Examining the Drivers of Readmissions and Reducing Unnecessary Readmissions for Better Patient Care

Nearly one-fifth of Medicare beneficiaries—roughly 2 million beneficiaries per year—discharged from a hospital return within 30 days, according to the Medicare Payment Advisory commission (MedPAC). Some of the readmissions are planned, some are unplanned and others are unrelated to the initial reason the patient came to the hospital. Identifying and reducing avoidable readmissions will improve patient safety, enhance quality of care, and lower health care spending. That is why policymakers, consumers, hospital leaders and the medical community are focused increasingly on readmissions to hospitals.

Policymakers are proposing incentives to reduce hospital readmissions by publicly posting data on readmission rates and lowering payments to hospitals with high rates. First, in 2009, hospitals began voluntarily reporting hospital readmission rates to the Centers for Medicare & Medicaid Services (CMS) for public review on its website, Hospital Compare. Rates of readmission occurring for any reason following hospitalization for one of three common conditions—heart attack, heart failure, and pneumonia—are displayed. Most recently, in the Patient Protection and Affordable Care Act (ACA), Congress enacted the Hospital Readmissions Reduction Program (HRRP) under which Medicare will penalize hospitals for higher-than-expected rates of readmissions beginning in FY 2013.

Careful planning is warranted to ensure that the HRRP achieves its dual aims of improving quality and reducing costs. There are opportunities to achieve cost savings by reducing readmissions, but not all readmissions can or should be avoided. Additionally, as CMS proceeds with the HRRP, evidence is mounting that the link between readmissions and quality of care is more complex than assumed. Further, the role of other factors—such as a patient’s demographic and socioeconomic characteristics, social support structure, and co-morbid conditions, all of which are crucial to appropriate risk adjustment of readmission rates—is still not fully understood.

America’s hospitals are committed to improving the safety and quality of care they deliver, and many are already working to reduce avoidable readmissions. Innovative programs focus on improving care transitions, bolstering post-discharge monitoring and follow-up care, and strengthening linkages with other community providers. Payment rules should encourage hospitals to invest in programs proven effective, and should avoid unintended adverse consequences for other aspects of patient care.

This TrendWatch examines recent research on hospital readmissions, including the linkages between readmissions and quality of care, and the various circumstances that may drive readmissions. It also discusses the changes put in place by the ACA and highlights the considerations and additional research that are warranted as policymakers implement the new HRRP.

“Patients who have chronic disease like heart failure are a vulnerable group. At the hospital, they receive 24-hour monitoring, so if there is any change, the doctors and nurses can respond immediately. Yet when they are discharged home, they are pretty much on their own.”

Sarwat I. Chaudhry, M.D., assistant professor, Yale School of Medicine
The AHA, in consultation with clinicians, has developed a framework to help policymakers and providers consider the different types of readmissions. While some readmissions might have been avoided if the patient received the right care at the right time, still others may be unavoidable due to the natural progression of disease, accepted treatment protocol, or a patient’s preferences. Some readmissions are part of a planned course of treatment. The framework can aid policymakers in designing a program for reducing readmissions that targets those rehospitalizations that are less desirable and potentially avoidable.

The framework contemplates four distinct types of readmissions:

1) A **planned** readmission related to the initial admission, such as a series of chemotherapy treatments or reconstructive surgery following removal of a body part.

2) 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.

3) An **unplanned** readmission unrelated to the initial admission, such as readmission for a fracture sustained in a car accident following an initial stay for an appendectomy.

4) An **unplanned** readmission related to the initial admission, such as readmission for a surgical site infection or adverse reaction to a medication. (Chart 1)

It is this last group of readmissions—those unplanned but related to the initial admission—on which AHA seeks to focus public policy efforts to reduce readmissions. Hospitals cannot influence the occurrence of unplanned, unrelated readmissions because they are not predictable or preventable.

Likewise, hospitals ought not to be expected to eliminate planned readmissions, as these are typically part of clinically appropriate treatment plans. For example, clinical guidelines for implantation of an implantable cardiac defibrillator (ICD) do not recommend implantation of an ICD within 40 days of myocardial infarction for prevention of sudden cardiac death. In this case, a patient admitted for a heart attack would have to be readmitted later for implantation of the ICD. Similarly, if a patient experienced a significant side effect during outpatient administration of chemotherapy, then the patient would typically be admitted for inpatient administration for all subsequent courses of chemotherapy. These repeat admissions should not be targeted as they are markers of appropriate care.

