



Richard J. Umbdenstock
President and
Chief Executive Officer

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 626-2363 Phone
www.aha.org

June 7, 2011

Donald M. Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

Dear Dr. Berwick:

The existence of racial disparities in health and health care is well established. Similar racial disparities in the health and health care of Medicare beneficiaries, in particular, have also been documented. These disparities extend to readmission to hospitals. Just this year, the *Journal of the American Medical Association* (JAMA) published an article showing that blacks have a higher likelihood of being readmitted to the hospital than do whites. In addition, the JAMA article concluded that hospitals serving a disproportionately large number of minorities have higher readmission rates. Proper accounting for these racial disparities is crucial as the Department of Health and Human Services (HHS) implements the Hospital Readmissions Reduction Program (HRRP) contained in Section 3025 of the *Patient Protection and Affordable Care Act*.

Congress established the HRRP to create a financial incentive for hospitals treating Medicare beneficiaries to reduce preventable readmissions. The presumption underlying the program is that readmissions most commonly occur due to a hospital's inadequate care and follow-up. But there is another critical factor at play. As noted above, research from both the government and private sector shows that African-American patients in general have a higher risk of readmission and that hospitals serving disproportionately large numbers of minorities have higher readmission rates across the board. Given these facts, a hospital may end up being penalized under the HRRP simply for serving large numbers of minority patients rather than for actually providing poor quality care. Stated



differently, the HRRP may disproportionately affect hospitals serving a large number of minorities. And, by penalizing these hospitals, the HRRP will in turn disproportionately harm minority patients. This is an unacceptable result on both legal and policy grounds.

In enacting the HRRP, Congress incorporated a mechanism to avoid such unintended disparities: risk-adjustment. The HRRP requires a hospital's excess readmission rate to be determined by comparing its risk-adjusted readmissions to risk adjusted expected readmissions. The theory is that appropriately accounting for differences among hospital patient populations through risk adjustment can avoid unintended consequences in the administration of the HRRP stemming from such disparities. The theory is well-intentioned, but in practice, traditional risk-adjustment methodologies will not be sufficient to achieve the goal. As noted in a Congressional Research Service report last year, "hospitals with more complex patient populations may have more difficulty, on average, in preventing readmissions than hospitals with less complex patient populations. This could include complications caused by patient behavior, a factor which could vary by the area in which hospitals are located, and which could contribute to readmission rates." Traditional risk-adjustment methodologies consider patients' diagnostic data (e.g., the severity of underlying medical conditions and co-morbidities) and demographic characteristics (e.g., age and gender). They do not consider patients' race or life circumstances, which can have just as great an impact on health outcomes. Therefore, as HHS proceeds to implement the HRRP, the risk-adjustment methodology must include recognition of such patient characteristics as race and limited English proficiency. This is necessary not only as a matter of sound policy, but also to comply with the law.

Title VI of the *Civil Rights Act of 1964* provides that "[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Although the Supreme Court has interpreted Title VI as prohibiting only intentional discrimination, the Court also has recognized that an agency may promulgate more expansive regulations that prohibit disparate-impact discrimination. One such regulation is 45 C.F.R. § 80.3, which prohibits discrimination in programs receiving federal assistance from HHS. Specifically, it provides: "No person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program to which this part applies." 45 C.F.R. § 80.3(a). This regulation is broader than the statute and is most naturally read to prohibit both disparate-treatment discrimination and disparate-impact discrimination. And disparate-impact discrimination is the probable result of the implementation of an HRRP program that fails to take into account the racial and ethnic composition of the participating hospitals' patient populations. It is therefore necessary to incorporate this factor into the HRRP's risk-adjustment methodology. Otherwise, the program may run afoul of both 45 C.F.R. § 80.3 and the congressional policy of non-discrimination in federal programs underlying Title VI.

Dr. Donald M. Berwick

Page 3 of 3

June 7, 2011

We urge HHS to recognize that patient characteristics beyond those such as medical diagnosis, age and gender greatly affect health status. As it implements the HRRP, HHS should incorporate these additional characteristics into its risk-adjustment methodology both to comply with the law and to avoid penalizing the very providers who are trying to eliminate racial disparities in health care.

Sincerely,

Rich Umbdenstock
President and CEO