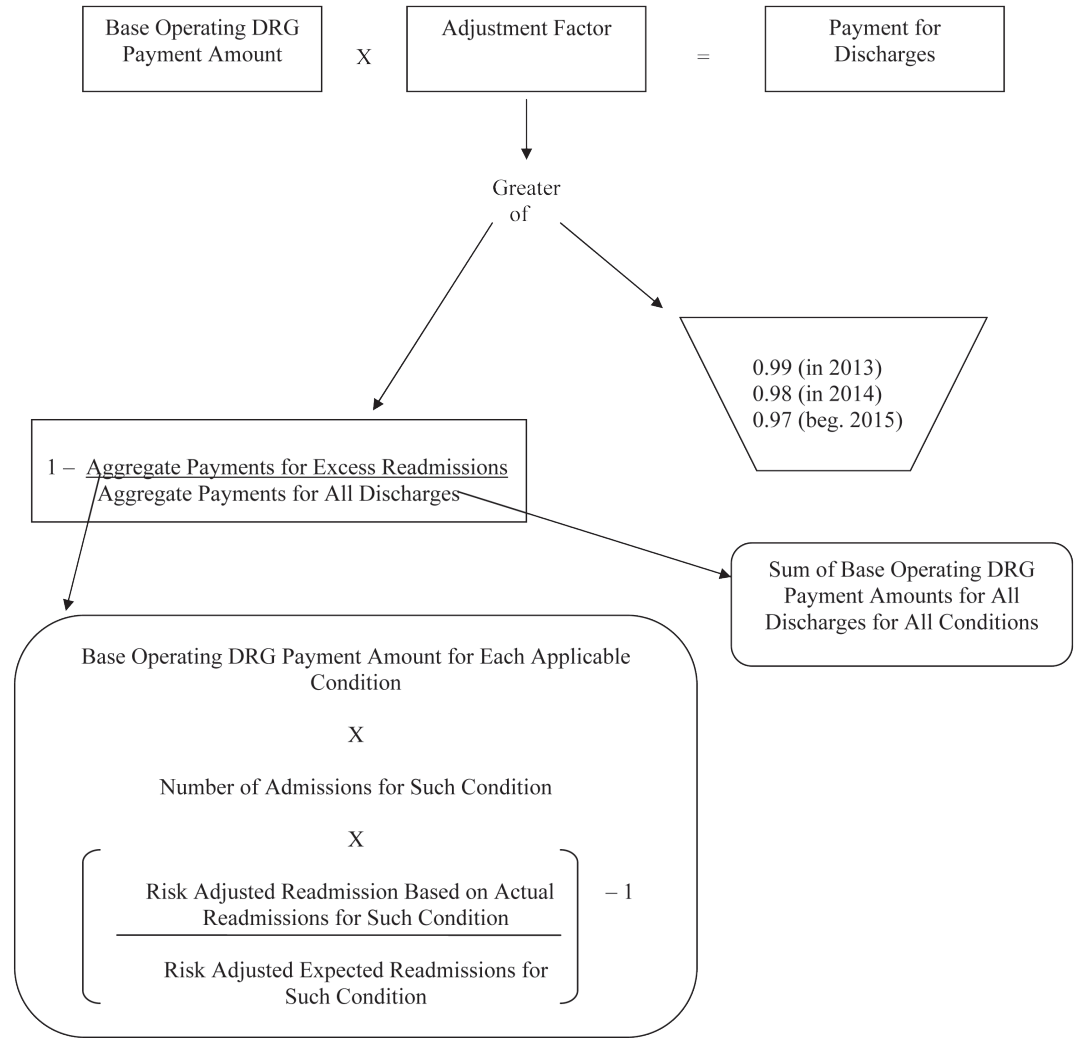
little or no control. A prime example is as a patient discharged with a diagnosis of PN who is subsequently readmitted to any acute care facility in connection with injuries suffered in a car accident. Not only is the readmission entirely unrelated to the care provided by the original STACH, but if the patient is admitted to a different acute care facility, the original STACH will also be penalized for the readmission without having the opportunity to decrease the penalty amount by providing care for the acute injury. Whether the risk adjustment included in the adjustment factor will adequately protect STACHs in these situations is unclear.