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**Unplanned readmissions related to the initial stay likely offer the best opportunity for savings and care improvements.**

Chart 1: A Framework for Classification of Readmissions

<table>
<thead>
<tr>
<th>Planned Readmission</th>
<th>Unrelated to Initial Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>A planned readmission for which the reason for readmission is related to the reason for the initial admission.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Unplanned Readmission</th>
<th>Related to Initial Admission</th>
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<tbody>
<tr>
<td>An unplanned readmission for which the reason for readmission is related to the reason for the initial admission.</td>
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</table>

Source: American Hospital Association.

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“I think that the message to patients and the general public is that they should be wary of seemingly simple measures of quality of care. One simple measure is not enough.”

Eiran Z. Gorodeski, M.D., researcher and associate staff member in cardiovascular medicine, Cleveland Clinic, OH
The ACA Hospital Readmissions Reduction Program

The HRRP creates an incentive to reduce hospital readmissions by lowering Medicare payment rates to hospitals showing greater-than-expected, or “excess,” readmissions. Beginning in FY 2013, 30-day readmission rates for a hospital’s Medicare patients with heart attack (AMI), heart failure and pneumonia will be compared to the expected rate of readmissions, using risk adjustment to account for age, gender, medical diagnosis and selected medical history. In FY 2009, 2.5 percent of discharges from hospitals paid under the inpatient prospective payment system and included in Hospital Compare had a principal diagnosis of AMI, 5.7 percent had heart failure, and 4.2 percent had pneumonia.7 The rate of excess readmissions for these three conditions will translate to a payment reduction for the hospital for each Medicare admission, capped at 1 percent of Medicare payments in FY 2013 and at 3 percent by FY 2015. The HHS Secretary may expand HRRP to additional conditions beginning in FY 2015.8

The Obama administration has also launched the Partnership for Patients: Better Care Lower Costs, a new public-private partnership that will help improve the quality, safety and affordability of health care for all Americans.9 This program will build on the Community-based Care Transition Program, a five-year program created by the ACA in which hospitals and community-based organizations will work together to improve care transitions, including post-discharge follow-up, and thus aim to reduce readmissions for high-risk Medicare beneficiaries.10 Together these programs will receive $1 billion in funding.11

Other challenges in risk adjustment exist around race, ethnicity and limited English proficiency. (Chart 2)

The ACA specifies that certain readmissions will be excluded from hospitals’ readmission rates. These exclusions include “readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).”13 This language is consistent with AHA’s readmissions framework. However, the statute also reflects the difficulty in distinguishing each of the four types of readmissions, as it specifically addresses only one of the four types discussed above. How these exclusions are accounted for in regulation remains a key policy concern.
The hospital readmissions reduction program in the ACA directs the Medicare program to recoup payments made to hospitals for “excess” readmissions for patients with heart attack, heart failure or pneumonia by reducing payment for each Medicare admission moving forward.

However, the AHA has identified a technical error in the ACA language that leads to an overstatement of the amount of money hospitals must pay back to the Medicare program. As shown in the example, the formula was intended to use a hospital’s number of expected readmissions for each condition as the basis for the calculation in order to calculate the payments associated with excess readmissions. Instead, the formula in the statute uses a hospital’s total number of admissions for the conditions. This error, if left unresolved, will inappropriately inflate hospitals’ payment reductions.

For example, consider a hospital with the following statistics:

- 1,000 total admissions for the three conditions
- $5,000 average base diagnosis-related group (DRG) payment
- 51 actual readmissions
- 50 expected readmissions

In this example, the hospital had one more readmission than expected, or one “excess” readmission. Since the average base DRG payment for the hospital is $5,000, its payments should be reduced by $5,000—the payment amount for the one excess readmission. To arrive at this amount, the calculation is made by first determining the ratio of excess readmissions by subtracting 1 from the ratio of actual to expected readmissions ($(51/50) – 1 = 0.02$). Next, that factor (0.02) is multiplied by the average DRG payment ($5,000), and the number of expected readmissions (50) for a penalty of $5,000, correctly representing the dollar amount associated with the “excess” readmissions.

