



Through the Affordable Care Act (ACA), the health reform legislation commonly known as Obamacare, policymakers sought to identify and address opportunities to improve – and save money on – the delivery of healthcare in the U.S. One area that ended up in the crosshairs was hospital readmissions. Around the time the law went into effect, it was estimated that nearly 20 percent of Medicare

discharges were followed by a readmission within 30 days.

While some of these return visits were expected as a planned component of treatment, many were not.¹

Unplanned readmissions are a problem from several perspectives. Not only does additional hospitalization result in added healthcare treatment costs, it also suggests that patients are remaining sick – or even getting sicker – when the goal, of course, is for them to effectively manage their care and continue to improve after they are discharged. The causes of avoidable hospital readmissions are complex but usually are related to a failure to develop or carry out an effective plan for care following discharge. There are a variety of factors that can come into play, including patient illness level; communication with patients and families; reconciliation of medications; coordination with community clinicians and non-acute care facilities; access to necessary resources in the community; and the availability of post-hospital care that can recognize problems early and work towards their resolution.²

Readmissions Reduction Program Overview

The Hospital Readmission Reduction Program is the initiative created by the ACA aimed reducing readmissions by penalizing providers that are deemed to have too many Medicare patients returning for care within 30 days of discharge. Under the program hospitals with readmission rates that exceed the national average are penalized by a reduction in payments across all of their Medicare admissions—not just those that resulted in readmissions.³

Before measuring an individual hospital's rate against the national average, the Centers for Medicare and Medicaid Services (CMS), the federal entity responsible for Medicare reimbursement, performs something called risk adjustment. This is a way of accounting for differences among various hospitals' patient populations. Through this process, CMS adjusts for certain characteristics of both the patients being readmitted and each hospital's patient population, such as age and illness severity. After these adjustments, CMS calculates a rate of "excess" readmissions. The higher the rate of excess readmissions, the higher the penalty for the upcoming year.⁴

CMS started imposing readmission penalties in fiscal year 2013, during which the maximum penalty was 1 percent of the hospital's base inpatient claims. This increased to 2 percent for 2014, and to 3 percent for fiscal year 2015 and beyond. For penalties levied in 2013 and 2014, CMS focused on readmissions occurring after initial hospitalizations for heart attack, heart failure, and pneumonia. To these, in 2015 CMS added chronic obstructive pulmonary disorder (COPD) and elective hip or knee replacement. Beginning in 2017, coronary artery bypass graft (CABG) surgery will also be included.⁵

This year, 78 percent of hospitals are receiving a penalty. This is up from 64 percent in 2013 and 66 percent in 2014, an increase that isn't surprising given that additional diagnoses are included for the first time this year. Average penalties are also higher compared to previous years, but will remain below 1 percent, despite the maximum cap on the penalty increasing to 3 percent. From a patient perspective, for 2015, most Medicare beneficiaries – 83 percent – will stay in hospitals with low or no penalties. Only 0.5 percent will stay in hospitals that received the maximum penalty of 3 percent. CMS estimated total hospital penalties at \$428 million in 2015, compared to \$290 million in 2013 and \$227 million in 2014.⁶

Given that the program has been in effect for a couple of years, it is timely to evaluate whether it is having its intended effect. Early evidence indicates progress is being made in reducing hospital readmissions. For many years, the national readmission rate for patients returning to the hospital – either the same one or a different one – held steady at around 19 to 19.5 percent. However, in 2013 the rate fell to 17.5 percent.⁷ An analysis by the Kaiser Family Foundation found that readmissions for heart failure, heart attack and pneumonia started to decline in 2012, suggesting that hospitals already had begun making progress.⁸

Strategies for Reducing Readmissions

Policymakers' intent for the program is to keep people out of the hospital unnecessarily. The expectation is that the initiative creates incentives for hospitals to work with patients and other care providers to ensure that, once discharged, patients are able to avoid having to return due to problems that could have been prevented.

