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Hospitals Find Ways to Reduce Seven-Day Readmissions, But 30-Day Denials Provoke Ire

By Nina Youngstrom

When a patient with sickle cell disease was readmitted to the hospital 15 times in the last 12 months of her life, the Medicaid managed care plan denied the claims. It was one of the more frustrating experiences that Self Regional Healthcare in Greenwood, South Carolina, had with readmissions, which is an ongoing challenge because hospitals don't always control the variables that affect readmissions, including physician shortages and patient compliance. Although the Medicaid managed care plan has a more reasonable readmission policy than other payers in terms of timing—they don't pay when a patient is readmitted within 15 days of an admission vs. 30 days—it seemed absurd the hospital was "dinged" for readmissions in this circumstance, says Phillip Baker, M.D., medical director of case management at Self Regional Healthcare.

"She was in terrible pain and had liver damage because she had been transfused so many times," Baker says. "We tried to appeal and they said within 15 days 'we are not going to pay for this.'"

Denials for readmissions are a thorn in the side of hospitals, which are trying various strategies to reduce them. Denying payment for readmissions within seven days is one thing—that's a good demarcation line for discharge planning and follow-up to prevent readmissions—but hospitals are exasperated when payers won't cover them up to 30 days later, sometimes for unrelated conditions depending on the payer.

"The only potential hospitals have for impacting readmission is seven days," Baker says. "You can have huge impact on readmissions in the first week. It's a valuable thing to track. Did we miss something on discharge? Is the primary care physician seeing the patient? Are we getting indigent patients on a medication program?" But a month is another story. Hospitals are skeptical about the influence they exert on readmissions beyond the week after discharge, when they try to make sure patients are seen by a primary care physician or specialist and fill their prescriptions and understand how to take them. "Do you know why they chose 30 days? There's no rhyme or reason. Why not two weeks or 6 weeks? There's nothing magic about a 30-day timeline," Baker says. "This policy is driving us all up the wall."

A 2016 study in JAMA Internal Medicine found only about a quarter of readmissions "are potentially preventable when assessed using multiple perspectives" (Preventability and Causes of Readmissions in a National Cohort of General Medicine Patients).

Self Regional has reduced readmissions significantly over the past decade, partly by using a transitional care clinic and having pharmacy technicians explain medications to patients at discharge and nurses phone patients at home. "We want everyone to say we're a high-quality hospital."

With commercial and MA plans, readmission denials translate into no payment. That's different from original (fee-for-service) Medicare, which has two policies: (1) When a patient is discharged from the hospital and readmitted on the same day for symptoms related to the evaluation and management of the condition treated earlier, the two stays must be combined on a single claim; and (2) Under the Hospital Readmission Reduction Program, CMS penalizes hospitals with excess readmissions for six conditions/procedures by reducing their total

MS-DRG reimbursement up to 3% based on data from prior years.

United Denies Preventable Admissions

In the MA and commercial world, readmission payment policies can get complicated. For example, UnitedHealthcare's updated April 1 hospital readmission policy for commercial plans says readmissions will be reviewed only if they're related and preventable. Hospitals like the related part—why should they be on the hook for a heart failure patient who is admitted for a hip fracture three weeks later?—but the preventable part is trickier.

"When you think of a 'preventable readmission,' it's typically been a case in which a patient was discharged too early, while he or she still required a hospital level of care," says Martie Ross, a principal at PYA in Overland Park, Kansas. But she thinks United's policy goes beyond this. It says readmission reviews may be conducted to determine if a related readmission could have been prevented with "optimal" quality of care during the inpatient stay, "optimal" discharge planning, "optimal" post-discharge follow-up and "improved coordination between inpatient and outpatient health care teams." The kicker: In its readmission reviews, United will consider whether the hospital adequately addressed the social determinants of health, Ross says. If readmissions are declared clinically related, reviewers move onto whether they were "potentially preventable," and one of the factors is "whether documentation supports that all salient financial and social needs of the patient have been addressed." That presents new challenges for hospitals, Ross says. "Is it now hospitals' responsibility to address food insecurity, arrange for transportation, or complete a home assessment to address potential fall risks before they send patients home?" Any of these factors may result in a readmission: the patient suffers from inadequate nutrition, misses a follow-up appointment, or trips and falls in the home. There's an expectation with payers that "hospitals will be more directly involved in patients' transitions of care," she says.

Baker also takes issue with the idea of basing claims for readmissions on "optimal" post-discharge care for patients. "What do they consider optimal? Making sure the air conditioning is on? That drugs are delivered to their house? Sending a nurse to their house to make sure they're taking their drugs? Sending physicians to their house? Nobody does these things," he says. "It takes us weeks sometimes to get patients an appointment with a primary care physician because of a shortage," even though the physicians benefit because "the reimbursement they can get for office visits for hospital follow-up within seven days is significantly more. Why wouldn't they want to do that? Because they are booked for a month."

Cheaper Nebulizers Help COPD Patients

Baker says all hospitals have readmissions, and some are unavoidable. For example, if chronic obstructive pulmonary disease (COPD) patients resume smoking when they leave the hospital, they will be back, Baker says. The same goes for congestive heart failure patients who eat high-salt diets. Medication compliance is also a problem, but that's sometimes compounded by finances or difficulty complying with confusing medication regimens, especially if they live alone.

To help reduce readmissions, Self Regional has a committee that meets daily to review all patients who have been admitted within 30 days of the initial admission. It has found that COPD patients top the list. The committee came up with a clever idea to help the patients. "A lot of inhalers they use are ridiculously expensive—hundreds of dollars a month. We found we can use much cheaper nebulizers that can accomplish the same goal," Baker says. "For a lot of our patients who can't afford expensive meds, it is an alternative—a few dollars vs. hundreds." And the hospital sends heart failure patients home with a scale to weigh themselves every day, and they're told to call their physicians if they gain more than two pounds a day.

The hospital also established a transitional care clinic for patients who don't have a primary care physician or

can't get an appointment with theirs to ensure they have follow-up care after a hospital stay. If patients don't have insurance, the hospital eats the cost, Baker says. Another strategy: keeping patients in the hospital an extra day to reduce the odds they will return anytime soon.

Ronald Hirsch, M.D., vice president of regulations and education at R1 RCM, says many payers, taking their cue from CMS, deny payment for readmissions whether or not they're related to the initial admission. The "related" aspect tends to fall down as two admissions get farther apart, he explains. A study reported in the June 5, 2018, edition of the Annals of Internal Medicine found a "drastic difference" in readmissions that occur in seven versus 30 days, he says ("Preventability of Early Versus Late Hospital Readmissions in a National Cohort of General Medicine Patients").

Because flat-out claim denials for readmissions is an MA and commercial payer thing, "hospitals need to know what their contracts say," Hirsch says. If payers are applying a readmission policy to hospitals that don't have it in their contracts, that's inappropriate and should be challenged. "If the contract says the standard readmission policy will be in place, you are stuck. If they're silent on that issue, does that mean they can apply it or not? Does it have to be present to be penalized or is it there by default?"

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