A Proposal for an Alternative Approach for Improving the Fairness of the RRIP and Combining the RRIP and RSSP

Presentation to the Performance Measurement Work Group

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Background and Overview of Presentation

- Rationale for this proposal:
  - Desire to address a dilemma facing staff in the RRIP draft Policy Recommendation.
  - Desire to combine and streamline the HSCRC's methodologies pertaining to readmission reductions.
- Presentation Topics:
  - Discussion of current issues in the RRIP proposed methodology.
  - Proposal to borrow from prior HSCRC policy approaches that are reasonable and have been widely understood and accepted.
  - Proposal to combine the elements of the RRIP and the Readmission Shared Saving Program (RSSP) to streamline the HSCRC incentives related to readmission reduction.
  - Discussion of the broader applicability of the proposed approach
  - Other considerations.

Dilemma facing Staff in Reformulating the RRIP

- The RRIP is focused on incentivizing readmission rate *improvement*.
- Staff's modification of the RRIP methodology (to adjust the RRIP reduction percentage for hospitals with low Base Year readmission rate *attainment*) – was intended to improve the fairness of the policy.
- The presumption was that each hospital's ability to improve its readmission rate by the uniform percentage reduction target applied to all hospitals, may be a function of its actual attainment level.
- However, as noted by staff, it is difficult to assess a hospital's true attainment in the absence of adjustments for patient Socio-Economic Status (SES) and adjustments for readmissions to out-of-state hospitals.
- Staff was unable to develop these adjustments – yet, it still proposed a modification to reduce the percentage readmission rate reduction requirement for hospitals with "low" Base Year readmission rate levels.
- While well-intentioned, this change contradicts staff's conclusion that it is unable (in the absence of the above mentioned adjustments) to make fair and accurate assessments of hospital readmission rate attainment.
- The proposed approach was also arguably not ideal, because it applied only to hospitals that were below the statewide average.

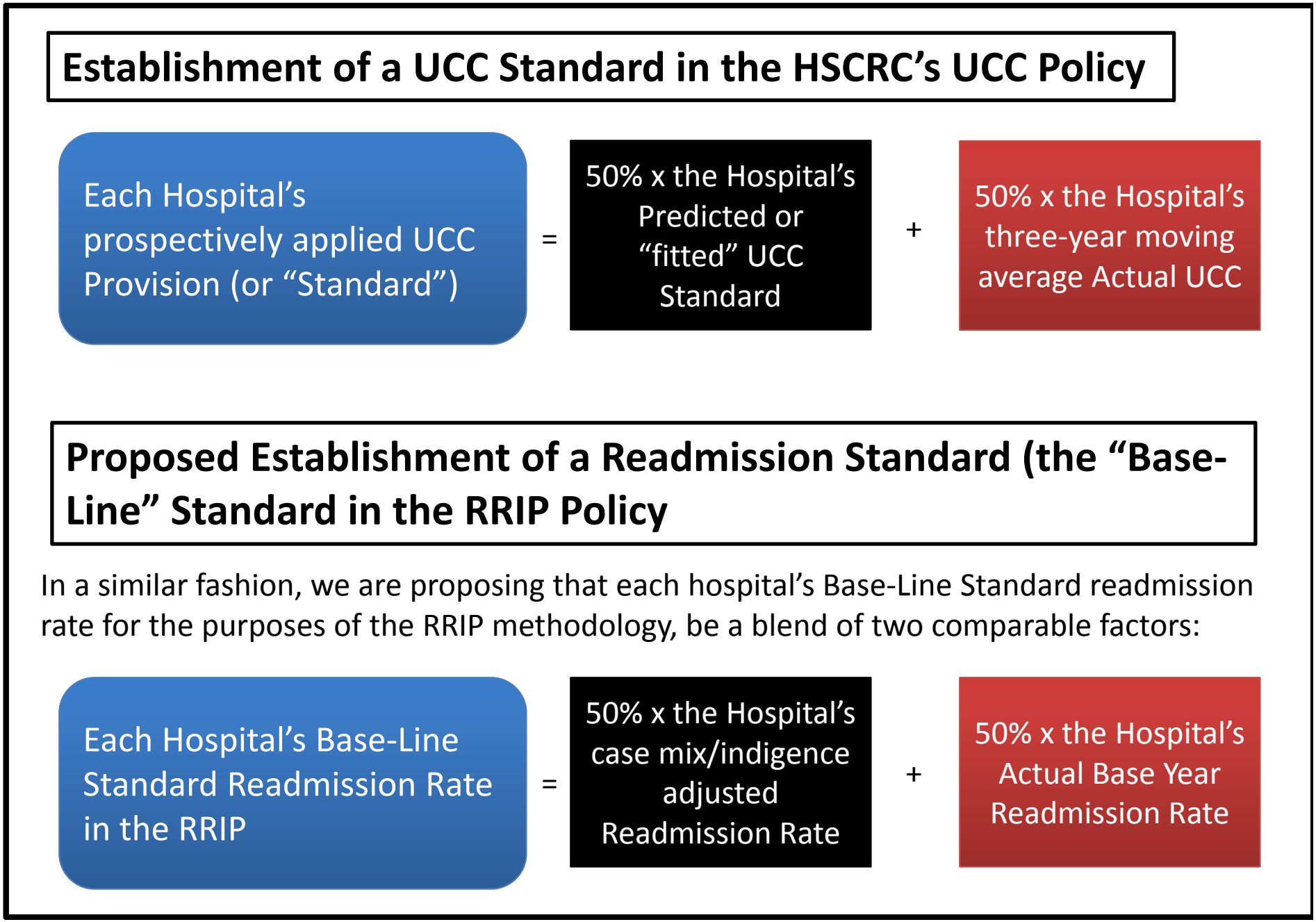
Alternative Approach – Adjusting for Patient Indigence

