A for Effort, I for Innovation: Hospital Readmissions Reduction Program and Its Positive Progress

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I. INTRODUCTION

As one of many efforts to decrease costs while maintaining or increasing the quality of health care, Section 3025 of the Patient Protection and Affordable Care Act (“ACA”) established the Hospital Readmissions Reduction Program (“HRRP”). This program required Centers for Medicare and Medicaid Services (“CMS”) to find a method to reduce payments to Acute Inpatient Payment System hospitals with excessive readmission rates. The program originally provided that CMS enforce a penalty when a patient, originally hospitalized for one of three conditions (acute myocardial infarction, congestive heart failure, and pneumonia), was readmitted within thirty days of being discharged. Other conditions were subsequently added to the list, including chronic obstructive pulmonary disease (“COPD”) and total hip arthroplasty/total knee arthroplasty (“THA/TKA”). In order to carry out the program, CMS calculates a ‘readmissions adjustment factor’ for Acute Care Hospital Inpatient Prospective Payment System (“IPPS”) hospitals. The final rule contains policies aiming to shift Medicare payments from volume-based to value-based. These expected rates are then compared

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2. Id. (codified in part as 42 U.S.C.A § 280j-3 (2010) (covering the ACA’s readmission reduction program)).
with actual readmission rates. If the readmission rates are above the projected rate, Medicare fines the hospital.

While the program has in many ways achieved the overall goal of lowering readmission rates, it has met opposition from the medical community. Hospitals have pushed Medicare and Congress to consider different factors when addressing readmission rates, such as a patient’s socioeconomic background or situations where a patient’s reason for re-admittance differs from that of the original admission. Nevertheless, the program has jolted hospitals to not only take notice of high readmission rates, but to also create innovative and cost-effective methods of achieving lower readmission rates.

This article argues that CMS is properly responding to concerns of high readmission rates by continuing to lower such rates in hospitals. Although the HRRP is not without fault, the policy contributes to widespread innovation and collaboration among providers and entities in the healthcare field. This article will begin by examining the negative implications of high hospital readmission rates and acknowledge the positive data associated with recent studies of the HRRP. The article will then move to an analysis of the perceived failures of the HRRP by addressing commonly voiced complaints and the backlash from the medical community. Next, the article will distinguish the commonly voiced complaints by highlighting the program’s success in recent years and prove that the HRRP is accomplishing exactly what it was intended to do—lower readmission rates. The final section will expound on the success of the HRRP as creating and inviting an environment for innovation and collaboration to achieve better quality in health care. Moreover, this section will examine how innovations such as the HRRP are affected by legal, regulatory, or economic challenges, and how the program will be primed to answer those challenges while continuing to successfully

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8. Id.
11. See Colleen K. McIlvennan et al., Hospital Readmissions Reduction Program, 131 CIRCULATION 1796, 1798 (2015) (“The HRRP has helped forge collaborative relationships – within hospitals, between medical institutions, and in surrounding communities – that focus on improving the overall patient experience through hospitalization and beyond.”).
lower readmission rates in the future.

II. IMPLICATIONS OF HIGH READMISSION RATES AND
THE FIRST YEARS OF THE HRRP

The HRRP’s creation arose out of concern for the high percentage of adults readmitted after hospitalization, oftentimes in situations that appeared to be discretionary or avoidable through improvements in care. In addition to signaling poor quality or inefficient care, readmissions are also associated with hospital complications, functional decline, and death. According to CMS, about one in five Medicare patients discharged from a hospital is readmitted within thirty days. High readmission rates contribute to avoidable health expenditures in the inpatient and post-acute care setting – contributing to sixteen percent of all hospitalization expenditures. In fact, a single preventable return trip to the hospital more than doubles the cost of care for Medicare patients.

