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Medicare Hospital Readmissions Reduction Program. To improve care and lower costs, Medicare imposes a financial penalty on hospitals with excess readmissions.

WHAT'S THE ISSUE?

Policy makers are constantly searching for ways to improve the quality of patient care and lower Medicare program spending. One indicator of inadequate quality that results in increased Medicare spending is the rate of readmissions to a hospital. *Readmission* refers to a patient's being admitted to a hospital within a certain time period from an initial admission. In the context of Medicare, *readmissions* have been generally defined as a patient's being hospitalized within 30 days of an initial hospital stay. If a hospital has a high proportion of patients readmitted within a short time frame, it may be an indication of inadequate quality of care in the hospital or a lack of appropriate coordination of postdischarge care. Although not all readmissions can be prevented, research shows that there are strategies that hospitals can employ to avert many readmissions.

This brief describes the Medicare Hospital Readmissions Reduction Program (HRRP) established in the Affordable Care Act (ACA) that provides a financial incentive to hospitals to lower readmission rates. Although the program has been in operation for only a few years, initial results show potential. A number of technical issues in the program design have been identified and are being addressed by the Centers for Medicare and Medicaid Services

(CMS) through the administrative process. However, there are also concerns about potential flaws in the program's methodological approach. Others fear unintended consequences for safety-net hospitals that may threaten care for vulnerable populations.

WHAT'S THE BACKGROUND?

According to CMS, historically about one in five Medicare patients discharged from a hospital are readmitted within 30 days. Readmission rates vary substantially by hospital and by geographic area, even after the type of disease and the severity level of the patient's condition are considered. Readmission rates are generally higher for hospitals serving vulnerable populations.

There are many factors that affect readmissions, including patients' diagnoses and severity of illness; patients' behavior, such as adherence to discharge instructions; and the availability and quality of postdischarge care. Some readmissions may be planned, such as follow-up surgery or rehabilitation, or the result of transferring a patient from one hospital to another. There is no clear consensus on how many readmissions may be preventable—indeed, conclusions by various studies have deemed the proportion of readmissions that may be preventable to be anywhere from 5 percent to 79 percent. An analysis of 2005 Medi-

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care claims data by the Medicare Payment Advisory Commission (MedPAC) concluded that about three-quarters of readmissions within 30 days were potentially preventable, representing an estimated \$12 billion in Medicare spending.

In 2009 CMS began public reporting of hospital readmission rates on the Hospital Compare website to provide an incentive for hospitals to pay more attention to coordinating care and implementing other strategies to reduce readmissions. Although ethically and professionally driven to provide the best care, hospitals had no direct financial incentive to reduce readmissions prior to the ACA. Indeed, Medicare hospital payment policies may have contributed to, or at least not discouraged, preventable readmissions. Medicare pays most hospitals using the inpatient prospective payment system (IPPS), under which hospitals receive a fixed average amount per admission based on patient diagnosis, regardless of actual resources used. Hospitals do not receive any additional reimbursement to cover the costs of interventions that may prevent readmissions, such as after-discharge follow-up. Moreover, hospitals that reduce readmissions may even lose revenues unless they can fill unused beds with other patients.

Reducing readmissions has proved to be difficult and not straightforward. Nonetheless, hospitals have been employing a number of strategies to reduce preventable readmissions. These include providing better and safer care during the inpatient stay, such as reducing the risk of infection; paying more careful attention to patient medications; discharge planning and improved communication with patients and caregivers regarding follow-up care; and improving care transition through better communication and collaboration with other community providers. Despite their promise, interventions like these have shown mixed results, with limited evidence of success.

One example of a program that has had some success in reducing readmission rates is Project BOOST (Better Outcomes by Optimizing Safe Transitions). Project BOOST has developed a toolkit that includes medication reconciliation forms, a checklist for discharge patient education, and a checklist for post-discharge continuity checks. A semicontrolled pre-post study in 11 hospitals showed a 2 percent drop in 30-day readmission rates after one year for units that participated in BOOST

compared to a slight increase in rates for units that did not participate.