- We suggest that staff might try to address this dilemma by using approaches adopted by the HSCRC to solve similar policy issues.
- In the context of the HSCRC DSH policy, staff developed an indicator of patient indigence by looking at a proportion of a hospital's patients that were likely to have lower SES.
- The data used to identify this cohort was the HSCRC's inpatient case mix data.
- Similarly, the staff could identify two cohorts of patients: 1) one cohort – the "indigent cohort" - identified by the payer classes, Medicaid, Medicaid secondary payer (largely Dual Eligibles) and Selfpay/Charity, that is likely have a lower SES; and 2) a cohort – the "non-indigent cohort" – of all other patients.
- The staff should first test the relevance of making an adjustment to a hospital's readmission rate based on its distribution of indigent and non-indigent patients.
- If there is a demonstrable difference in readmission rates of these two cohorts on a statewide basis, then this adjustment should be applied to each hospital's readmission rate along with an adjustment for each hospitals case mix.
- Using these two adjustments, staff could calculate a hospital's indigence/case mix adjusted (what we refer to as the "Standardized") readmission rate.
- Appendix I provides an example of how a indigence/case mix adjusted readmission could be calculated.

Accounting for a Hospital's Actual Readmission Rate

- Per its revised RRIP methodology, staff indicated that it wished to give some credit to each hospital's actual readmission rate attainment.
- Accordingly we suggest borrowing from the HSCRC's Uncompensated Care (UCC) policy, which establishes a hospitals Base-Line Standard level of UCC for each facility by taking a 50/50 blend of the hospital's three-year moving average UC and a Standardized provision based on a state-wide data and a regression.
- Similarly, the HSCRC could establish a reasonable Base-Line Standard readmission rate by taking a 50/50 blend of each hospital's indigence/case mix adjusted readmission rate and its Actual base year readmission rate.
- Just as the UCC policy establishes a reasonable overall standard for a hospital's UCC provision, using a blend of a hospital's Actual and Standardized readmission rates would combine information that is specific to each facility (their actual performance) and at the same time factor in a Standardized factors based on statewide information.
- Figure 1 on the next slide illustrates how this approach is similar to the Commission's UCC Policy approach.

Figure 1: HSCRC UCC Policy vs. Proposed RRIP Modification



Accounting for a Hospital's Actual Readmission Rate (continued)

- We then propose that the HSCRC apply the uniform 9.5% required cumulative reduction percentage to each hospital's blended "Base-Line Standard" readmission rate.
- Hospitals that have actual readmission rates that are below their Standardized (indigence/case mix adjusted) readmission rate would catch a "break" on their required percentage reduction while hospitals with actual readmission
- Hospitals with actual readmission rates that are above their (indigence/case mix adjusted) Standardized readmission rate would face a more challenging reduction target.
- But the staff could apply the same 9.5% readmission reduction percentage to each hospital and hospitals' new targets would reflect their individual Actual relative to their Standardized readmission rate performance.

