



Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov



HOSPITAL GUIDE

to Reducing Medicaid Readmissions

Hospital Guide to Reducing Medicaid Readmissions

Developed by



and



Sponsored by



The Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
www.ahrq.gov

AHRQ Publication No. ##-####-XX
June 2014

INTRODUCTION

Reducing readmissions is a national priority for payers, providers, and policymakers seeking to achieve Triple Aim objectives of improved health and enhanced care at lower cost.¹ Hospital readmissions are frequent, costly, and highly variable across providers and geographies. A large body of evidence documents the numerous ways in which the transition out of the hospital and into the next setting of care can be inconsistent, unsafe, rushed, confusing, and ineffective. These processes can and must be improved as a system property of safety, quality, and efficiency. The process of reorganizing systems and services to effectively reduce readmissions is foundational to healthcare delivery redesign and accountable care.

During the past several years, the Centers for Medicare and Medicaid Services (CMS) and the CMS Center for Innovation (CMMI) have created incentives, instituted penalties, and provided technical assistance to providers and communities to improve care across settings and reduce readmissions. Prominent examples of these initiatives include: the Hospital Readmission Reduction Program, the Community-based Care Transitions Program, the Bundled Payments for Care Improvement, the Partnership for Patients, the Hospital Engagement Networks, and the Quality Improvement Organization 10th Scope of Work. In addition, physician practices and accountable care organizations are receiving incentives to reduce readmissions for Medicare fee-for-service beneficiaries.

Powerful incentives can create much-needed attention and action. However, the vast majority of the incentives, new financing, and technical assistance have focused providers and communities on reducing readmissions only for the Medicare fee-for-service population. Many of the tools and best practices for reducing readmissions were developed based on insights from the geriatric health service research literature. Taken together, it is reasonable that many hospital readmission reduction initiatives target Medicare beneficiaries or conditions on the CMS readmission penalty list only.

However, all-payer data analyses at the national, state and local levels show that the adult, non-obstetric Medicaid population has readmission rates as high as – or even higher – than the Medicare fee-for-service population. The growing recognition of Medicaid readmissions as a significant issue is reflected in the trend of regulatory actions from state governments, Medicaid expansions, and a growing emphasis on alternative payment arrangements. Hospitals are facing increasing pressures to improve care transitions and reduce Medicaid readmissions.

The Agency for Healthcare Research and Quality commissioned this work to identify the ways in which evidence-based strategies to reduce readmissions can be adapted or expanded to better address the transitional care needs of the adult Medicaid population. This Guide was developed over a two-year period using quality improvement methodologies to identify: the clinical case for improvement, the similar and distinct transitional care needs of the population, the readmission reduction strategies of high-volume Medicaid hospitals and the extent to which those strategies specifically addressed Medicaid patients' needs, pragmatic adaptations to existing best practices, and identification of new or expanded strategies not contained in the existing body of readmission reduction best practice toolkits.

Created by Collaborative Health Strategies and John Snow Inc. with funding from AHRQ, this Guide is available for all hospitals to use free of charge. All information it contains is up to date as of June 2014.

¹ Berwick, Nolan, Whittington. The Triple Aim: care, Health, and Cost. *Health Affairs* 27(3):759-769. 2008.

WHY FOCUS ON MEDICAID READMISSIONS?

To a large extent, best practice recommendations to reduce readmissions have emerged from the geriatric health services research literature and/or analyses conducted on the Medicare fee-for-service population. Few analyses have been published on readmissions in the Medicaid population. There may be a perception that there is not a “readmission problem” in Medicaid, as whole-population Medicaid analyses (including pediatric and obstetric patients) reveal comparatively low readmission rates. However, adult Medicaid patients who are not hospitalized for childbirth experience readmission rates that are as high as or higher than those experienced by Medicare beneficiaries.