In only three years of the program, national readmission rates have dropped. In 2013, Medicare levied the maximum penalty against 276 hospitals. The average penalty amounted to an estimated $125,000 per hospital. Nonetheless, CMS estimated that hospital readmissions declined by a total of 150,000 from January 2012 to December 2013 – “a substantial improvement.” Furthermore, for 2015, eighty-three percent of Medicare

13. Id. at 13.
15. Nuckols, supra note 12, at 13; see also Andrew S. Boozary et al., The Medicare Hospital Readmissions Reduction Program Time for Reform, 314 JAMA 347, 347 (2015) (“[P]atients are still being readmitted too often, potentially costing Medicare more than $26 billion annually. According to the Centers for Medicare & Medicaid Services (CMS), an estimated $17 billion of that expenditure is related to readmissions that could have been avoided.”).
18. Brown, supra note 16.
19. Id.
20. Brown, supra note 4 (“While CMS will continue to administer fines, hospitals are seeing significant declines in readmission rates.”).
patient admissions are projected to be in hospitals receiving either no readmission penalty or penalties of less than one percent. These rates suggest that hospitals are beginning to work with the HRRP and find successful methods for lowering readmission rates.

III. PERCEIVED FAILURES OF THE HRRP

Despite declining readmissions, concerns about fairness and long-term sustainability arise from the HRRP penalty process. A commonly voiced issue with the HRRP is the lack of risk adjustment for key sociodemographic factors that influence the likelihood of readmission. Individuals with lower socioeconomic status have higher readmission rates due to a number of factors, such as language and cultural barriers, failure to comply with discharge instructions, lack of resources to purchase medications, and fewer options for post-discharge care. The issues surrounding socioeconomic factors suggest that hospitals serving larger numbers of low-income patients are twice as likely to receive penalties than hospitals serving fewer poor patients.

Another criticism of the HRRP is the presence of numerous factors that are outside of a hospital’s control that translate into penalties. Readmission rates are not only affected by providers’ actions but also by a number of clinical and nonclinical factors beyond provider control. Readmissions that occur a few days after discharge may reflect poor care coordination or inadequate recognition of post discharge instructions; however, readmissions four weeks later are far more likely due to the underlying severity of a patient’s disease.

Furthermore, unavoidable readmissions contribute to the high rates adversely affecting hospitals. Many argue CMS should not hold hospitals accountable for unplanned, unrelated admissions because they are

22. Demehin & Ward, supra note 9, at 25.
23. Id.
24. See James, supra note 14, at 4.
25. Id. at 3-4.
27. Id. (“For example, Medicare beneficiaries with six or more chronic conditions have a readmission rate of 25 percent, compared with 9 percent for those having only one or no chronic condition.”).
29. Id.
30. Dehemin & Ward, supra note 9, at 25 (“Many readmissions are unavoidable due to the natural progression of disease, accepted treatment protocol or a patient’s preference.”).
unpredictable and not typically preventable; however, these readmissions are included in the HRRP penalty. While the list of the HRRP’s perceived faults extends past the few examples given here and there are undoubtedly economic and social issues that must be addressed, the HRRP has achieved its intended objective of lowering hospital readmission rates across the nation in the few years since its implementation.

IV. ACHIEVING THE INTENDED OBJECTIVE

Decreasing readmission rates for many patients translated to an estimated 150,000 fewer hospital readmissions between January 2012 and December 2013. Even though it may be argued that external factors attribute to this decline in readmissions, the HRRP demonstrates either through direct or indirect effects that it is achieving its intended purpose.

The program is intended to impose incentives (and a sense of pressure) on hospitals to improve performance by avoiding preventable readmissions through various methods. However, the public may perceive success in policy making or the political success of a program differently. Many different ways to measure the success of the HRRP exist. One could measure success by asking whether the program achieved outcomes in line with its stated objectives, whether the program benefitted a specific subgroup, whether the program achieved economic success, or whether the program was an efficient use of resources.