Hospital Examples

- Again, this proposal is intended to combine information about a hospital's actual performance with a standardized measure of performance, to develop an overall Base-Line Standard readmission rate that would be used in the HSCRC' RRIP methodology.

- It is best to explain this approach by considering several examples:

  - Consider a hospital with a 10% Actual readmission Rate and a calculated indigence/case mix adjusted Standardized readmission rate of 12%.

  - This hospital would have favorable actual readmission rate performance relative to what it would have experienced, had it realized the statewide average readmission rate experience at an APR-DRG SOI level, while also accounting for the hospital's mix of indigent and non indigent patients (this example is based on the hospital experience presented in appendix I).

  - In this case the hospital would have a Base-Line Standard Readmission Rate of 11% (50% x 10% actual rate + 50% x 12% Standardized rate).

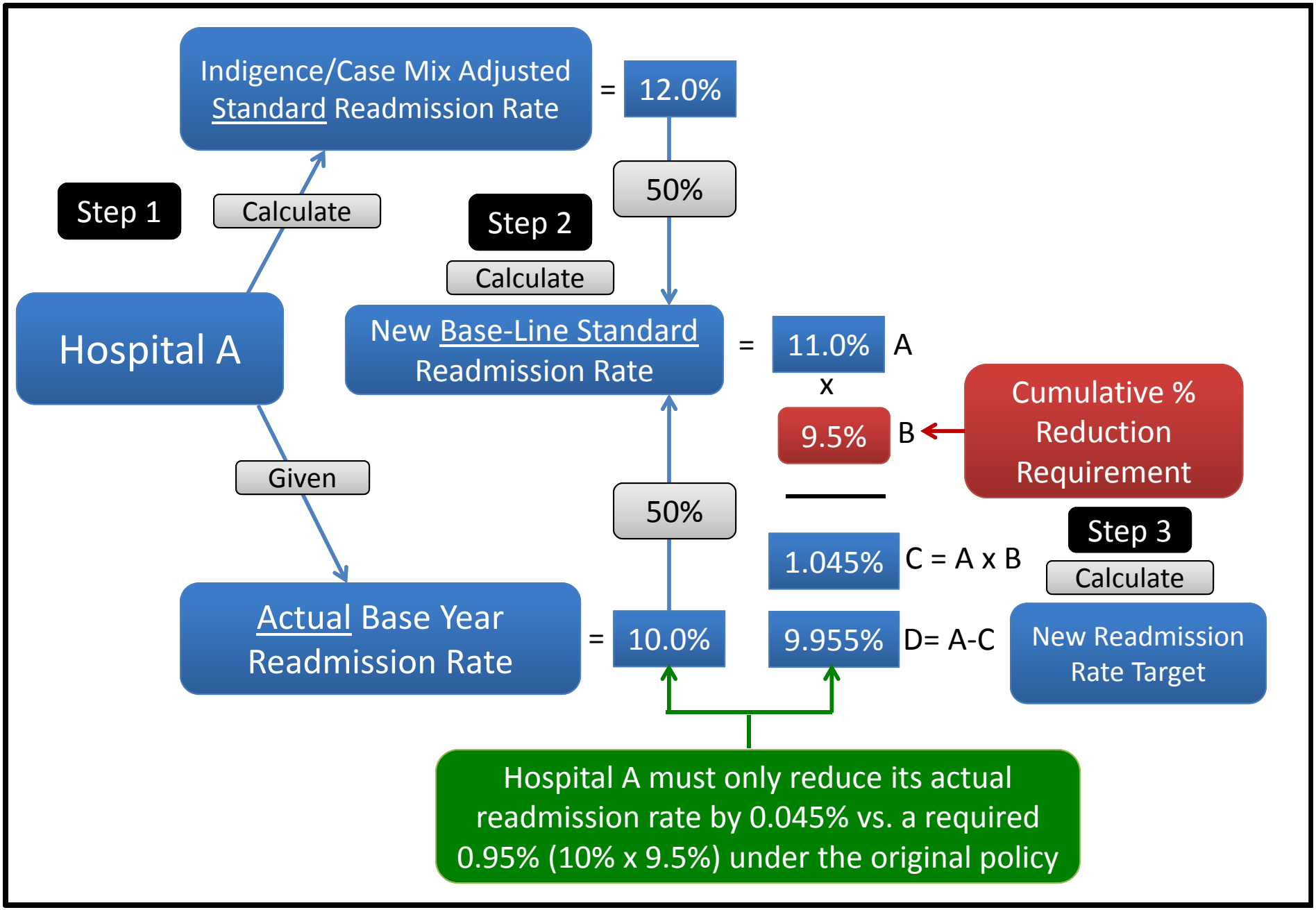
  - Our approach would have the HSCRC apply the uniform cumulative readmission reduction percentage of 9.5% to this hospital's Base-Line Standard rate (instead of applying the 9.5% to its actual readmission rate which is essentially done in the staff proposal).

