THE HOSPITAL READMISSIONS REDUCTION PROGRAM: FOUR YEARS OF DATA

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KEY FINDINGS:

- Hospitals faced a shifting landscape under the Medicare Hospital Readmissions Reduction Program (HRRP), as the Centers for Medicare & Medicaid Services (CMS) increased the maximum penalty and added new measures.
- Hospitals that serve a large volume of low-income patients are 2.67 times more likely than other hospitals to receive penalties under the HRRP for fiscal year (FY) 2016.
- Hospitals that received higher penalties as a percentage of their Medicare payments showed the most improvement between FY 2013 and FY 2016.

HOSPITAL READMISSIONS REDUCTION PROGRAM

As the HRRP enters its fourth year of penalties, many experts are starting to question its impact on essential hospitals—those that fill a safety net role in their communities.

To encourage reductions in the rate of costly readmissions, the HRRP began penalizing hospitals in FY 2013 for patients readmitted within 30 days of a discharge. But these cost-saving measures might have unintended consequences for hospitals treating the nation's vulnerable patients.

CMS, which administers the HRRP, currently adjusts readmissions penalties for patient age, sex, diagnosis, and comorbidities. The agency does not consider social determinants of health that have been shown to affect patient outcomes.[1,2]

A recent Harvard Medical School study found that current risk adjustment strategies fail to control for many patient characteristics that put essential hospitals at risk for unfair penalties.[3] This failure, according to experts, could cause hospitals treating a large proportion of low-income or minority people to face penalties at an increased rate, further diminishing resources at hospitals that often operate at a loss.[4] Our analysis of CMS data for the HRRP supports this conclusion.

DATA SOURCE

In this brief, we examine HRRP penalties using CMS' final rule for fiscal years 2013 through 2016.[5] Data are limited to acute care hospitals eligible for the Inpatient Prospective Payment System. This excludes some types of hospitals: psychiatric, rehabilitation, and some cancer and critical access hospitals. Maryland hospitals also are excluded due to a special arrangement with CMS.

> Failing to control for patient characteristics "could cause hospitals treating a large proportion of low-income or minority people to face penalties at an increased rate."

FINDINGS

- We found that essential hospitals are 2.67 times more likely than other hospitals to be penalized under the HRRP in FY 2016.
- Hospitals serving greater than 20 percent Medicaid patients are 1.69 times more likely to receive penalties in FY 2016 than those serving fewer Medicaid patients.
- On average, hospitals in the top 25 percent for penalties in FY 2013 saw a slight increase (0.02 percentage points) in penalties by FY 2016. However, those receiving lesser penalties in FY 2013 had average penalties that were 0.28 percentage points higher by FY 2016.

- Hospitals receiving large penalties in FY 2013 were likely to also receive high penalties in FY 2014 (r=0.87).

- New measures added in 2015, covering readmissions related to chronic obstructive pulmonary disease and total hip arthroplasty/ total knee arthroplasty, brought a shift in the patient population covered by the program, impacting hospital penalties.

- Due to new measures being added, hospital penalties from FY 2014 to FY 2015 were more weakly correlated than previous years (r=0.48).

This brief reveals a potential bias in the HRRP against hospitals treating vulnerable patients. Its findings echo growing concerns within the research and hospital community that this program fails to accurately measure hospital quality of care.

FIGURE 1: AVERAGE PENALTIES BY MEDICAID VOLUME

The highest average penalties are found in those treating between 10 and 20 percent Medicaid patients. Average penalties decline as Medicaid discharges increase at levels above 20 percent. One potential explanation is that hospitals gain expertise in preventing discharges among vulnerable populations.

