Death vs. another hospital stay: Study suggests Medicare should weigh them equally

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In the last few years, American hospitals have focused like hawks on how to keep patients from coming back within a few weeks of getting out.

Driven by new Medicare penalties for such events, the effort has slowed a 'revolving door' of readmissions for heart attack, heart failure and pneumonia patients that costs the nation billions of dollars.

But a new analysis suggests that Medicare should focus more on how well hospitals do at actually keeping such patients alive during the same time.

If hospitals got paid less when their patients died soon after a hospitalization, just like they get paid less when those patients end up back in the hospital, it would be a game-changer for one-third of hospitals, say researchers from the University of Michigan Medical School and VA Ann Arbor Healthcare System who published their findings in *JAMA Cardiology*.

About 17 percent of hospitals are getting punished for excess readmissions, but are keeping patients alive more often than would be expected, they find.

And another 16 percent of hospitals essentially get rewarded for low readmission rates, but their patients are more likely to die in the first month after leaving their hospital beds.

In other words, some of the hospitals that get penalized for high readmissions are those that may actually do the best job at keeping patients alive - and vice versa.

Preventive incentives

If the penalties took both readmission and mortality into account, the Medicare system would save the same amount of money, but incentivize good outcomes more fairly, the researchers say.

"Under most circumstances, hospital patients would much rather avoid death than readmission," says Scott Hummel, M.D., M.S., senior author of the new paper and a heart failure cardiologist. "But the incentive to prevent death in the first 30 days after a hospitalization is 10 times less than the incentive to prevent a return hospital visit."

He and his colleagues hope their analysis will spark a conversation about how to fine-tune the Medicare system's effort to encourage better performance by America's hospitals.

Their work is based on data from 2014, the first year when hospitals could both be penalized for readmission rates that were higher than expected, and earn a financial reward based on a mix of measures that include everything from 30-day death rates to how well patients rated the care they received and the hospital environment.

Under the current policy, hospitals can lose up to three percent of condition-related payments from Medicare for excess readmissions, but can recoup only about 0.2 percent of such payments for having low mortality rates.

First author Ahmad Abdul-Aziz, M.D., an internal medicine resident at U-M, helped coordinate the data analysis using publicly available data

from the Centers for Medicare and Medicaid Services, called CMS for short. Some of it was accessed via an online system created by Kaiser Health News, based on data from CMS. In all, data from 1,963 hospitals was included.

The authors, who also include senior team members Rodney Hayward, M.D., and Keith Aaronson, M.D., M.S., calculated a ratio for each hospital based on observed and expected readmissions and mortality in the first 30 days for heart attack, heart failure and pneumonia. Although other conditions were added to the readmission program in 2015 and 2016, they weren't included because these diagnoses are not yet included in the reward program for low mortality rates.

All the data were adjusted for how sick each hospital's patients were when they started, using standard methods that allow an apples-to-apples comparison. The socioeconomic status of each hospital's patients, which can also affect patient outcomes but aren't in a hospital's control, wasn't included because CMS hadn't yet started taking it into account in 2014.

The authors don't take issue with the idea of penalizing excess readmissions - though they do note that readmissions for any cause are included in the program, not just readmissions for the problem that sent the person to the hospital in the first place.

Admissions to any hospital within 30 days of discharge count against the hospital that the patient was discharged from, which may work against large hospitals that patients travel to for advanced care before returning to their home area.

Other researchers have shown there isn't a tight link between a hospital's 30-day readmission rate and the 30-day mortality rate for its patients with these conditions - suggesting that there's more to the story when thinking about using them as measures of hospital quality.

The authors also call for continued improvement in risk models that will more precisely predict a patient's risk of readmission, just like current, well-tested models to predict their risk of death.

Better tools would mean better ability to test a hospital's actual performance against what might be expected based on their entire patient population. The researchers also plan to examine what kinds of hospitals are most likely to win or lose financially if the balance shifts between penalties for reducing readmissions and those for reducing early mortality.

"The misaligned incentives for preventing readmission and preventing death may help explain why some hospitals are doing really well on one, but not on the other," says Hummel. "It's important that we continue to reduce preventable readmissions, but we need to watch out for unintended consequences too.

"Sometimes, a readmission might be a good thing - no one wants to see patients die because they should have been readmitted," he adds. "If financial penalties drive hospitals to figure out how to improve outcomes, increasing incentives to reduce early post-hospital deaths seems like a good place to start."

More information: Ahmad A. Abdul-Aziz et al, Association Between Medicare Hospital Readmission Penalties and 30-Day Combined Excess Readmission and Mortality, *JAMA Cardiology* (2016). DOI: 10.1001/jamacardio.2016.3704

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