The HRRP arguably achieves all four measures of success. The program has achieved economic success by encouraging hospitals to take measures to reduce their readmission rates lest they face a financial penalty. Jim Hoffman, COO of Besler Consulting, and Mary Cronin, Director of Product Development at Besler Consulting, looked to answer the question of whether

31. Id. at 26.
32. McIlvannan et al., supra note 11, at 1797 (“According to recently released U.S. Department of Health and Human Services data, from 2007 to 2011, the all-cause 30-day readmission rate among Medicare beneficiaries held relatively constant at nineteen percent to nineteen and a half percent; in 2012 and 2013, this rate fell to eighteen and a half percent and seventeen and a half percent, respectively.”).
33. Id.
34. Id. (“Although these favorable trends may reflect any number of other changes occurring over this period, the temporal relationship argues that the HRRP may be meeting its intended purpose, to reduce hospital readmissions and to decrease CMS spending.”).
36. Nuckols, supra note 12, at 13 (“Success in the policy making process and political success are both based on perceptions by the public; therefore, policies can perform poorly on these dimensions despite being programmatic success and vice versa.”).
37. Id.
38. Hoffman & Cronin, supra note 5, at 73.
the readmissions penalty exceeds or is lower than the revenue received from readmission after the cost of those admissions is taken into consideration.\textsuperscript{39}

In reviewing publicly available nationwide claims, cost-to-charge ratios, and readmission penalty data, Hoffman and Cronin found positive results for the HRRP.\textsuperscript{40} In 2014, 2,225 facilities were penalized for excessive readmissions.\textsuperscript{41} Of those facilities, 502 would have generated at least $100,000 more if they had eliminated readmission rates.\textsuperscript{42} Other hospitals would have had a smaller positive financial impact but no hospital in the country would have been negatively impacted for eliminating excess readmission.\textsuperscript{43} The statistics show that the HRRP and the cost of lowering readmission rates does in fact outweigh the cost of a possible penalty under the program.

The HRRP also achieves operational success because it is implemented in accordance with other objectives apart from lowering readmission rates.\textsuperscript{44} For the HRRP, operational success could be defined as whether hospitals respond in a manner consistent with the underlying motivations of improving quality of care and reducing costs.\textsuperscript{45} This does not mean the program cannot grow and change with each year.\textsuperscript{46} To the contrary, this leads to innovation and achievement of other types of success, such as working not to harm specific subgroups like hospitals that primarily serve low-income populations.\textsuperscript{47}

Another favorable study conducted by Kathleen Carey, Professor at Boston University School of Public Health and Meng-Yun Lin, Research Data Analyst in General Internal Medicine at the Boston Medical Center, investigated the intended impact of the HRRP.\textsuperscript{48} The study examined changes in thirty-day readmissions before and after the HRRP’s introduction by comparing three groups: Medicare patients admitted for three conditions targeted by the HRRP in New York State; Medicare patients with other conditions; and patients with private insurance.\textsuperscript{49} They found that Medicare thirty-day readmissions fell for the three conditions targeted by CMS –

\textsuperscript{39} Id. at 72 (“Is excess readmission revenue, minus the variable cost related to those admissions, greater or less than the readmissions penalty?”).

\textsuperscript{40} Id. at 71–72.

\textsuperscript{41} Id.

\textsuperscript{42} Id. at 73.

\textsuperscript{43} Id.

\textsuperscript{44} Nuckols, supra note 12, at 13.

\textsuperscript{45} Nuckols, supra note 12, at 14 (“In terms of improving quality, a recent meta-analysis of randomized trial found that interventions designed to prevent readmissions tended [sic] be moderately effective.”).

\textsuperscript{46} Id. at 16.

\textsuperscript{47} Id.

\textsuperscript{48} Carey & Lin, supra note 35.

\textsuperscript{49} Carey & Lin, supra note 35, at 980.
consistent with the goals of the program. They also found that although reductions were not as great for the target group, the Medicare comparator group’s readmission rate dropped considerably.

Through the analysis of the HRRP and the data yielded to date, many signs point to the program not only meeting its intended objectives but also promoting and influencing innovation throughout the healthcare field.

