FACTSHEET

Hospital Readmissions Reduction Program

THE ISSUE

The Affordable Care Act (ACA) required the Centers for Medicare & Medicaid Services (CMS) to penalize hospitals for "excess" readmissions when compared to "expected" levels of readmissions, beginning on Oct. 1, 2012.

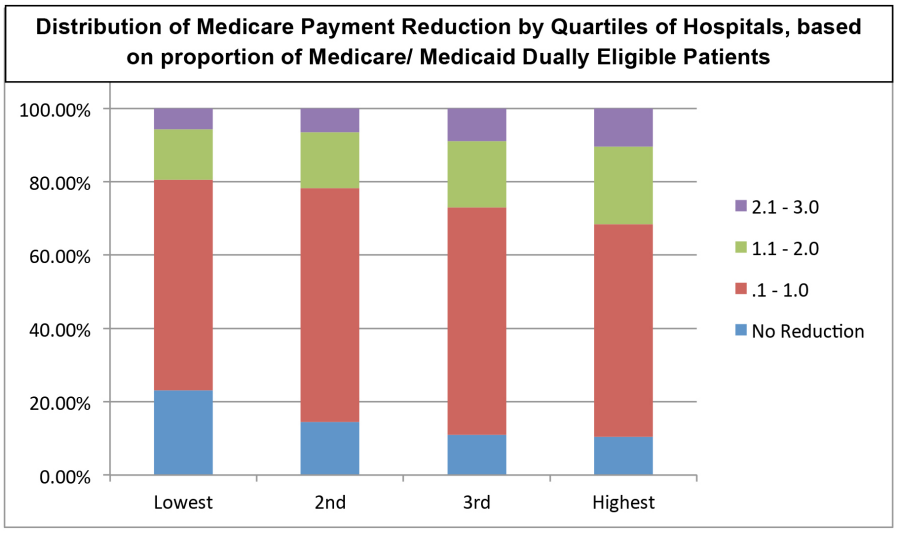
In fiscal year (FY) 2013, payment penalties were based on hospital readmissions rates within 30 days for heart attack, heart failure and pneumonia. In 2015, CMS will add readmissions for patients undergoing hip or knee replacement, and in 2016, readmissions for patients with chronic obstructive pulmonary disease. CMS is likely to add other measures in the future.

AHA POSITION

America's hospitals are focused on reducing unnecessary readmissions. However, the Hospital Readmissions Reduction Program (HRRP) is deeply flawed and must be reformed to adequately account for socioeconomic factors of communities and appropriately exclude unrelated readmissions that are not related to the initial admission. AHA supports the Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2014 (H.R. 4188), which would adjust the HRRP to account for certain socioeconomic and health factors that can increase the risk of a patient's readmission, such as being dually eligible under Medicaid and Medicare.

WHY?

- **The formula fails to account for sociodemographic factors, depriving the neediest hospitals and their patients of critical resources.** A body of research demonstrates that readmissions are higher in communities that are economically disadvantaged. Koenig and colleagues demonstrated this relationship in Health Services Research in 2013, as shown in the chart below. Hospitals with the highest proportion of dually eligible patients constitute the lowest proportion of hospitals without a penalty and the highest proportion of hospitals with the largest penalties. A Kaiser Health News analysis of FY 2013 readmissions penalties showed that hospitals serving the poorest patients were more likely to incur a penalty, that penalty was more likely to be the maximum penalty.



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- **The Medicare Payment Advisory Commission (MedPAC) concurs that changes need to be made to the HRRP.** In June 2013, MedPAC urged Congress and CMS to make changes to the program, including altering the calculation of the payment penalties to recognize that sociodemographic factors affect the likelihood that a patient will be readmitted.
- **The policy penalizes hospitals for unrelated admissions that occur within 30 days of the original hospitalization.** Readmissions unrelated to the initial reason for admission should be excluded from the readmission measures. Although the ACA requires that unrelated readmissions be excluded from the program, CMS has not fully implemented this policy. For example, a patient may be hospitalized for pneumonia, and then readmitted within 30 days for a hip fracture, which is clearly unrelated to the pneumonia. The current measures would count this readmission against the hospital.

KEY FACTS

The ACA requires that inpatient prospective payment system hospitals with higher-than-expected readmissions rates will experience decreased Medicare payments for all Medicare discharges. Critical access hospitals and post-acute care providers are exempt.

Performance evaluation is based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program and reported on Hospital Compare. The base inpatient payment for hospitals with actual readmission rates higher than their Medicare-calculated expected readmission rates are reduced by an adjustment factor that is the greater of:

- A hospital-specific readmissions adjustment factor based on the number of readmitted patients in excess of the hospital's calculated expected readmission rate; or
- 0.98 in FY 2014 and 0.97 in FY2015 and beyond.

This means the largest potential reduction for a hospital would be 2 percent in FY 2014; and 3 percent in FY 2015 and beyond. These reductions apply to all Medicare discharges. Hospitals with a small number of applicable patient cases, as determined by the Secretary of Health and Human Services, are excluded.

Beginning in FY 2015, the law allows the secretary to expand the list of conditions and the secretary has chosen to add chronic obstructive pulmonary disorder and total hip and knee replacement. The secretary is directed to seek endorsement from the National Quality Forum for all measures used to assess readmissions performance. If the problems with the program are not fixed now, they will likely create even more serious challenges for hospitals.