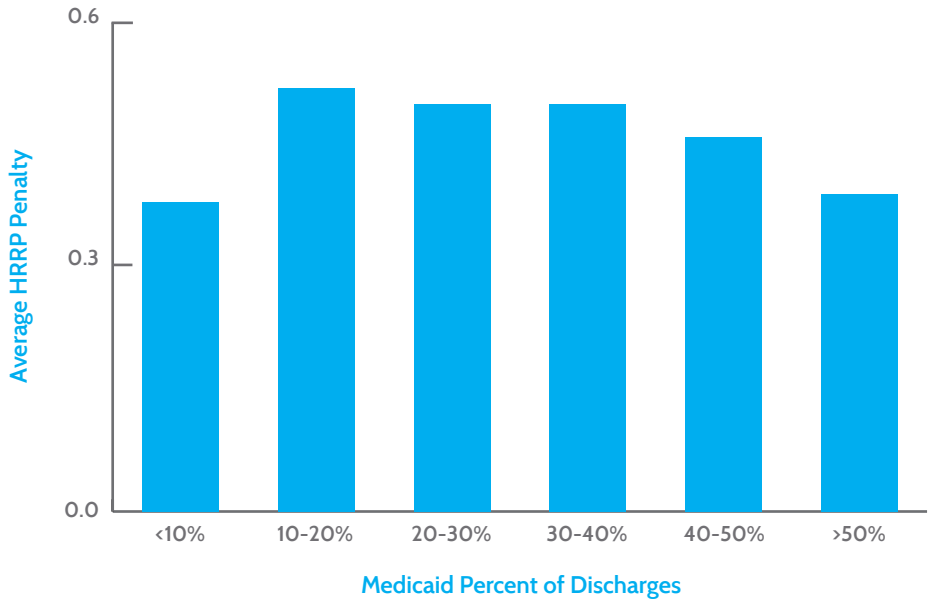

FIGURE 2: TRACKING AVERAGE PENALTIES BY FY 2013 QUARTILE

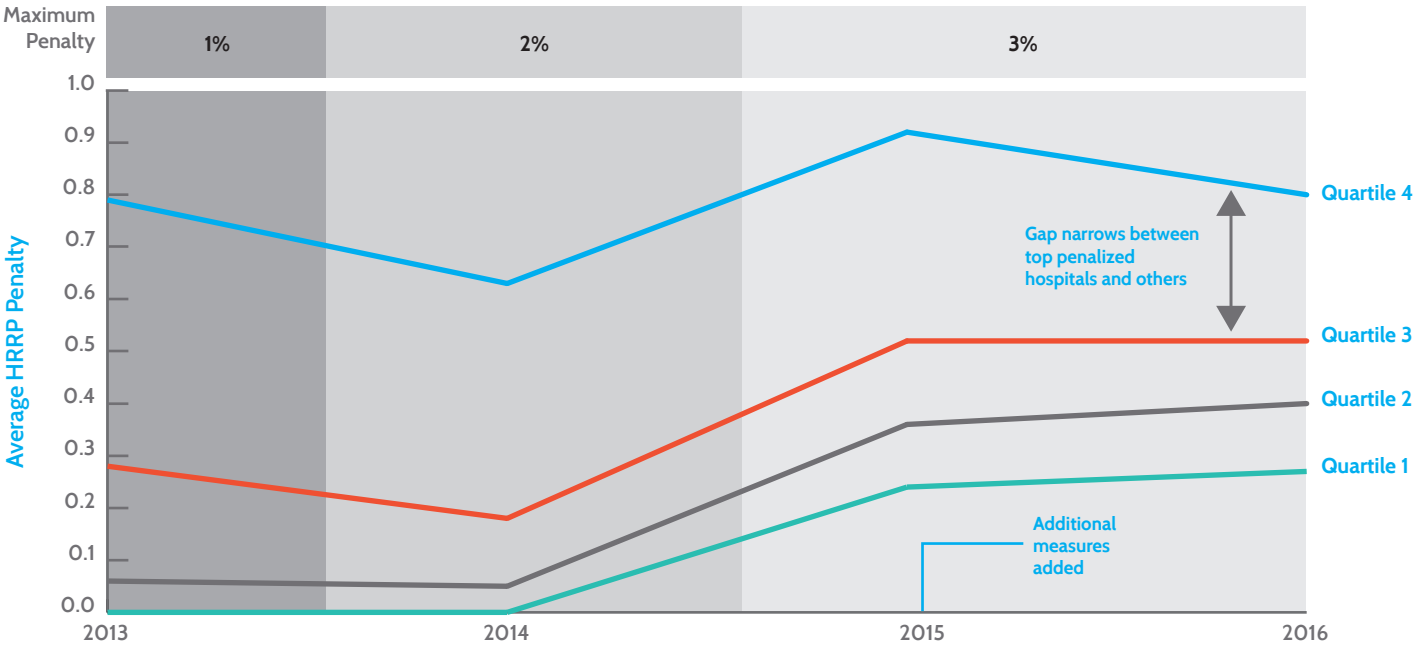

TABLE 1 MOVEMENT BETWEEN AVERAGE PENALTY QUARTILES, FY 2013 TO FY 2016

Percentages indicate the share of hospitals in a given 2013 quartile that appear in the cross-referenced 2016 quartile (poorest performers in 4th quartile)

ESSENTIAL HOSPITALS

FY 2013	FY 2016: 4th Quartile	3rd Quartile	2nd Quartile	1st Quartile
4th Quartile	42.31	19.23	34.62	3.85
3rd Quartile	34.48	27.59	20.69	17.24
2nd Quartile	9.62	38.46	38.46	13.46
1st Quartile	2.08	20.83	52.08	25.00

OTHER HOSPITALS

FY 2013	FY 2016: 4th Quartile	3rd Quartile	2nd Quartile	1st Quartile
4th Quartile	48.82	22.81	15.83	12.54
3rd Quartile	21.47	32.00	28.00	18.53
2nd Quartile	15.95	26.14	31.23	26.68
1st Quartile	8.37	15.95	27.32	48.37

Notes

1. Adler NE, Newman K. 2002. Socioeconomic Disparities in Health: Pathways and Policies. *Health Affairs*. Vol. 21 no. 2 60-76.

2. For further information on the social determinants of health and health outcomes, see http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes.

3. Barnett ML, Hsu J, McWilliams JM. 2015. Patient Characteristics and Differences in Hospital Readmission Rates. *JAMA Intern. Med.* doi:10.1001/jamainternmed.2015.4660.

4. Reiter KL, Jiang HJ, Wang J. 2014. Facing the recession: how did safety-net hospitals fare financially compared with their peers? *Health Services Research*. 49(6):1747-66. doi: 10.1111/1475-6773.12230.

5. Centers for Medicare & Medicaid Services. Fiscal Year 2013-2016 Impact File, Inpatient Prospective Payment System Final Rule Data Files. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html. Accessed November 2015.