

## 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. Since the start of the program on Oct. 1, 2012, hospitals have experienced nearly \$1.9 billion of penalties, including \$528 million in fiscal year (FY) 2017.

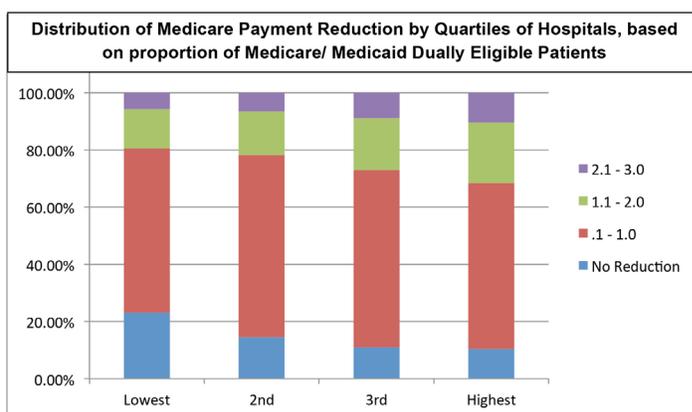
In FY 2013, payment penalties were based on hospital readmissions rates within 30 days for heart attack, heart failure and pneumonia. In FY 2015, CMS added readmissions for patients undergoing elective hip or knee replacement and patients with chronic obstructive pulmonary disease. CMS will add readmissions for coronary artery bypass procedures in FY 2017 and likely will 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 sociodemographic factors of communities and appropriately exclude unrelated readmissions that are not related to the initial admission. Further, the measures may need to be adjusted to account for decreases in admissions as well as readmissions. We support the Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2015, S. 688/H.R. 1343, which would address the need for a sociodemographic adjustment. Portions of S. 688/H.R. 1343 were included in H.R. 5273, the Helping Hospitals Improve Patient Care Act, which passed the House this summer.**

### 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. Lane Koenig and colleagues demonstrated this relationship in Health Services Research in 2013, as shown in the chart at right. 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, and 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.
- **As demonstrated in a recent study from Altarum Institute,\* hospitals' efforts to reduce readmissions have had the additional benefit of reducing admissions.** Hospitals are engaged in the hard work of better addressing patients' needs, and their success is reflected in the evidence that they are not only keeping patients from being readmitted within 30 days, they also are keeping patients from being admitted within 60 days or more. Because CMS's measure is based on a rate of readmissions per hospital discharge, these efforts decrease the number of admissions in the denominator of the calculation at least as fast, if not faster, than they reduce the numerator. Thus, CMS's readmission measure may mask the full effect of hospitals' efforts to reduce readmissions.

## 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, pneumonia, hip/knee replacement and chronic obstructive pulmonary disease 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

- 0.97 in FY 2015 and beyond.

This means the largest potential reduction for a hospital is 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 allowed the secretary to expand the list of conditions. In addition to hip/knee replacement and chronic obstructive pulmonary disease added in FY 2015, the secretary has chosen to add coronary artery bypass procedures in FY 2017. 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.

\* Altarum Institute. (16 December 2014). Medicare's Measure for Readmissions Fails to Identify Excellence and Improvement. <http://altarum.org/about/news-and-events/medicare%E2%80%99s-measure-for-readmissions-fails-to-identify-excellence-and-improvement>.