



## High Rehospitalization Rates: Causes, Costs, and Accountability

## FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

**Norbert I. Goldfield, MD**

*Medical Director*

3M Health Information Systems

**Denise Remus, PhD, RN**

*Chief Quality Officer*

BayCare Health System

**Stephen Rosenthal**

*President and Chief Operating Officer*

The Care Management Company

**Wayne Lerner, DPH**

*President and Chief Executive Officer*

Holy Cross Hospital

FRIDAY, MAY 29, 2009

11:45AM–12:15PM—Lunch

12:15PM–2:15PM—Discussion

### LOCATION

Reserve Officers Association  
One Constitution Avenue, NE  
Congressional Hall of Honor  
Fifth Floor

*(Across from the Dirksen  
Senate Office Building)*

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**OVERVIEW**

*The President's 2010 budget proposes to cut Medicare payments to hospitals that have a high share of patients rehospitalized shortly after a previous inpatient stay. This proposal is consistent with an option of the Senate Committee on Finance and recommendations by the Medicare Payment Advisory Commission. This reduced payment would provide hospitals with incentives to decrease preventable rehospitalizations, a goal with which few would argue. Indeed, some might say that reducing rehospitalizations is the kind of low-hanging fruit needed to bankroll health care reform. Harvesting this fruit, however, requires hospitals, physicians, and post-acute providers to work together to better coordinate care. This Forum session will explore the reasons for rehospitalizations, what hospitals can do to reduce them, and the costs and consequences of holding hospitals financially accountable for rehospitalizations.*

**SESSION**

Almost 20 percent of Medicare beneficiaries are rehospitalized within 30 days of discharge from a previous hospitalization, and 34 percent are rehospitalized within 90 days.<sup>1</sup> Patients with medical diagnoses, such as heart failure and pneumonia, are more likely to be rehospitalized than those hospitalized for surgery. Older patients, those with more severe conditions, and those with major mental health or substance abuse problems are more likely to be readmitted than others.<sup>2</sup> Rehospitalizations may result from poor quality of care during the initial hospital stay, inadequate support transitioning out of the hospital, or insufficient follow-up services.

Reducing rehospitalizations could lower health care spending as well as improve quality of care. While many rehospitalizations are planned or appropriate, others could be eliminated by substituting outpatient or post-acute care services, which might be less expensive. Yet, under current fee-for-service payment methods, none of the providers involved in an episode of care is accountable for services or costs over the entire course of treatment. Compounding the problem of lack of accountability are perverse financial incentives in the payment system. For example, hospitals that successfully reduce rehospitalizations may face lower revenues because of foregone admissions.

The Medicare Payment Advisory Commission (MedPAC), recognizing the problems with fee-for-service payments, endorsed the concept of bundling payments under Medicare.<sup>3</sup> A bundled payment for all of the care delivered during an episode would provide incentives for providers to accept accountability for both the quality and costs of care over the entire episode. The Commission recommends an incremental approach to bundled payments that involves confidential and then public reporting of rehospitalization rates, followed by payment reductions to hospitals with relatively high rates. The Senate Committee on Finance policy options paper and the President's fiscal year 2010 budget include similar provisions to hold hospitals accountable for high rehospitalization rates through reduced payments.<sup>4</sup>

Key features of these proposed policies, however, will determine how effective they can be in achieving the desired outcomes while minimizing adverse consequences. These features include identifying which admissions are potentially preventable, determining which factors will be recognized as beyond a hospital's control, establishing the benchmarks used to define high rehospitalization rates, and accounting for any geographic or market area factors that may affect rehospitalizations.

## KEY QUESTIONS

- Why target rehospitalizations in Medicare payment reform? Why should a hospital be held financially accountable for high rehospitalization rates?
- What patient characteristics affect rehospitalization rates? What social, environmental, or health care delivery system factors affect rehospitalization rates? What factors are within a hospital's control? What factors are beyond its control?
- What is the physician's role in reducing rehospitalizations? The post-acute care provider's? The patient's? How can a hospital engage physicians, other providers, and patients in reducing rehospitalizations?

## SPEAKERS

**Norbert I. Goldfield, MD**, medical director at 3M Health Information Systems, will begin the session by describing his work in defining potentially preventable readmissions. Dr. Goldfield was instrumental in developing a methodology for establishing a clinical relationship between an initial admission and a readmission to use in calculating

a hospital's expected readmission rate. He has worked with states and hospital organizations to examine potentially preventable readmissions and to compare hospital performance in reducing them. **Denise Remus, PhD, RN**, is the chief quality officer for BayCare Health System. Florida has required public reporting of rehospitalizations for about one year. Dr. Remus will discuss BayCare's efforts to understand their rehospitalization rate and reduce preventable rehospitalizations. **Stephen Rosenthal**, president and chief operating officer of The Care Management Company, affiliated with Montefiore Medical Center in New York, will discuss the business case for initiating programs to reduce rehospitalizations and the incentives in a fee-for-service model that inhibit such initiatives. **Wayne Lerner, DPH**, president and chief executive officer of Holy Cross Hospital in Chicago, will discuss the challenges and opportunities facing financially stressed hospitals in responding to incentives to reduce hospitalizations. Dr. Lerner has held leadership positions in many hospitals that represent a range of the types of facilities and populations that will be affected by a rehospitalization policy.

## ENDNOTES

1. Stephen F. Jencks *et al.*, "Rehospitalizations among Patients in the Medicare Fee-for-Service Program," *The New England Journal of Medicine*, 360, no. 14 (April 2, 2009): pp. 1418–1428; available with subscription at <http://content.nejm.org/cgi/content/full/360/14/1418>.
2. Norbert I. Goldfield *et al.*, "Identifying Potentially Preventable Readmissions," *Health Care Financing Review*, 30, no. 1 (Fall 2008): pp. 75–91.
3. Medicare Payment Advisory Commission (MedPAC), "A path to bundled payment around a hospitalization," ch. 4 of *Report to the Congress: Reforming the Delivery System*, June 2008; available at [www.medpac.gov/chapters/Jun08\\_Ch04.pdf](http://www.medpac.gov/chapters/Jun08_Ch04.pdf).
4. Office of Management and Budget, "President Obama's Fiscal 2010 Budget, Transforming and Modernizing America's Health Care System," fact sheet, available at [www.whitehouse.gov/omb/fy2010\\_key\\_healthcare](http://www.whitehouse.gov/omb/fy2010_key_healthcare); and Committee on Finance, U.S. Senate, "Description of Policy Options. Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs," April 29, 2009, available at <http://finance.senate.gov/sitepages/leg/LEG%202009/042809%20Health%20Care%20Description%20of%20Policy%20Option.pdf>.