V. Grading High for Innovation

Another strong implication of the HRRP has been its influence in the medical field by pushing for innovation and collaboration between all players involved. By understanding the negative implications of high readmission rates combined with the perceived issues of the program in its few years, it is evident that hospitals, nurses, pharmacies, legislators, and even researchers have found ample motivation for suggesting and promoting innovative solutions. Such examples come from hospitals that look to promote more collaborative ‘Care Transitions’ addressing issues surrounding medication for patients. Such issues include when patients leaving a hospital fail to fill their prescriptions, feel too ill to travel, or simply do not understand the importance of immediately beginning medication. To combat these issues, certain pharmacy departments enacted strategies to reduce readmission by focusing on medication-related targets. For example, Barnes-Jewish Hospital in St. Louis, Missouri implemented bedside prescription transactions to enable patients to leave the hospital with their medication as opposed to getting it for themselves later. The hospital pharmacy at Einstein Medical Center in Philadelphia, Pennsylvania developed a multidisciplinary initiative - Reconciliation, Education, Access, Counseling, Healthy Patient at Home (“REACH”) - which cut its number of readmissions within thirty days by thirty percent in high-risk heart patients. In this extensive program, a

50. Id. at 983.
51. Id.
52. See generally Jo Ann Brooks, Reducing Hospital Readmissions: A Closer Look at the Medicare Hospital Readmissions Reduction Program, 115 AM. J. OF NURSING 62, 64 (2015) (“Improving information sharing among care providers, patients, and families during care transitions may improve patient outcomes, keep patients safer at home, and prevent unplanned readmissions.”).
53. Improving Care Transitions to Reduce Readmissions, HEALTHCARE FIN. MGMT. ASS’N 1, 1 (2014) (“Given that many patients, especially those with chronic conditions, use more than one pharmacy and take medications prescribed by more than one physician, the room for error between hospital and after-care setting abounds.”).
54. Id. at 2.
56. Id.
57. Id.
patient’s prescriptions are compared at arrival and departure and the staff verifies dosages and checks for missing or duplicative items. Hospital staff meet with patients in their rooms before discharge, review each medication, and provide pictures of each medication and instructions for use. Hospitals send patients home with medications even if it means billing patients later or pursuing insurance claims at a later date. After discharge, a follow-up phone call is made within three days and another is made after one month. The Einstein Medical Center believes that doing all of the above leads to healthy patients at home who are at low risk of being readmitted.

Additionally, evaluating the effect the number of nurses staffed at a hospital has on readmission may help improve both readmission rates and health care quality. "Nurses who work in well-staffed hospitals have the time and the resources to more effectively execute the care processes that influence readmissions. They are also better equipped than other nurses to monitor for complications and adverse events that increase readmission risk."

In a 2013 study, researchers found that hospitals with higher nurse staffing had a twenty-five percent lower chance of being penalized than hospitals with less nursing staff. In addition to increasing the nursing staff, some hospitals have assigned nurses to visit recently discharged patients at home to prevent the need for readmission by ensuring the patients are properly taking care of themselves.

In remediating these regulatory and social issues, healthcare providers are not the only ones who must act. Between March and June of 2014, both the Senate and House of Representatives introduced bipartisan-backed bills that would revise the HRRP to adjust for certain socioeconomic and health factors that increase the risk of a patient’s readmission. A replacement bill

