Study Snapshot:

Hospital Readmissions Reduction Program Prompts Action, Reveals Challenges

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key points

- Preliminary analyses have shown a reduction in Medicare readmissions since passage of the ACA, but more detailed analyses are needed to determine the reasons for the decline.
- Better care management is needed to reduce readmissions, including significant work to improve inpatient processes and coordinate post-discharge care.
- The penalty formula should be adjusted to address the unfair level of penalties for hospitals serving a greater-than-average percentage of low-income patients.
- The HRRP methodology pushes hospitals to decrease excessive readmissions continually. More evidence is needed to determine the appropriate rate of readmissions and to set benchmarks.

The Question:

How are hospitals and providers responding to the Hospital Readmissions Reduction Program?

In November 2013, the Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) initiative convened health care practitioners, administrators, health services researchers, and policy experts from private sector and government agencies to discuss the implementation status of Medicare's Hospital Readmissions Reduction Program (HRRP). Established by the Affordable Care Act (ACA), the HRRP institutes a formula for applying Medicare payment reductions (1 percent in 2012 up to 3 percent in 2014) for excess hospital readmissions within 30 days of discharge for designated conditions.[1] The meeting participants agreed that the HRRP has become a focal point for hospitals' efforts to respond to growing pressure to reduce costs and increase the effectiveness and quality of patient care. Yet, a clear consensus emerged among the meeting participants that refinements to the program are needed to improve its effectiveness and equity. A full meeting summary is available in the related issue brief.

The Implications:

The HRRP has focused hospitals' attention on improving efficiency and quality, yet refinements to the program are needed to address implementation challenges.

The meeting participants agreed that the HRRP has garnered significant attention and spurred a response from hospitals and providers; however, the implementation experience to date uncovered several issues that need to be addressed. First, hospitals with a high share of low-income patients have higher readmission rates and thus incur greater penalties. The meeting participants agreed that, rather than adjusting for income within the penalty formula, the Medicare Payment Advisory Commission (MedPAC) recommendation to evaluate hospitals within a peer group serving a similar share of low-income patients would address the issue without accepting poor performance. Second, the meeting participants recommended moving toward an all-condition measure. The HRRP's focus on a small, albeit important, set of conditions is problematic, particularly for small hospitals with an insufficient number of cases to generate reliable performance measures. The formula used to calculate the readmissions penalty is codified in law; as such, the suggested revisions may require legislative changes. While the HRRP, among other ongoing reforms, is an important step toward improving quality and efficiency, system-wide changes in care coordination and better alignment of financial incentives are likely needed to achieve a substantial reduction in excessive readmissions.

Contact Us

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1. Conditions include heart attack, heart failure, and pneumonia. In October 2014, applicable conditions will also include acute exacerbation of chronic obstructive pulmonary disease, elective total hip arthroplasty, and total knee arthroplasty.

Robert Wood Johnson Foundation

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