  - This hospital's resulting required readmission target would be: 11% minus (11% x 9.5% = 1.0145%) or 11% - 1.045% = **9.955%**

Example Case (continued)

- This can be compared to this hospital's readmission reduction requirement and target readmission rate in per the staff's most recent modified RRIP recommendation:
- Per the original RRIP approach, this hospital would have a required readmission reduction percentage 10% actual x 9.5% = 0.95% or a targeted actual readmission rate of **9.05%** (10% – 0.95% = 9.05%). This is compared to the a readmission rate target of **9.955%** in the case of our alternative approach as shown on slide 8.
- In our proposed alternative approach, this hospital is realizing an advantage due to its Actual readmission rate being lower than its Standardized readmission rate.
- The fact that the new Base-Line Standard reflects 50% of its indigence/case mix adjusted Standardized readmission rate effectively cuts this hospital a "break."
- Slide 10 provides a graphical representation of this example.
- Slide 11 and 12 provide a table illustrating how this approach would operate in the case of three different hospitals:
  - Hospital A, with performance identical to the hospital in the above example;
  - Hospital B, with less favorable Actual readmission rate performance relative to its Standardized readmission rate; and
  - Hospital C with highly favorable Actual readmission rate experience relative to its Standardized readmission rate.

Figure 2: Hospital Example (Case 1 Hospital A)



Three Case Examples (Proposed Alternative Approach)

Table 1

Revised/Proposed Approach	Three Scenarios of Hospital Performance (1)		
	Case 1 Favorable	Case 2 Unfavorable	Case 3 Very Favorable
A. Calculating each Hospital's Required Reduction Percentag	Hospital A	Hospital B	Hospital C
1 Actual Readmission Rate	10.00%	12.00%	9.00%
2 Standardized Readmission Rate (1)	12.00%	10.00%	12.00%
3 Base-Line Standard Rate (50%x L1 + 50% x L2)	11.00%	11.00%	10.50%
4 RRIP Required Culmulative Reduction (given)	9.50%	9.50%	9.50%
5 Required Percentage Reduction (L3-L4)	1.045%	1.045%	0.998%
B. Establishing the Hospital's New Readmission Rate Target			
6 Base-Line Standard Rate (L3)	11.00%	11.00%	10.50%
7 Required Reduction (L5)	1.045%	1.045%	0.998%
8 New Target (L3 - L5)	9.955%	9.955%	9.503%
9 Actual Readmission Rate	10.00%	12.00%	9.00%
10 Reduction/Offst vs. Actual rate (L9 - L10)	9.955%	9.955%	9.503%
11 Required Reduction	0.045%	2.045%	-0.503%

(1) Favorable performance means a hospital has a lower actual readmission rate vs. its Standardized readmission rate.

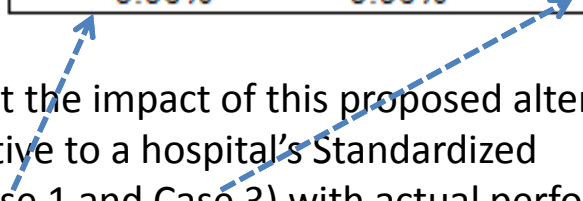
(2) The Standardized readmission adjustsfor a hospital's case mix and the indigence of its patient mix

Three Case Examples (Original Policy)

Table 1 (continued)

Original Policy

	Three Scenarios of Hospital Performance (1)		
	Case 1 Favorable Hospital A	Case 2 Unfavorable Hospital B	Case 3 Very Favorable Hospital C
D. Calculation of each Hospital's Required Reduction Percentage:			
1 Actual Readmission Rate	10.00%	12.00%	9.00%
2 RRIP Required Culmulative Reduction (given)	9.50%	9.50%	9.50%
3 Required Percentage Reduction (L1 - L2)	0.950%	1.140%	0.855%
E. Comparison of Readmission Rate Targets under Original/Revised Approaches			
4 Actual Readmission Rate	10.00%	12.00%	9.00%
5 Required Reduction (L3)	0.950%	1.140%	0.855%
6 New Target (L4 - L5)	9.05%	10.86%	8.15%
7 Compared to Target under Proposed method (L8 table 1)	9.96%	9.96%	9.50%