(0.02) * $5,000 * 50 expected readmissions = $5,000

However, the technical error in the ACA’s language results in this hospital’s payments being reduced much more than $5,000. According to the legislative language, the excess readmissions ratio (0.02) and average DRG payment ($5,000) would be multiplied by the hospital’s total number of admissions for the three conditions (1,000) for a penalty of $100,000. The calculation mandated by the statute is:

(0.02) * $5,000 * 1,000 total admissions = $100,000

Because the formula uses the total number of admissions for the three conditions, the penalty for this hospital will be 20 times the amount of payment for excess readmissions. The AHA believes Congress intended to recoup money paid out for excess readmissions, which the current formula fails to do. Therefore, the error in the legislative language should be clarified to reflect “expected readmissions,” instead of the total number of admissions.

The Relationship Between Readmissions and Quality of Care Is Complex

In the AHA framework, only one type of readmission—a readmission that is unplanned and related to the initial admission—could indicate a lapse in providing the right care at the right time within the hospital. Yet, payers and others commonly use global readmission rates, along with mortality rates, as indicators of the quality of care delivered to patients during a hospital stay.

Conventional wisdom is that higher rates of either mortality or readmission within 30 days of hospital discharge indicate lower quality care. However, growing evidence reveals that mortality and readmissions may in fact be inversely associated with one another, calling into question the assumption that low readmission rates are always desirable.

Researchers at Cleveland Clinic (OH) recently used Medicare data posted on the Hospital Compare website to study the link between readmissions and mortality for beneficiaries admitted for heart failure. They found that hospitals with higher readmission rates actually had lower 30-day mortality rates.14

A similar analysis using Hospital Compare data conducted by the Greater New York Hospital Association also concluded that mortality is inversely related to readmissions.15 (Chart 3) And comparison of better- and worse-than-expected hospital referral regions (HRRs)16 with respect to 30-day mortality and readmissions shows that some hospitals with better-than-expected mortality actually had worse-than-expected readmissions.17

Another analysis compared hospitals
Experts do not all agree that readmission rates are valid as quality measures. A review of the literature on hospital readmissions concluded that readmission rates are not useful indicators of quality of care. In part, these measures do not typically distinguish among the different types of readmissions arrayed in Chart 1—meaning they do not consider which readmissions are within or beyond the hospital’s control. For instance, patients may be readmitted as a result of unpreventable progression of disease, planned follow-up care, their own preference for treatment timing, or an unrelated diagnosis or trauma.

Additionally, there are multiple factors such as patient characteristics and patterns of care that cloud the picture. For example, patients hospitalized for heart failure in the Veterans Affairs (VA) Health Care System became sicker over a four-year study period, with greater co-morbidities, yet mortality rates declined, in part due to more frequent use of recommended therapies. At the same time, readmission rates climbed, ranked among the top 50 “America’s Best Hospitals” in cardiac surgery by *U.S. News & World Report* and those not ranked. For patients treated for heart failure, the study found lower rates of mortality among ranked hospitals but no difference in readmission rates between ranked and non-ranked hospitals. Interestingly, among the top-ranked hospitals, there were no hospitals that performed better than expected on both mortality and readmissions.

Similarly, a study of 39 children’s hospitals in 24 states examined the relationship between readmissions and the state’s child health system performance, as ranked by The Commonwealth Fund. The ranking is based on 13 indicators measuring access, quality, costs, equity and the potential for children to lead healthy lives. The likelihood of readmission in the year following discharge rose as the states’ performance ranking improved. States with the highest-performing systems had significantly higher readmission rates than states with the lowest-performing systems.

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**Readmission Rates May Be Ill Suited as Measures of Quality**

There appears to be an inverse relationship between mortality and readmissions.
perhaps because sicker patients who might have otherwise died remained alive, and thus were at greater risk for rehospitalization. Further, providers reported heightened monitoring of discharged patients, a factor that may have resulted in more readmissions but saved more lives.23

One argument in favor of using readmission rates to measure quality of care is that a readmission is an indicator of an omission of needed care, or an error in the care given to a patient. Yet, as the AHA framework describes, this theory is unsupported for readmissions that are a specified step in a treatment plan, and for unrelated, unplanned readmissions that could not have been anticipated.