There are a wide variety of specific strategies and programs hospitals can implement, but essentially what they all aim to do is to ensure an effective plan is in place for care following discharge and that patients both understand the plan and have the knowledge and support they need to follow it. Usually this means working closely with patients before they go home and often includes following up with patients a few days later. Some of the strategies hospitals are using include:

- Increased coordination with other providers and care settings to ensure discharged patients receive the level of care they need for a safe transition out of the hospital.
- Prior to discharge, having nurses, case managers and discharge planners assess high-risk patients, identify patient needs, and make sure there is a plan for meeting each need.
- Following up with patients after discharge to ensure they understand their plan for continued care and have access to needed resources and medications.
- Implementing policies and procedures to notify physicians of their patient's discharge, follow-up on test results, and checks on patient progress.⁹

Drawbacks of the Program

While the overall goal of reducing unnecessary hospitalizations has broad support, the program, as it is currently structured, is not without flaws. Specifically, concerns have been raised about:

1. The inclusion of readmissions unrelated to the initial admission in the determination of penalties.
2. The dated nature of the time periods used to calculate excess readmissions.
3. The lack of risk-adjustment for key sociodemographic factors, usually outside of hospital control, that influence the likelihood of readmission.¹⁰

Unrelated Readmissions

When calculating each hospital's readmissions, CMS excludes patients who had certain planned readmissions, were transferred to other hospitals, or who left against medical advice. However, CMS includes patients readmitted for reasons unrelated to the initial hospital stay.¹¹ This is problematic because it can result in hospitals being penalized for readmissions that are in no way a result of problems with patient care or transition planning.

Recognizing the potential for confusion when evaluating readmissions, the American Hospital Association (AHA) consulted with clinicians to create the following framework for the types of readmissions that can occur:

- A planned readmission related to the initial admission, such as placement of a ventricular assist device following a heart attack.
- A planned readmission unrelated to the initial admission, such as readmission for removal of a lung tumor discovered during an admission for a heart attack.
- An unplanned readmission unrelated to the initial admission, such as readmission for a fracture sustained in a car accident following an initial stay for pneumonia.
- An unplanned readmission related to the initial admission, such as readmission for a surgical site infection or adverse reaction to a medication.¹²

Planned readmissions are typically part of clinically appropriate care. For example, during an inpatient stay, clinicians may identify the need for a hysterectomy or hernia repair and plan these procedures within 30 days of the original hospital admission. At first, CMS did not adequately exclude these and other planned readmissions from calculating penalties in the program. However, after receiving feedback from hospitals, CMS developed an algorithm to omit planned readmissions from the penalty calculation.¹³

Similarly, CMS should not hold hospitals accountable for unplanned, unrelated admissions because they are unpredictable and not typically preventable, and are not associated with the care delivered by the hospital. However, these readmissions are currently included in the penalty calculation. Avoidable, unplanned readmissions related to the original admission—such as an infection after receiving a surgical procedure in the hospital—are included in the penalty calculation. These types of readmissions should be the focus of hospital improvement efforts.¹⁴

Performance Period

The readmissions reduction program bases hospital penalties on their performance during a three-year time period. These performance periods take place significantly before the present year. For example, the fiscal year 2015 performance period is July 1, 2010, to June 30, 2013. This means that hospitals face penalties this year despite improvements they had achieved in the prior 18 months. In addition, performance periods take place before requirements of the program are even known. For example, CMS did not finalize inclusion of elective total hip replacement in the program until August 19, 2013, well after the initial performance evaluation period (July 1, 2010, to June 30, 2013) for this condition had ended.¹⁵

Sociodemographic Factors

Chief among the concerns regarding the methodology for determining acceptable and excess readmission rates is the significant influence of factors outside of hospital control that impact patient outcomes following discharge. Factors such as race, ethnicity, education, income, and payer have been found to be related to readmission risk in various studies.¹⁶ Current risk-adjustment models include clinical variables such as comorbidity (that is, the presence of additional illnesses or conditions) and disease severity. This reflects the belief that hospitals and other providers should not be held accountable for the effects of those factors on quality measures such as readmission. The question of whether hospitals should be held accountable for the effects of factors such as poverty, illiteracy, lack of proficiency in English, or lack of social support has been hotly contested.¹⁷

CMS' rationale for not adjusting for patients' socioeconomic characteristics is that differences in the quality of care received by groups of patients of different

socioeconomic status can contribute to readmissions.

