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The Medicare Hospital Readmissions Reduction Program: Time for Reform

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Hospital readmissions are costly and detrimental to both patients and taxpayers. In 2013, almost 18% of Medicare patients were readmitted to the hospital within 30 days. Although this rate is somewhat lower than in previous years, patients are still being readmitted too often, potentially costing Medicare more than \$26 billion annually. According to the Centers for Medicare and Medicaid Services (CMS), an estimated \$17 billion of that expenditure is related to readmissions that could have been avoided.

Hospitals and taxpayers have a major stake in improving the way Medicare considers patient readmissions. In 2010, Congress instituted new penalties for hospitals with high readmission rates. The Hospital Readmissions Reduction Program (HRRP), authorized in the Patient Production and Affordable Care Act, requires CMS to penalize hospitals up to 3% of Medicare reimbursement when a substantial proportion of their patients return to the same or another acute hospital setting within 30 days of discharge. The program has shown promise by encouraging hospitals to invest in improvements in care coordination and effective discharge planning.

The effects of the policy have been widespread. According to CMS, roughly two-thirds of US hospitals were subject to a penalty in their first year. The latest numbers suggest nearly 80% of hospitals are now being penalized (\$428 million in the 2014-2015 fiscal year).

Asking hospitals to be accountable for readmission is an important step forward, but a closer look at the effect of the HRRP reveals important concerns about the complexity of readmissions and what drives them. With 3 years of data on penalties, the evidence suggests that hospitals that care for chronically ill and low-income patients are far more likely to be penalized than other institutions. Based on analyses of CMS data from 2014, safety-net hospitals – defined as those in the upper quartile of the Disproportionate Share Hospital (DSH) index – were nearly 60% more likely to have been penalized all 3 years compared with non-safety net hospitals. That is, among 660 safety-net hospitals, 455 (69%) were penalized all 3 years, whereas among the 660 hospitals in the bottom quarter of the DSH index, only 291 (33%) were penalized over the same period. Similarly, hospitals that are struggling financially – those with the lowest (often negative) margins – were 36% more likely to be penalized than hospitals that are performing better financially.

The Medicare Payment Advisory Commission, which provides guidance to CMS, reviewed the effect of the HRRP and found that a higher proportion of vulnerable patients – mainly older patients living in poverty or with disability – correlates closely with the hospital's likelihood to receive penalties because of HRRP. However, despite the data and potentially serious consequences, CMS has not yet made any refinements for socioeconomic status to the penalty formula.

Accountability is an integral part of health care, and the HRRP has the potential to encourage accountability where it is currently lacking. Finding methods to keep older patients healthy and out of the hospital is an important goal. A policy that does not consider other important factors in patients' lives is fundamentally unwise, and likely not to be effective over time.

Hospitals should not be penalized simply because of the demographic characteristics of their patients. However, the evidence indicates that HRRP is doing exactly that, penalizing the safety-net institutions that provide care for patients who otherwise would struggle to find care. Targeting hospitals for penalties, even if indirectly, simply because those hospitals care for more poor patients is not good policy.

As a response to these unintended consequences, 2 of us (J.M. and R.F.W.) have introduced The Hospital Readmissions Program Accuracy and Accountability Act of 2014. The bill is straightforward. It requires CMS to consider socioeconomic status when calculating penalties for readmissions. The bill preserves the key features of greater accountability that the HRRP introduced, but also directly addresses the problems created by this provision for safety-net hospitals that serve the most vulnerable U.S. populations. This effort has garnered bipartisan support from 8 senators in Congress, and the goal is to get the legislation enacted this year. A similar effort is also underway in the House of Representatives.

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