A review of the literature found mixed evidence linking readmissions with the care patients received during the initial hospital stay.24 Another study found that patients who were readmitted within 28 days of discharge were no more likely to have received low-quality care than patients without a readmission.25

### Chart 4: 30-day Readmission Rate for Non-dual, Disabled Medicaid Beneficiaries by Number of Chronic Illness and Disability Categories

![Chart 4: 30-day Readmission Rate for Non-dual, Disabled Medicaid Beneficiaries by Number of Chronic Illness and Disability Categories](image-url)


Note: Number of chronic illnesses and disabilities measured using Chronic Illness and Disability Payment System (CDPS), a risk adjustment model used to adjust capitated payments to health plans that enroll Medicaid beneficiaries. Study included 941,208 Medicaid beneficiaries hospitalized from 2003-2005 in 50 states and DC.
as compared to only 16.9 percent of non-ESRD patients.31

Other studies have focused on patients admitted for a particular condition or procedure. One such study found that patients readmitted after being hospitalized with heart failure—one of the targets of the HRRP—were more likely to have diabetes, peripheral vascular disease, stroke and coronary artery disease than their counterparts who weren’t readmitted.32 An analysis of readmissions for complications of coronary artery bypass graft (CABG) surgery had similar conclusions. Six co-morbid conditions were associated with readmission within 30 days of discharge: vascular disease, congestive heart failure, chronic obstructive pulmonary disease (COPD), diabetes, liver failure and dialysis.33

Depression
Psychological conditions, such as depression, can adversely affect patient recovery and increase the likelihood of readmission. Following hospitalization for coronary artery disease, “distressed” patients were found to have significantly higher rates of readmission within six months than “non-distressed” patients.33 Similarly, a Canadian study found that heart attack patients who were depressed were more likely to be readmitted in the year after discharge.36 The link between depression and readmission is not limited to patients with cardiac conditions; a study of 142 internal medicine patients at a hospital in Australia also found that depression predicted higher rates of readmission.37

Demographic Factors
Numerous studies have demonstrated the influence of patient characteristics such as age, gender, race, geographic region and Medicaid coverage on the risk of readmission. There is not yet consensus on the most important predictive factors, but it is evident that demographic and socioeconomic factors have a significant effect on readmissions.42

Race and ethnicity have been shown to be a predictor of readmissions but how this plays out is not completely understood. One study of general medicine patients in a large urban, university medical center found that African American patients had a higher risk of readmission than patients of any other race.43 A different study of just Medicare beneficiaries with heart failure found that minority patients, other than African Americans, had a higher risk of readmission.44

Another recent study explored whether disparities in readmission rates are attributable primarily to race itself or to the site of care, given that care for minorities is concentrated in a relatively small number of hospitals. Overall, black Medicare patients had higher readmission rates than whites,45 and patients from what the authors call “minority-serving hospitals” (hospitals in the top decile of proportion of black Medicare patients) had higher readmission rates than those from “non-minority serving hospitals.” The article concludes that racial disparities in readmissions are related to both race and site of care, recognizing there also are factors beyond hospitals’ control that could explain the findings.46

Language barriers lead to greater risk of readmission because patients and their families are less likely to understand their diagnosis or discharge instructions. Among more than 7,000 patients admitted to a northern California hospital, Latino and Chinese patients who did not speak English were significantly more likely to be readmitted within 30 days than English speakers.47

Income and socioeconomic status also play a role. One study of Medicare patients found that patients discharged from hospitals in counties with low median income had higher readmission rates than those discharged in counties with high median income. Income.48 Another found that Medicare beneficiaries receiving Supplemental Security Income (SSI) were more likely to be rehospitalized.49
Public insurance coverage also appears associated with greater risk of readmission.¹⁰ Using hospital data from 10 states, one study found that non-obstetric, adult Medicaid patients had higher readmission rates than their privately insured counterparts, nearly 11 percent compared to only 6 percent.¹¹ (Chart 5)

Hospitals serving disproportionate numbers of minority, low-income, or otherwise vulnerable patients may have higher readmission rates than other hospitals because of the risk factors of their patient population. This scenario is illustrated in Chart 6 in a comparison of the Bronx, NY, to Fairfield, CT, two communities with very different demographic profiles located in close proximity to each other. The Bronx has a median household income less than half that in Fairfield, nearly triple the minority population, and lower levels of educational attainment. Yet, nearly all of the hospitals in the Bronx performed better than the U.S. average on giving discharge instructions to heart failure patients, while only half of the hospitals in Fairfield performed the same. One might then expect hospitals in the Bronx to have better readmission rates for heart failure patients; but in fact, nearly all had worse rates than the U.S. average, while none of the hospitals in Fairfield were below the national average.¹²

