Volume 7, Number 4 April 2018

Readmissions NEWS

Using The Hospital Accreditation Process To Prevent Patient Readmissions

by Patrick Horine

Patients who wind up back in the hospital are one of healthcare's biggest burdens. Nearly 20 percent of all Medicare patients are readmitted to the hospital within 30 days of readmission, while 11 percent of privately insured patients are readmitted.

Readmissions cost hospitals $41.3 billion during the first 11 months of 2011, according to data from the Agency for Healthcare Research and Quality (AHRQ). According to the Center for Health Information and Analysis, readmissions were costing the Medicare program alone at least $26 billion a year as of 2013, of which $17 billion of those costs are considered avoidable.

Although hospitals are not particularly proud of readmissions, for decades they were paid for that second chance. But not anymore.

As a result, the U.S. government has put into place financial penalties for hospitals that have too many patient readmissions. Under the Affordable Care Act and other legislation, hospitals can not only be denied reimbursement treating readmitted patients, but it can also lose a significant amount of its revenue from the Medicare program. Altogether, up to 3 percent of a hospital's entire Medicare revenue is at risk if it has experienced excessive patient readmissions. For some larger facilities, that can mean tens of millions of dollars a year in lost revenue, further squeezing already tight operating margins. Altogether, the Centers for Medicare & Medicaid Services is expected to penalize hospitals to the tune of $528 million this year for avoidable patient readmissions, up more than 25 percent since 2016.

According to a recent survey by Amedisys, 73 percent of hospital executives said that a lack of preventative care and monitoring of patients with chronic conditions was the biggest cause of readmissions.

(continued on page 2)

In This Issue

Readmissions Prevention Through a Post-Acute Network

by By Dr. Josh Luke, FACHE & Harry Nelson

You may be familiar with a hospital that has its own Post-Acute Network, Senior Network, or Community Collaborative. These are all different names for a similar approach. The goal is to set an expectation for your post-acute providers that encourage a commitment to quality, communication between providers, and working together to prevent readmissions.

Current CMS regulations require that every home health agency who submits a written request to the hospital be added to that hospital's list of providers. In urban areas such as Los Angeles, it is not uncommon to see a hospital have more than 100 home health agencies listed on its provider list. Similarly, federal regulations require that hospitals provide a "complete list" of local skilled nursing providers. However, there is no specificity as to how to interpret the word "local", as this interpretation is left to the hospital. While hospitals have traditionally been extremely hesitant to narrow their network of post-acute providers due to these regulations, the trend is changing as a result of alternative payment models (ACO's and Bundled Payment programs).

(continued on page 5)