High rates of hospital readmissions—admission to a hospital within 30 days of discharge from an earlier hospital stay—among Medicare beneficiaries have concerned policymakers for some time and have been the subject of recommendations from the Medicare Payment Advisory Commission (MedPAC) and others.\(^1\) According to MedPAC, the adjusted\(^2\) readmission rate for all causes of admissions was 15.3 percent in 2011. While there is disagreement about the proportion of 30-day readmissions that are truly preventable, a recent systematic review of studies reported a range from 5 to 79 percent with a median of 27 percent.\(^3\) Regardless of the magnitude, most observers agree that reducing readmissions would benefit both the Medicare program through lower costs and beneficiaries through improved care.

To spur the hospital industry to reduce avoidable readmissions, Congress included a hospital readmissions reduction program (HRRP) as part of the Patient Protection and Affordable Care Act of 2010 (ACA). The goal of HRRP is to encourage hospitals to improve discharge planning and care transitions and to coordinate more closely with outpatient providers to reduce avoidable readmissions. Beginning in fiscal year 2013, hospitals whose risk-adjusted readmission rates for three conditions—myocardial infarction, heart failure, and pneumonia—were greater than the national average rates received reduced payments.\(^4\) Each hospital’s potential penalty was capped during the first year at 1 percent of its inpatient base operating payments.\(^5\) The cap will increase to 2 percent in 2014 and 3 percent in 2015, and cap will remain at 3 percent beyond 2015. Three more medical conditions will be added to the program in 2015.\(^6\)

About $280 million in penalties were assessed in 2013 or about 0.3 percent, in aggregate, of base inpatient hospital payments. Of 2,217
hospitals penalized, 307 were subject to the maximum penalty of 1 percent. The average penalty for hospitals with a penalty was about $125,000; about 30 percent of all hospitals paid no penalty.\(^7\)

The HRRP is not without its critics. Some have argued that the penalty is too small to change hospitals’ behaviors. For some hospitals, net revenue gained from readmissions or the cost of additional actions to reduce readmissions may be greater than the penalty. For these hospitals, continuing to do business as usual may be financially advantageous, at least until the set of conditions for which readmission penalties are assessed is expanded and/or until the penalty caps grow. Others claim that the program is unfair to hospitals that treat large numbers of economically disadvantaged patients and/or operate with small or negative margins. They argue that socioeconomic status and hospital resources play a role in readmissions rates, and warn that disparities could be exacerbated if hospitals shun patients with complex medical needs because of concerns about adverse effects on readmission rates.\(^8\)

Some observers have questioned the reliability of the performance measure set in the ACA. They note that random variation may be at play, creating problems especially for hospitals whose admissions are only slightly above the minimum number of 25 per condition needed to calculate an “expected” readmission rate. The computation of the readmission penalty has also been criticized as being insensitive to improved hospital performance over time. The negative correlation between readmissions and mortality for heart failure patients has also received attention in the academic literature, with some arguing that some readmissions for heart failure may be a “good thing” and should not be penalized.\(^9\) In addition, there is concern about the effect of expanding the number of conditions included in the program.

Supporters of the program generally acknowledge that the HRRP is not perfect, but point to its success in beginning to reduce hospital readmission rates. In their view, doing “nothing” is not a viable alternative.\(^{10}\) However, modifications to the program, some agree, may be warranted.

**SESSION**

This Forum session described the hospital readmission reduction program as implemented, examined the criticisms that have been leveled against it, and discussed potential modifications. Drawing from MedPAC’s June 2013 report, Mark Miller, PhD, executive director,
provided an overview of the Commission’s recent work on the HRRP, including potential ways to modify the program. Karen E. Joynt, MD, MPH, from the Harvard School of Public Health and Brigham and Women's Hospital, discussed some of the concerns that have been raised about the program with a focus on the relationship between readmission and mortality. Elna Nagasaki, MD, PhD, MPH, from Washington University School of Medicine in St. Louis, described how patients’ socioeconomic status can affect the hospital’s ability to prevent avoidable readmissions.

### ENDNOTES


2. MedPAC’s all cause readmission rate excludes planned readmissions and “chains” of readmissions—multiple readmissions for the same individual. Data are also risk adjusted for changes in age, sex, and primary diagnosis. CMS (Centers for Medicare & Medicaid Services) readmissions numbers are based on raw numbers and include chain readmissions.


6. The three conditions to be added are chronic obstructive pulmonary disease (COPD) and hip and knee replacements. CMS, “Readmissions Reduction Program.”