Penalizing hospitals in these circumstances may further disadvantage their patients, perhaps exacerbating health disparities. (Chart 6)

Even when considering unplanned, related readmissions, it is not feasible for a hospital to prevent all such readmissions, and too low a rate might actually indicate poor quality care.¹⁴ The best way to improve quality of care as it relates to readmissions is to focus on those readmissions that may be avoidable. The challenge is that there are varying methods, with no agreed-upon standards, for identifying such potentially preventable readmissions.¹⁵

There is also little agreement on the characteristics that might best predict which patients are at greatest risk of readmission, and thus should receive the most attention or be targeted for intervention. A review of five statistical models intended to predict patient risk of readmission found little consistency among patient characteristics—including demographic variables and co-morbid conditions—that are significant predictors.¹⁶ Further work is warranted to help hospitals better focus their efforts on those patients most likely to benefit.

However, there are some promising findings indicating that hospitals’ investments in enhanced discharge planning and follow-up care can help reduce readmissions. For example, one study examined the impact of early follow-up care (within seven days) on readmissions of patients with heart failure. The authors found that patients with an initial admission in a hospital in the lowest quartile of performance on early follow-up care had a greater risk of readmission than patients initially admitted to hospitals with higher rates of early follow-up care.¹⁷

Already, hospitals are moving forward

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**The effect of socioeconomic factors raises questions about using readmissions to measure quality.**

Chart 6: Community Characteristics and Hospital Quality Measures for a Suburban and an Urban Community

<table>
<thead>
<tr>
<th>Community Characteristics</th>
<th>Fairfield, CT</th>
<th>Bronx, NY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Population</td>
<td>895,030</td>
<td>1,391,903</td>
</tr>
<tr>
<td>Median Household Income</td>
<td>$80,020</td>
<td>$34,031</td>
</tr>
<tr>
<td>Persons Below Poverty Line</td>
<td>7%</td>
<td>27%</td>
</tr>
<tr>
<td>Non-Hispanic White Population</td>
<td>70%</td>
<td>13%</td>
</tr>
<tr>
<td>No English Spoken at Home (aged ≥ 5)</td>
<td>24%</td>
<td>53%</td>
</tr>
<tr>
<td>Bachelor Degree or Higher (aged ≥ 25)</td>
<td>40%</td>
<td>15%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Quality Data</th>
<th>Fairfield, CT</th>
<th>Bronx, NY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals in County with Quality Data on CMS Hospital Compare Site</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Hospitals with HF Discharge Instruction Rate Better than the U.S. Average</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Hospitals with HF Readmission Rate Significantly Worse than U.S. Average</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Hospitals with HF Mortality Rate Significantly Worse than U.S. Average</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>


Note: HF=Heart Failure.
with efforts to reduce readmissions and improve quality of care. Hospitals are testing varying approaches, including partnering with post-acute care providers and enhancing discharge planning and follow-up services. (Chart 7)

Metro Health Hospital in Wyoming, MI initiated its Congestive Heart Failure (CHF) readmissions program in August of 2010 and—only six months into the program—cut its CHF readmission rate in half, from 15.5 percent for the first and second quarters of 2010 to 7.4 percent for the third and fourth quarters of 2010. Metro established a CHF unit staffed only by nurses with advanced training in CHF care. The nurses on the CHF floor developed education materials for patients, including information on appropriate diet and self health care, and they review these materials with patients during their stay in the hospital. Additionally, clinical secretaries schedule primary care provider (PCP) appointments for each CHF patient before they leave the hospital and the PCP receives clear and concise information on the patient's hospitalization, including what kind of follow-up care may be needed. Each patient is scheduled to see his/her doctor within seven days of discharge.