Based on the examples on Slides 11 and 12 one can see that the impact of this proposed alternative approach is to recognize favorable actual performance relative to a hospital's Standardized Readmission rate. The result is that hospitals (such as in Case 1 and Case 3) with actual performance that is favorable relative to their indigence/case mix adjusted Standardized readmission rate, are advantaged by this approach.

In the case of highly favorable performance (Case 3), the hospital has a readmission rate Target of 9.5% under the proposed approach (versus 8.15% under the original RRIP Policy). Yet Hospital C actual readmission rate is already 9.0% - thus it would not be required to improve any additional amount because of its past highly favorable performance

HSCRC Readmission Shared Saving Program

- The HSCRC's RRIP was first implemented in FY 2015, however, the HSCRC initially implemented the "Readmission Shared Savings program" (RSSP) in FY 2014.
- This program was created to supplement the original Admission-Readmission Revenue (ARR) program created in 2011, and it was intended to help the HSCRC retain its exemption from Medicare's national Hospital Readmission Reduction Program (HRRP).
- The RSSP is structured to prospectively offset hospital's rates (and their GBR rate base) at the time of the annual Update by some prescribed magnitude each year.
- In FY 2014 that offset was 0.3%, in FY 2015 it was 0.4%, in FY 2016 the offset was 0.6% and in FY 2017 it appears staff is proposing a 1.1% offset to rates.
- This offset was nominally tied (at the individual hospital level) to each facility's readmission rate attainment.
- However, the proposed methodology for scaling the offset resulted in minimal variation in the scaling (at an individual hospital level) of the overall industry-wide offset (in FY 2015 for instance the 0.4% industry offset resulted in hospital-specific offsets effectively ranging from 0.23% to 0.49%.
- Despite these limitations, the RSSP policy has the benefit of specifying amount of savings at the beginning of each year that is offset against hospital rates and thus guarantees savings to payers regardless of eventual hospital performance.

HSCRC Readmission Shared Saving Program (continued)

- In addition, although the staff described the RSSP as a program to provide incentives to reduce readmissions, other than the very limited relative scaling of the statewide offset, there was nothing that provided specific incentives for hospitals to reduce readmissions.
- In the RSSP recommendation, the staff indicated that the "RSSP provides strong incentives for hospitals to reduce their readmissions because they can "earn back" the annual prospective offset to their rates by reducing readmissions."
- While this is nominally true, the real incentives to reduce readmissions come from the incentives hospitals face under their fixed Global Budgets and not substantively from the methodologies of the RSSP.
- In truth, hospitals could "earn back" the prospective offset imposed by the RSSP by doing any number of things: 1) reduce readmissions; 2) reduce admissions; 3) reduce length of stay and ancillary use; 4) reduce unnecessary outpatient utilization; 5) or allow patients to migrate to other facilities.
- While the RSSP has some limited incentives related to readmission reduction, the policy is really a mechanism to reduce hospital rates and Global Budget (in a limited way based on readmission rate levels).
- We believe the general concept of the RSSP to be very useful. However, the implementation of this policy could be improved and integrated with the incentives of the RRIP.

Proposal to Combine Favorable Elements of the RRIP and RSSP

- We believe that the favorable elements of the RRIP (including the suggested modifications as presented in this alternative) and the RSSP could be combined to provide a more streamlined/powerful incentive system for readmission rate reduction.
- In particular, under the RRIP methodology (as modified per this alternative proposal) it would be possible to quantify each hospital's required readmission rate reduction in terms of its readmission revenue.
- For instance, in the example on Slide 11 (also shown on slide 16) in Case 2, Hospital B would be required to reduce its actual readmissions from 12% to 9.955%. If that hospital had readmission related revenue of $20 million, that 2.045% required reduction could be quantified as 2.045% x $20 million or $409,000 (2.045% x $20,000,000 = $409,000).
- This would then be the amount of the prospective offset to the hospitals rate base.
- Thus, by combining elements of the RRIP with the concept of prospective offsets in the RSSP, the hospital could be held to achieving a 2.045% reduction in its readmission rate level and payers could be guaranteed savings commensurate with this required reduction level (whether or not the hospital achieved these required reductions).
- In this way, the system of prospective offsets to hospital rates could be made more meaningful, because they would be directly tied to each hospital's readmission reduction performance.
- The incentives for hospitals to reduce their readmissions would be strengthened because the performance targets would be rolled forward each year.