A study by Yale University researchers identified six strategies that were modestly successful in lowering readmission rates for patients with heart failure. These included partnering with community physicians, partnering with local hospitals, having nurses reconcile medications, arranging follow-up appointments prior to discharge, sending discharge papers to patients' primary care physicians, and assigning staff to follow up on test results after discharge. Hospitals that implemented more of these strategies had substantially lower readmission rates. However, the study also found that several strategies intended to reduce readmissions actually increased readmission rates, potentially because they reduced informational and logistical barriers to hospitalization.

Another approach that has been shown effective in reducing readmissions is Project RED (Re-Engineered Discharge), developed by researchers at the Boston University Medical Campus (BUMC). Two key features of Project RED are a nurse-discharge advocate assigned to follow a patient throughout the discharge process and production of a simple after-hospital care plan. BUMC was successful in decreasing hospital use (combined emergency department visits and readmissions) within 30 days of discharge by about 30 percent. The Agency for Healthcare Research and Quality has partnered with BUMC to develop a toolkit and provide technical assistance to hospitals interested in implementing Project RED.

WHAT'S IN THE LAW?

The ACA contains a number of provisions intended to improve quality and reduce spending in the Medicare program, which may have the effect of reducing preventable readmissions. One of the provisions establishes the HRRP to provide a financial incentive for hospitals to reduce preventable readmissions. Beginning in fiscal year 2013 (October 1, 2012), the HRRP imposed a financial penalty on hospitals with excess Medicare readmissions. The HRRP applies to all general hospitals paid under the Medicare IPPS.

The HRRP defines readmission as a Medicare patient who is readmitted to the same or another acute care hospital within 30 days of discharge. It excludes certain readmissions, such as transfers to another IPPS hospital, and readmissions classified by CMS as “planned,”

2,225

Hospitals

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such as chemotherapy or rehabilitation. For the first two years (fiscal years 2013 and 2014), the HRRP applies to readmissions of Medicare patients ages 65 and older with diagnoses of acute myocardial infarction (that is, heart attack), heart failure, or pneumonia.

The ACA gives the secretary of the Department of Health and Human Services the discretion to expand to additional high-volume or high-expenditure conditions to the extent practical. The Department of Health and Human Services has announced that the program will expand in October 2014 (fiscal year 2015) to include two additional conditions: elective hip or knee replacement and congestive obstructive pulmonary disease. Hospitals must have a minimum of 25 discharges for each applicable condition to be included for that condition.

For purposes of the HRRP, *excess readmissions* are defined as those that exceed a hospital's "expected readmission rate." A hospital's expected readmission rate for each of the HRRP conditions is the national mean readmission rate, risk-adjusted for the demographic characteristics (for example, age and sex) and severity of illness of the hospital's patients. The penalty is calculated using a complex formula based on the amount of Medicare payments received by the hospital for the excess readmissions. The penalties are collected from the hospitals through a percentage reduction in their base Medicare inpatient claims payments, up to a cap. The ACA set the penalty cap at 1 percent of aggregate IPPS base payments for the first year, 2 percent for the second year, and 3 percent for each year thereafter.

The ACA also contains a new public reporting requirement for hospitals related to readmissions. Hospitals are required to report data to CMS to determine hospitalwide, all-cause readmission rates for all patients (that is, not only Medicare patients). These hospitalwide, all-cause readmission rates are to be posted on the Hospital Compare website. CMS has not yet implemented this all-patient reporting provision.

CMS began applying the excess readmissions penalties to hospital payments on October 1, 2012 (fiscal year 2013) based on Medicare hospital data from 2008–11. More than 2,200 hospitals were penalized an aggregate of about \$280 million in Medicare payments because of their excess readmissions. This amounts to 0.3 percent of total Medicare

base payments to hospitals. About 9 percent of hospitals received the maximum 1 percent penalty, and about 30 percent paid no penalty. Hospitals serving the poorest patients were not only more likely to incur a penalty but also more likely to incur the maximum penalty.

In the second year of the HRRP, beginning October 1, 2013, CMS estimates 2,225 hospitals will be penalized \$227 million because of excess readmissions, representing 0.2 percent of total Medicare base payments to hospitals. About 34 percent of hospitals will receive no penalty. Although the number of hospitals penalized is close to the same, there are considerable shifts among facilities from the first year's experience. An analysis of the hospital data by *Kaiser Health News* found that 1,371 hospitals are receiving a lower fine, while 1,074 will have greater penalties. As in the first year, hospitals serving a large number of low-income patients were about twice as likely to receive penalties (77 percent) as hospitals with the fewest poor patients (36 percent).