When patients require more than PCP follow-up care, hospital case managers enroll them in home health care before they leave the hospital. Case managers call each patient within 24-48 hours of discharge from the hospital to make sure they are following discharge instructions and keeping their PCP appointments. Metro planned to expand its CHF readmissions program to include pneumonia and acute myocardial infarction patients beginning in August 2011. Metro has also developed a high-risk readmission assessment tool based on information gathered from all patients upon admission which allows the hospital to identify patients as moderate- to high-risk for a hospital readmission and develop an individualized care plan.58

Rush University Medical Center in Chicago, IL implemented its hospital-wide Enhanced Discharge Planning Program (EDPP) randomized controlled trial from June 2009 to March 2010 and during that period patients participating in the program had 15 percent lower 30-day readmission rates, 24 percent lower 60-day readmission rates and 23 percent lower 90-day readmission rates than patients not participating in the program. EDPP uses the hospital’s electronic medical record, which includes clinical data as well as information on the patient’s social support structures, to identify patients at risk for readmission. Social workers then telephone those patients after discharge to ensure they are receiving the services detailed in their care plans, identify any additional needs, and link patients to community services and providers to resolve any issues. Social workers may continue to follow-up for a week to a month, depending on the patient’s needs. The majority of the patients participating in the program require social worker intervention post-discharge. From June 2009 to March 2010, EDPP identified problems for 83 percent of program participants which did not emerge until after hospital discharge for 74 percent of the patients. More than one follow-up call was needed for 254 of the 360, or 70.6 percent, of patients in this program.59

The Agency for Healthcare Research and Quality is funding a project through the AHA’s Health Research and Education Trust to help hospitals adopt Project RED (Re-engineered Hospital Discharge), a
program developed by Boston University that led to 30 percent fewer readmissions at Boston University Medical Center. Hospitals use Project RED workflow processes from the time a patient is admitted and throughout the stay to help the patient prepare for discharge. Each patient is assigned a nurse “discharge advocate” who assists the patient in understanding his or her diagnosis, arranges follow-up appointments, and confirms medication plans. Upon discharge, the discharge advocate provides each patient with a personalized set of discharge instructions, which are also shared with the patient’s regular physician, and follows up via phone within two days to identify and resolve any problems.

Some hospitals are saving workforce resources by using Project RED’s “virtual discharge advocate,” Louise, to deliver discharge instructions to patients. Louise speaks to the patient using the communication style of a nurse and her dialogue is tailored for each patient based on the information entered into a workstation. Louise can answer questions and repeat information the patient may not have understood the first time. Health First, of Rockledge, FL, used Project RED to reduce readmissions of congestive heart failure patients in one unit by 29 percent, compared to similar patients in units where Project RED was not deployed. Health First also hired discharge advocates to assist patients with home care and ensure they see a doctor within seven days. One of the noted barriers to wider use of these programs is the high level of provider investment required to achieve savings that accrues primarily to the health plans.

Readmissions can be categorized as planned or unplanned, and related or unrelated to the initial admission. Planned readmissions and those unrelated to the initial admission either should not or cannot be prevented by hospitals. Thus, public policies should focus on readmissions that may be avoidable—those that are unplanned and related to the initial admission, such as a surgical site infection. Additionally, the AHA believes the technical error in the ACA should be clarified in order to recoup an appropriate amount from hospitals with excess readmissions.

While the ACA aims to improve quality and save costs by reducing readmissions, recent evidence suggests that it is difficult to draw conclusions about quality of patient care using data only on readmissions. Most confounding is the evidence of an inverse relationship between readmissions and mortality. Other factors, from patient characteristics and patients’ life circumstances to the nature of post-hospital care, also seem to matter in determining the rate of readmissions.

More research is needed on the drivers of readmissions. Such insight will be integral to developing risk adjusters that appropriately account for patient characteristics, including socioeconomic factors, and hospitals’ particular circumstances and patient mix in determining financial penalties for readmissions.

Policymakers seeking statutory or regulatory levers to reduce readmissions should carefully weigh the potential for unintended adverse consequences. Payment penalties intended to shrink readmission rates could exacerbate inequities and leave hospitals with fewer resources to make needed investments in improving patient care. Further, misaligned policies could direct hospitals to reduce readmissions that are appropriate for safe patient care and may actually save lives.

**POLICY QUESTIONS**

- How can the HRRP account for patients’ life circumstances and socioeconomic factors in calculating expected and actual readmission rates?
- How can regulators best focus the ACA’s HRRP on unplanned, related readmissions—those that hospitals are best able to prevent?
- How can policymakers effectively encourage hospitals and other providers to continue to design and implement innovative approaches to reduce readmissions?
- What are the best approaches for disseminating information about programs proven to be effective in reducing readmissions?
- How can regulators anticipate and avoid unintended adverse consequences for patients and providers in imposing financial penalties for excess readmissions?
- What additional research is warranted to ensure appropriate risk adjustment of readmission rates for the HRRP?