Three Case Examples (Proposed Alternative Approach)

Table 1a

Revised/Proposed Approach	Three Scenarios of Hospital Performance (1)		
	Case 1 Favorable	Case 2 Unfavorable	Case 3 Very Favorable
A. Calculating each Hospital's Required Reduction Percentage	Hospital A	Hospital B	Hospital C
1 Actual Readmission Rate	10.00%	12.00%	9.00%
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3 Base-Line Standard Rate (50%x L1 + 50% x L2)	11.00%	11.00%	10.50%
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B. Establishing the Hospital's New Readmission Rate Target			
6 Base-Line Standard Rate (L3)	11.00%	11.00%	10.50%
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8 New Target (L3 - L5)	9.955%	9.955%	9.503%
9 Actual Readmission Rate	10.00%	12.00%	9.00%
10 Reduction/Offst vs. Actual rate (L9 - L10)	9.955%	9.955%	9.503%
11 Required Reduction	0.045%	2.045%	-0.503%
C. Calculating each Hospital's Prospective Offset/(Restoration) amount July 1			
12 Hospital's Assummed Readmission Related Revenue	$20,000,000	$20,000,000	$20,000,000
13 Prospective Offset/(Restoration) to Rates July 1 (L11xL12)	$9,000	$409,000	-$100,500

(1) Favorable performance means a hospital has a lower actual readmission rate vs. its Standardized readmission rate.

(2) The Standardized readmission adjustsfor a hospital's case mix and the indigence of its patient mix

Magnitude of The Prospective Offset (Restoration) to a hospital's Rate Base July 1

Advantages to the Proposed RRIP Modifications and Combined Approach

1. The combined approach simplifies the HSCRC's readmission incentive strategy by combining and unifying what are arguably two duplicative and overlapping policies (the separate RSSP and RRIP);

2. The Revised RRIP Methodology provides a straightforward and clear method for taking into account the impact of the indigence of each hospital's patient population using readily available data that is updated each year (the HSCRC case mix data) in a fashion that is similar to a method utilized in years past in the context of the Commission's DSH policy;

3. The use of a blend of each hospital's actual readmission rate and its Standardized rate (similar to the HSCRC's UCC Policy) accounts for hospital relative performance and rewards facilities with high performance levels and penalizes facilities with less favorable performance levels;

4. By establishing prospective reductions to hospital rates at the time of the annual Update, the combined policy would meaningfully increase the incentives to reduce readmissions. This is because (unlike the RSSP) our proposed approach will roll the hospital-specific readmission rate targets forward each year. If a hospital fails to bring its readmission rate down by the required amounts in a given performance year, it will be faced with the same (or greater) performance requirements in the next year;

Advantages to the Proposed RRIP Modifications and Combined Approach

5. The proposed and combined program continues to work effectively with the incentives of each hospital's GBR in that reductions in readmission rates that are greater than the targeted amounts will continue to afford the hospital 100 cents on the dollar savings for those incremental additional reductions;

6. All-payers would benefit by realizing the targeted level of savings each year whether hospitals reduced their readmission by the required amounts or not, because these required savings would be offset in rates at the start of each Rate Year through an adjustment to each hospital's Update Factor; and

7. Our proposed policy has very broad applicability and could be extended to any category of unnecessary utilization (such as PQIs, Sepsis or unnecessary imaging or procedures) as long as an acceptable Base-Line Standard rate for these measures can be established.

Other Considerations

- In our paper on these topics, we also propose:

  - We would be prepared to "model" the results for the industry if we can gain access to the HSCRC data necessary to develop these result.
  - A methodology to first test the relevance of making adjustments for out-of-state readmissions.
  - If adjusting for out-of-state readmissions is determined to be a relevant adjustment, how staff might accomplish such an adjustment.
  - Use of a Medicare-specific Readmission rate target in lieu of an All-Payer Readmission rate target for the reasons discussed by CareFirst previously.
  - The potential use of a Medicaid-specific readmission rate target and/or a combined Medicare/Medicaid readmission target – utilizing the methodologies proposed in this alternative RRIP proposal.