It is important to note that because of the program's underlying structure, about half of the hospitals in the program are always going to face a penalty, and the overall magnitude of the penalty will stay the same even as hospitals overall improve over time.

There is some early evidence that the HRRP has had a positive effect on lowering readmissions. CMS reported to Congress in February 2013 that the all-cause Medicare readmission rate had dropped to 17.8 percent in the last quarter of 2012, down from the historical 19 percent; that represents 70,000 fewer readmissions in Medicare. MedPAC reported in June 2013 that the reduction in readmission rates for the three conditions subject to the HRRP was greater than the reduction in readmission rates for all causes, suggesting that the HRRP may be having a positive impact.

WHAT'S THE DEBATE?

Although there is widespread support for focusing attention on lowering hospital readmission rates, major concerns about specific provisions of the Medicare HRRP have been expressed by academics; the hospital industry; and policy makers, including MedPAC. The concerns center on whether hospitals are being treated fairly, especially those hospitals that care for the sickest and most vulnerable patients. They question whether hospitals should be held accountable for things beyond

"There is some early evidence that the HRRP has had a positive effect on lowering readmissions."

their control, such as patient behavior and postacute care provider performance.

Critics question the methodology for determining excess readmissions and computation of the penalty, such as which readmissions are excluded and how reliable risk-adjustment models can be. A major objection is that there is no adjustment for the socioeconomic status of patient populations. Critics point to a number of factors that contribute to higher readmission rates for the poor, such as language and cultural barriers to complying with discharge instructions, lack of resources to purchase medications, and fewer options for postdischarge care. CMS maintains that it does not adjust for race or socioeconomic factors because it does not want to hold hospitals to different standards for the outcomes of their patients with low socioeconomic status, and that adjusting for socioeconomic factors may mask potential disparities in care for the disadvantaged.

CMS notes that its monitoring of quality consistently shows evidence that many safety-net and teaching hospitals perform as well as or better than hospitals without substantial numbers of patients with low socioeconomic status. They also note that the fact that patients of low socioeconomic status tend to be sicker and have a greater number of health conditions is taken into account by the existing risk-adjustment methodology.

In its June 2013 Report to the Congress, MedPAC endorsed the continuation of the HRRP but made a number of recommendations on technical adjustments to the HRRP methodology. Among the recommendations are a change in the computation of the penalty and a proposed method for adjusting readmission penalties for patients' socioeconomic status. CMS has committed to continue tracking the issue of socioeconomic status.

Another concern of hospitals is the overall financial impact of the program on hospi-

tals' bottom lines. Employing effective readmission reduction strategies, such as having nurses follow up with patients after discharge, is expensive and unaffordable for many institutions, particularly safety-net institutions. Because Medicare does not provide any direct payment to hospitals for services that may help prevent readmissions, such as discharge planning and follow-up, the additional, unreimbursed costs of employing strategies to reduce readmissions, together with reduced revenues from fewer readmissions, raise doubts about how cost-effective it is for hospitals to try and avoid the penalties.

To be sure, CMS has made additional funding available for readmission reduction strategies through initiatives, such as the Community-based Care Transitions Program and the Partnership for Patients.

WHAT'S NEXT?

The Medicare HRRP has been operational for only two years and has applied to only three conditions. A number of issues have emerged, and many more are likely to emerge as the program expands to include additional conditions. Hospitals will continue to experiment with various strategies for reducing readmissions to identify those that are most effective. The methodology for determining the readmission rates and computing penalties will continue to be refined by CMS through the annual rulemaking process to the extent allowed by law. Any major changes in the program, such as whether to change the amount of the penalty or change the cap on penalties, will require legislative action.

Over time, one consequence of the Medicare HRRP may be a growing recognition that reducing readmissions is a shared responsibility that belongs not only to hospitals but also to patients and their caregivers and to other community professionals and providers across the continuum of health and social services. ■

9%

In the program's first year, about 9 percent of hospitals received the maximum penalty, and about 30 percent paid no penalty.

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