

# The “Avoidable Admissions” Pitfall: What Your Physicians Must Know to Avoid Medicare Penalties

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Hospital and physician groups, take note: If you’re admitting patients to hospitals for complications that could have been prevented by better outpatient care, your Medicare revenues are in jeopardy.

Under the 2014 Value Based Payment Modifier (VBPM) formula, groups that admit more patients for conditions classified as “avoidable” will risk penalties if their admissions are higher than similar sized groups, and reap rewards if admissions are lower. ACOs have similar reward structures associated with their hospital costs; in 2015, groups participating in ACOs will also bear risk under the VBPM.

This is one of the ways that [Medicare is instilling competitive performance into its reward-penalty structure](#). To eliminate avoidable admissions, you must establish processes and approaches to patient care that will actually prevent admissions. Once the patient has been admitted, it’s too late. . . .

## Physicians Held Accountable for “Avoidable Admissions”

Medicare is targeting Ambulatory Care Sensitive Conditions (ACSCs), or conditions “for which good outpatient care can prevent complications or more serious disease.” As defined by CMS, each such avoidable admission is deemed a failure of ambulatory management—and the admitting physician, not the hospital, is held responsible. Specifically, hospital data is used to

identify preventable admissions, but CMS applies the measure to physicians.

## 10 Conditions Under CMS Scrutiny

The Agency for Healthcare Research and Quality (AHRQ) developed ACSCs as Prevention Quality Indicators (PQI) to measure the occurrence of avoidable admissions across a large population.

Admissions for these conditions are included by CMS in VBPM quality tiering:

- Diabetes Short-Term Complications
- Diabetes Long-Term Complications
- Uncontrolled Diabetes
- Lower-Extremity Amputation among Patients with Diabetes
- COPD or Asthma in Older Adults
- Heart Failure
- Dehydration
- Bacterial Pneumonia
- Urinary Tract Infection
- All-Cause Re-Admissions Within 30 Days of a Previous Discharge

## How to Reduce Financial Exposure from Avoidable Admissions

How can you use this information to ensure better scores under Medicare's VBPM, or generate saving in your ACO? Here are two strategies:

### *1. Analyze "Avoidable Admissions" Measures within CMS Quality Composite Score*

Evaluate the CMS "Avoidable Admissions" data in your Quality Resource Use Report (QRUR) reports. Viewing this data in a Registry allows you to segment the population by diagnosis and other criteria. You can identify patients with ambulatory failures and associate them with individual providers, and then apply additional data and analytics to determine why the admissions occurred.

Gather additional data from available sources and add it to the Registry. Then create criteria for identifying risk in patients who may have future admissions to establish a predictive Registry of patients. This should include:

- Historical information* from the data supplied by CMS to each practice in the QRUR.
- Interventions history* regarding steps to improve management of the conditions.

This data comes from the EMR, practice management system and measure

responses in your PQRS or Clinical Integration Registry, as well as software such as [ICLOPS Population Health](#) that includes interventions tracking.

*Outcomes information* about patients admitted because of diabetes or other conditions with clinical indicators. Knowing the level of condition control will provide insight into the patient's historical blood pressure, hemoglobin A1C and other situations that trigger a medical emergency.

For patients with past admissions, establish and test interventions in conjunction with physicians. A good research design will facilitate your analysis. It makes no sense to invest in patient programs that have little probability of success. While providers may favor their own interventions, over time the data will reveal the approaches with best results.

For patients with predicted admissions, create and test outreach and other interventions that have the potential to avoid hospitalizations. Again, a good research design will reveal which interventions have the potential for overriding the prediction.

## *2. Address Hospital Admissions within CMS Cost Score.*

The costs for patients with one or more of four conditions (diabetes mellitus, congestive heart failure, asthma/chronic obstructive pulmonary disease, and coronary artery disease) contribute in a major way to the calculated cost composite, another part of the VBPM quality tiering process. Note that three of these four conditions are also ACSCs.

Address patients with these conditions using Population Health, tracking interventions and services. Only by using Population Health can you assess what interventions are working, under which patient conditions—and for which providers.

Load CMS data into the Population Health Registry. This will also reveal in-network and out-of-network care, an important element of your care coordination.

By applying hospital outcome measures to physician groups, CMS has broached new territory, expanding physician responsibility for controlling costs. If your group is unprepared, you may be caught in a downward revenue spiral of Medicare penalties against future revenues.

As the same models are adopted by private insurance carriers and employers, via ACOs and other value-based purchasing programs, every health care organization with physicians will need tools to evaluate their “generated” costs, not just billed services.

*Founded in 2002, ICLOPS has pioneered data registry solutions for improving population health. Our industry experts provide comprehensive [PQRS Reporting with VBPM Consultation](#) that helps you both report and improve your performance. ICLOPS is a CMS Qualified Clinical Data Registry.*

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Image Credit: "A wounded American soldier is taken from an ambulance into the receiving room of a hospital in France," U.S. Army, August 20, 1944. [Images from the History of Medicine, U.S. National Library of Medicine.](#)