58. Id. (the “Reconciliation” prong of REACH).
59. Id. (the “Education” prong of REACH).
60. Id. (the “Access” prong of REACH).
61. Id. (the “Counseling” prong of REACH).
62. Id. (the “Health Patient at Home” prong of REACH).
63. Matthew D. McHugh et al., Hospitals with Higher Nurse Staffing Had Lower Odds of Readmissions Penalties Than Hospitals with Lower Staffing, 32 HEALTH AFFS. 1740, 1740 (2013) (“It is known, however, that when nurses work inadequately staffed environments, the delivery of these care processes is hampered.”).
64. Id. at 1740-41.
65. Id. at 1742 (“Among a national sample of hospitals, we found that even after closely matching on hospital and patient population characteristics, hospitals with better registered nurse staffing levels were significantly less likely to be penalized under the CMS HRRP than otherwise similar hospitals that were less well staffed.”); see id. at 1744.
introduced in March 2015, the “Establishing Beneficiary Equity in the Hospital Readmission Program Act” would require CMS to reevaluate the HRRP and improve overall quality of care, increase accountability for all inpatient hospitals, and further reduce preventable Medicare readmissions.68 This is an example of the environment the HRRP constantly invites to address the program’s negative ramifications.

Perhaps the strongest display of incentivized innovation through the HRRP is the new Enterprise Data Warehouse (EDW) mainframes that hospitals are beginning to incorporate in order to join the digital age and track numbers of patients and readmissions faster than ever.69 EDWs can help solve reporting burdens by enabling users to access integrated views of financial, clinical, and operational data from throughout the enterprise and data from inpatient and outpatient settings, as well as generating automatic reports to ensure that data gets to the correct audience at the right time.70 Beyond reporting, another benefit includes business intelligence tools that allow hospitals to drive real cost and quality improvement initiatives such as computed baseline for all quality measures, tracking success in certain interventions or improvements, and ensuring the ability to measure and sustain results over the long term.71 In fact, at one large health system results have been impressive.72 In just six months after implementing an EDW, the health system achieved twenty-one percent seasonally-adjusted reduction in thirty-day heart failure readmissions, a fourteen percent seasonally-adjusted reduction in ninety-day heart failure readmissions, and a sixty-three percent increase in post-discharge medication reconciliation.73

CMS has not circumvented the call to innovation and improvement of the program. They too have instituted a number of programs in accordance with the HRRP to further prevent and reduce readmissions.74 The Hospital Compare website provides an online database on hospital readmission rates; CMS Innovation Center has new payment and service delivery models as well as funding grants known as the Health Care Innovation Awards; and the Partnership for Patients launched a variety of public-private partnerships with more than 3,700 hospitals to improve patient safety and care transitions.75


69. Brown, supra note 16.

70. Id.

71. Id.

72. Id.

73. Id.

74. Brooks, supra note 52, at 64.

75. Id.
Through cutting edge technological improvements, all players involved in health care, including pharmacies, nurses, hospitals, and even Congress can increase the quality of health care while lowering readmission rates.

VI. CONCLUSION

In its few years, the HRRP has been a strong example of how a penalty-based incentive program can jolt healthcare providers into taking a closer look at their practices and care. The broadest goal of the ACA was to promote efficiency and quality health care in all sectors and the HRRP facilitates that goal. Despite some pushback such as concern over the program’s unintended effect on certain (low-income patient based) hospitals, the ACA charged CMS with an overarching goal—to address and lower readmission rates. Through many interventions, CMS, hospitals, and other healthcare providers have answered the call. Moreover, the HRRP has promoted an environment of cooperation and teamwork among all providers that cultivates growth and innovation, which only furthers the progress made in reducing readmission rates. Notwithstanding the growing pains that any pilot program certainly will have, the steady decline in readmission rates along with the response in learning how to avoid penalties demonstrates that the HRRP can continue to succeed.

76. Rau, supra note 66 (“The program was popular among nurses and doctors, with one saying we ‘understand, we know the importance of it,’ that ‘in order to get a response from administration, you have to penalize.’”).
77. Sara Rosenbaum, The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice, 126 PUBLIC HEALTH REP. 130, 130 (2011) (“A third aim is to improve health-care value, quality, and efficiency while reducing wasteful spending and making the health-care system more accountable to a diverse patient population.”).
78. Boozary et al., supra note 15, at 347.
79. McHugh et al., supra note 63 (discussing the positive effects of a hospital’s high nurse staff on readmission rates); see also Boesen, supra note 55, at 240.