Appendix I - Sample calculation of a hospital's indigence/case mix adjusted Readmission rate (its "Standardized" Readmission Rate) in a simplified case of a hospital with 3 APR-DRGs.

First, we generate the hospital's Actual Readmission rate and calculate its Statewide readmission rate (case mix adjusted or what we call its "Standardized" rate) for its Indigent patients:

Table 2a – Indigent Cohort Readmission Rates

APR DRG 1	Discharges	Hospital Actual Readmissions	Actual Readmission Rate	Statewide Avg. Readmission Rate Pct.	Hospital's Readmissions at Statewide Average Rate
SOI 1	175	15	8.6%	11.0%	19
SOI 2	125	17	13.6%	15.0%	19
SOI 3	75	13	17.3%	17.0%	13
SOI 4	25	6	24.0%	27.0%	7
Subtotal	400	51			58
APR DRG 2					
SOI 1	200	15	7.5%	10.0%	20
SOI 2	100	15	15.0%	15.0%	15
SOI 3	75	13	17.3%	19.5%	15
SOI 4	25	7	28.0%	30.5%	8
Subtotal	400	50			57
APR DRG 3					
SOI 1	200	16	8.0%	8.5%	17
SOI 2	150	15	10.0%	12.0%	18
SOI 3	100	14	14.0%	16.0%	17
SOI 4	50	12	24.0%	25.0%	13
Subtotal	500	57			65
Totals	1,300	158	12.2%	13.8%	180

Appendix I (continued)

Next, we generate the hospital's Actual Readmission and calculate its Statewide (case mix adjusted or Standardized) readmission rate for its non-indigent patients.

Table 2b – Non-Indigent Cohort Readmission Rates

APR DRG 1	Discharges	Hospital Actual Readmissions	Actual Readmission Rate	Statewide Avg. Readmission Rate Pct.	Hospital's Readmissions at Statewide Average Rate
SOI 1	350	18	5.1%	7.0%	25
SOI 2	200	22	11.0%	13.0%	26
SOI 3	100	13	13.0%	16.0%	16
SOI 4	50	11	22.0%	25.0%	13
Subtotal	700	64			79
APR DRG 2					
SOI 1	275	19	6.9%	9.0%	25
SOI 2	200	20	10.0%	12.0%	24
SOI 3	75	11	14.7%	17.0%	13
SOI 4	50	12	24.0%	27.0%	14
Subtotal	600	62			75
APR DRG 3					
SOI 1	375	21	5.6%	7.0%	26
SOI 2	275	18	6.5%	9.0%	25
SOI 3	200	20	10.0%	13.0%	26
SOI 4	50	7	14.0%	18.0%	9
Subtotal	900	77			86
Totals	2,200	192	8.7%	10.9%	240

Appendix I (continued)

Next, we combine the two sets indigent and non-indigent results to generate an overall actual readmission rate and an overall Standardized readmission rate (that is both case mix and indigence adjusted)

Table 2c – Summary Calculation of the Hospital's Base Line Standard

		A	B	C	D	E
		Discharges	Readmissions	Actual Readmission Rate	Hospital's Readmissions at Statewide Rate	Standardized Readmission Rate
L1	Indigent Readmissions	1,300	158	12.2%	180	13.8%
L2	Non-Indigent Readmissions	2,200	192	8.7%	240	10.9%
L3	Total Indigent and Non-Indigent Readmissions (L1+L2)	3,500	350	10.0%	420	12.0%

L4	Base Line Standard Readmission Rate = (50% x Cell C3 x 50% x Cell E3)	11.0%
L5	Required Readmission Reduction Percentage	9.5%
L6	Targeted Reduction (L4 x L5)	1.045%
L7	**New Actual Target: Proposed Method (L4 – L6)**	**9.995%**

Next, we take a 50/50 blend of its actual readmission rate and its Standardized readmission rate to develop what we call the hospital's Base-Line Standard readmission rate. This rate is analogous to a hospital's prospective UCC provision which is also a blend of actual and a standardized UCC measure (the "fitted value")

Finally, we apply the staff recommended and required readmission cumulative reduction percentage (of 9.5%) To this calculated Base-Line Standard to determine the hospital's required readmission reduction percentage and its new target. The approach recognizes favorable hospital performance (attainment) and also adjusts for the impact of SES on a hospital's readmission rate.