AHRQ’s Healthcare Cost and Utilization Project (HCUP) has produced a series of briefs on all-payer readmission patterns. These analyses reveal several novel insights about Medicaid readmissions, including:

- Readmission rates for adult Medicaid patients ages 45-64 are *demonstrably high*, at 24%;²
- Medicaid heart failure readmission rates are *higher than* Medicare rates: 30% versus 25%;^{3,4}

The readmission patterns of the Medicaid population differ in important ways from those of the geriatric population.⁵ Clinically, the younger adult Medicaid patient is hospitalized for a different set of illnesses – such as infections (including hepatitis, HIV, endocarditis), behavioral health conditions (including the consequences of substance use disorders), and sickle cell – in addition to the consequences of chronic illness and poor access to ambulatory care. Additionally, Medicaid patients experience numerous social and economic challenges that impact their health and their ability to navigate the health care system. Discontinuities in coverage, low literacy, language barriers, lack of transportation, unstable housing, unstable employment, and poverty all contribute to readmission risk. Because of these differences, the transitional care strategies that are effective for geriatric patients may need to be modified to better meet the post-hospital needs of adult Medicaid patients.

In addition to the evidence that Medicaid adults have the highest readmission rates of any payer, this year marks the beginning of a massive expansion in Medicaid eligibility that has provided millions of adults with health coverage. Many of the newly-covered adults will likely have little experience navigating the health care system, may be sicker, and may have even higher risk of readmission. Thus, the importance of developing strategies to ensure effective transitions in care and post-hospital support is more important now than ever to achieve the cost and quality objectives of the Affordable Care Act.

Furthermore, hospitals are facing mounting pressures to reduce Medicaid readmissions due to payment reforms and regulatory actions from state governments. Accountable care and other alternative payment models require hospitals to demonstrate reductions in avoidable admissions and readmissions. This trend is gaining additional momentum with the rapid growth of managed care enrollment and its extension to disabled and dual-eligible populations. Updated CMS discharge planning conditions of participation substantially raises the bar for standard hospital-based processes, applicable to Medicaid patients also. The evolving healthcare environment – regulation, payment, policy and best practice – is pushing hospitals to expand their efforts to improve transitions in care and collaborative cross-setting care to reduce readmissions for all – including Medicaid patients.

² Wier et al. All-Cause Readmissions by Payer and Age, 2008. HCUP Statistical Brief #115. June 2011.

³ Elixhauser, Steiner C. Readmissions to U.S. Hospitals by Diagnosis, 2010. HCUP Statistical Brief #153. April 2013.

⁴ Boutwell, Maxwell et al. Reducing Hospital Readmissions for Medicaid Patients through a Patient-Centered and Community-Based Approach: Final Report to the Agency for Healthcare Research and Quality. John Snow Inc, June 2013.

⁵ This Guide focuses on the adult, non-obstetric Medicaid population as a subgroup of Medicaid beneficiaries; further research is needed to describe readmissions in Medicaid obstetric and pediatric populations.

OVERVIEW OF GUIDE CONTENT

Section 1: Know Your Data

This Guide begins with an explanation of how to analyze hospital administrative data and gather qualitative insights about Medicaid readmissions as they compare to Medicare or all-payer trends. This section offers specific actions, tools, and diagnostic questions to assist with understanding and interpreting the root causes of readmissions at your hospital.

Section 2: Inventory Readmission Reduction Efforts

This section prompts an inventory of readmission reduction efforts, examining departments, service lines, business units, performance contracts, grants, and research efforts across your hospital. Similarly, it also offers guidance on how to conduct an inventory of Medicaid-specific partners' readmission reduction activities and relevant resources. Gathering all of this information in one place will allow your team to evaluate how well these efforts align with the needs of your Medicaid patients, what redundancies can be streamlined, and what gaps need to be addressed.

Section 3: Develop a Portfolio of Strategies

This section assists with synthesizing the information collected from the root cause data analysis and inventory and using it to inform a portfolio of strategies to reduce Medicaid readmissions. It walks through the process of specifying your readmission reduction objective and aims, selecting strategies for a multi-faceted approach to readmissions reduction, and quantifying the expected impact and return on investment for those strategies.