Therefore, hospitals should not be held to different standards of care based on the demographic characteristics of their patients, and specifically should not be held to lower standards for socioeconomically disadvantaged populations. However, some scholars have expressed concern that the current CMS policy disproportionately affects hospitals that provide care to patients of low socioeconomic status. They argue that the policy assumes readmissions are a result of poor quality care, but instead readmissions are driven largely by patients' circumstances after discharge, such as a lack of social supports, and are therefore outside the control of hospitals.¹⁸



The Medicare Payment Advisory Commission (MedPAC), a legislative agency that provides Congress with analysis and policy advice on the Medicare program, has devised a way to address this issue. Under the proposal, socioeconomic factors would not be included in risk adjustment, but hospitals would be divided into peer groups based on their share of low-income Medicare patients. A benchmark readmissions target would be established for each peer group, so that hospitals with higher shares of low-income patients would have a less stringent readmissions target and thus, on average, would receive lower penalties. The advantages of this approach are that it can be implemented quickly with some small modifications to the statutory language, and hospitals with the highest shares of low-income patients will still have an incentive to continue improving their readmission rates.¹⁹

Conclusion

The Medicare Hospital Readmissions Reduction Program appears to be having an effect on the levels of readmissions, with early data suggesting the numbers have begun to drop. However, the program is not without its flaws. Congress and CMS would be well advised to address the shortcomings of the program to ensure it achieves its intended aims without having negative, unintended consequences. Hospitals for years have been striving to improve the quality with which they care for patients under an increasingly tight reimbursement structure. Programs that further steer funding away from providers must be carefully evaluated to make certain they are achieving their purpose.

Endnotes

¹Robert Wood Johnson Foundation. "The Revolving Door: A Report on U.S. Hospital Readmissions." February 2013. <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf404178>

²Ibid.

³Boccuti, Cristina and Casillas, Giselle. "Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program." The Henry J. Kaiser Family Foundation. Jan. 29, 2015. <http://kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/>

⁴Ibid.

⁵Ibid.

⁶Ibid.

⁷American Hospital Association. "Trendwatch: Rethinking the Hospital Readmissions Reduction Program." March 2015. <http://www.aha.org/research/reports/tw/15mar-tw-readmissions.pdf>

⁸Boccuti, Cristina and Casillas, Giselle. "Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program."

⁹American College of Emergency Physicians. "Medicare's Hospital Readmission Reduction Program FAQ." Page updated May 6, 2015. Accessed August 26, 2015. <http://www.acep.org/Physician-Resources/Practice-Resources/Administration/Financial-Issues/-Reimbursement/Medicare-s-Hospital-Readmission-Reduction-Program-FAQ/>

¹⁰American Hospital Association. "Trendwatch: Rethinking the Hospital Readmissions Reduction Program."

¹¹Ibid.

¹²American Hospital Association. "Trendwatch: Rethinking the Hospital Readmissions Reduction Program."

¹³Ibid.

¹⁴Ibid.

¹⁵Ibid.

¹⁶Nagasako, Elna M., et. al. "Adding Socioeconomic Data To Hospital Readmissions Calculations May Produce More Useful Results." Health Affairs. May 2014. <http://content.healthaffairs.org/content/33/5/786.full.pdf>

¹⁷Jianhui, Hu, et. al. "Socioeconomic Status And Readmissions: Evidence From An Urban Teaching Hospital." Health Affairs. May 2014. <http://content.healthaffairs.org/content/33/5/778.full.pdf>

¹⁸Ibid.

¹⁹Medicare Payment Advisory Commission. "The hospital readmission penalty: How well is it working?"