Moreover, the HRRP, which lacks any positive economic incentive for hospitals with readmission rates near or below the national average, will result in reduced hospital funding while simultaneously requiring hospitals to implement costly measures to reduce readmission rates, making it increasingly difficult for hospitals to remain in compliance.

Finally, the PPACA expressly prohibits administrative and judicial review of the readmission measures, base-operating DRG payments, and the formulas for calculating the adjustment factor.<sup>28</sup> This lack of opportunity for future review further underscores the importance of public comment on the 2013 Proposed Rule.

Chart A

THE HRRP DISCHARGE PAYMENT FORMULA



1. Beginning in fiscal year 2015, CMS will expand the list of applicable conditions. See 42 U.S.C. § 1395ww(q)(5)(B).
2. See 76 Fed. Reg. 51476-01, 51669-51670 (Aug. 18, 2011) (finalizing proposal to count readmissions within a 30-day period from date of initial discharge from index hospitalization).
3. See 76 Fed. Reg. 51476-01, 51665.
4. Special rules apply for certain classes of hospitals, including sole community hospitals, Medicare-dependent hospitals, and acute care hospitals in Maryland reimbursed under a waiver.
5. See 76 Fed. Reg. 51476-01, 51666 and 51669-51670.
6. See 42 U.S.C. § 1395ww(q)(5)(A)(ii).
7. 42 U.S.C. § 1395ww(q)(4)(C)(ii); 76 Fed. Reg. 51476-01, 51672.
8. See 76 Fed. Reg. 51476-01, 51666-51668.
9. *Id.* at 51667.
10. See 76 Fed. Reg. 51476-01, 51665-51666.
11. See 42 U.S.C. § 1395ww(q)(5)(B) (CMS may expand applicable conditions beginning with fiscal year 2015).
12. See *id.* at (q)(3).
13. See *id.* at (q)(3)(B); see also 76 Fed. Reg. 51476-01, 5167 (finalizing 3 years as applicable period for FY 2013 HRRP).
14. See 42 U.S.C. § 1395ww(q)(4)(A).
15. See *id.* at § 1395ww(q)(4)(C).
16. *Id.* at § 1395ww(q)(4)(C).
17. *Id.* at § 1395ww(q)(3)(C); see also 76 Fed. Reg. 51476-01, 51671.
18. See 42 U.S.C. § 1395ww(q)(4)(A).
19. See 76 Fed. Reg. 51476-01, 51673 (final rule regarding Excess Readmission Ratio methodology)
20. See 77 Fed. Reg. 27870, 27958-27965. (May 11, 2012).
21. 42 U.S.C. § 1395ww(8).
22. 42 U.S.C. § 1395ww(q)(6); 76 Fed. Reg. 51476-01, 51672-51673; see also Medicare Hospital Compare website, available at <http://www.hospitalcompare.hhs.gov/>.
23. See 77 Fed. Reg. 27870, 27966-27967.
24. 42 C.F.R. §§ 412.509(c) (LTCH); 412.604(e) (IRF); 409.20 (SNF).
25. However, with respect to SNFs, certain services are specifically excluded from SNF billing, such as the professional component of certain diagnostic radiology procedures for covered Part A stays, which is billed by the servicing provider.
26. See 42 C.F.R. § 412.531(a)(1)-(2) (defining “interrupted stays” under LTCH PPS); 42 C.F.R. § 412.602 (defining “interrupted stay” under IRF PPS).
27. 77 Fed. Reg. 27870, 28129.
28. 42 U.S.C. § 1395ww(q)(7).