Section 4: Improve Hospital-Based Transitional Care Processes for Medicaid Patients

Building on best-practice recommendations from STAAR, BOOST and RED, this section describes how to adapt these best practices to better serve Medicaid patients' needs, such as understanding readmission risk and transitional care needs more broadly than a set of target diagnoses, and inquiring about and linking patients to needed behavioral health and social support services. It emphasizes the guidance enumerated in the CMS Conditions of Participation, which require standardized, improved transitional care processes for all patients, not just those determined to be high risk of readmission.

Section 5: Collaborate with Cross-Setting Partners

This section explains the essential utility of forming a cross-continuum team with partners who will be especially valuable in reducing Medicaid readmissions. Medicaid partners – social services, county health departments, crisis teams, community case workers, behavioral health centers, adult day care and Medicaid agencies and managed care plans are new stakeholders to align with when expanding a focused from Medicare-only to include Medicaid. It offers specific advice about how to evolve from cross-organizational relationship building to actionable collaboration in cross-setting care.

Section 6: Provide Enhanced Services for High Risk Patients

This section offers a description of enhanced services that your hospital may choose to offer for those patients who are at the highest risk of readmission. It explains different methods of how these different types of enhanced services can be funded, and provides specific advice on how to partner with payers.

ROADMAP OF TOOLS

This Guide offers a set of tools to assist your efforts in reducing Medicaid readmissions. The tools are included at the end of this Guide as a complete package, but they can also be downloaded online individually. The tools and their description are provided here for at-a-glance reference.

#	Tool	Description
1	Data Analysis Tool	Extensively vetted 10-point analysis of data to facilitate a compare and contrast view of readmissions by payer to identify differences between Medicare, Medicaid, commercial and all-payer rates.
2	Readmission Review Tool	Updated from the well-known STAAR approach, this one-page interview guide prompts clinical or quality staff to elicit the patient, caregiver, and provider perspective about the causes of readmissions.
3	Data Analysis Synthesis Tool	This template creates a written narrative to describe the results from the quantitative data and readmission interviews.
4	Hospital Inventory Tool	This tool prompts a comprehensive inventory of readmission reduction activity across departments, service lines, units within the hospital.
5	Cross-Continuum Team Inventory Tool	This tool prompts a comprehensive inventory of community-based providers and agencies that provide services helpful in the post-discharge settings.
6	Conditions of Participation Checklist	This one-page tool, adapted from the CMS Conditions of Participation surveyor guidance, prompts consideration of whether a set of standardized improvements are being provided to all patients, regardless of "risk."
7	Portfolio Design Tool	This tool prompts readmission reduction teams to expand readmission reduction efforts to include action in at least three broad domains: improve standard care for Medicaid patients, collaborate with partners, and provide enhanced services for high-risk patients.
8	Readmission Reduction Impact & Financial Analysis Tool	This Excel sheet facilitates modeling of the impact of the strategies in your hospital's readmission reduction portfolio. It prompts teams to quantify which patients will be served by each strategy, their baseline readmission rate, and the projected readmission reduction. It also helps estimate the avoided utilization (payer cost) due to each strategy, accounts for the investment cost of the intervention (in tools, staff, time) and net "savings" (to payers).
9	Readmission Risk Tool	This tool is an educational and awareness building tool for front line staff, cross-continuum teams, quality improvement leadership to quickly review the numerous factors that lead to risk of readmission. It highlights the fact that narrow targeting strategies will miss a majority of the risks of readmission.
10	Whole-Person Assessment	This tool provides a checklist to prompt front line staff to identify and address basic needs.
11	Discharge Information Checklist	This tool, adapted from the CMS Conditions of Participation, provides a checklist of information that needs to be provided to patients and their receiving provider(s) at the time of transition.
12	Cross-Continuum Team How to Tool	This tool explains the benefits and process of building a cross-continuum team, and offers a letter template for inviting partners to join it.
13	Community Resource Guide Tool	This tool is modeled off of a Community Resource Guide developed by a community-based care management agency. It prompts the hospital readmission reduction team to identify specific contacts at community agencies to facilitate efficient referrals.