

EDITORIAL COMMENT

# Evolving the Hospital Readmissions Reduction Program



## A Call for Peace, Happiness, and Improved Patient-Centered Outcomes\*

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The Hospital Readmission Reduction Program (HRRP) was enacted in 2010 as part of the Patient Protection and Affordable Care Act with a goal to reduce preventable hospital readmissions. Through public reporting and payment incentive programs, Medicare aimed to reduce variations in quality of care and reduce readmissions. In 2012, the program initiated plans to hold hospitals with above-average, risk-adjusted readmission rates for certain conditions, including acute myocardial infarction (AMI) and heart failure (HF), more accountable through payment reductions. Shortly after the program was announced, nearly 9 in 10 hospitals in the United States reported identifying reducing readmissions as a key objective and having quality improvement teams devoted to reducing preventable readmissions for patients with HF. More than one-half had quality improvement teams focused on AMI readmissions (1). Because of the financial penalties, the HRRP generated significantly more attention by health systems with structured programs, and a flood of new ventures were developed to reduce readmissions than previous policy efforts (e.g., public reporting) (2). In sum, HRRP

showed that financial incentives or penalties could stimulate actions broadly.

The impact of HRRP on AMI and HF care and outcomes has been difficult to decipher. Nearly all U.S. hospitals were affected by HRRP. Thus, there are limited ways to truly develop contemporaneous controls. Historical trends are beset with issues of confounding, ecological and secular changes, and multiple simultaneous interventions. All of this adds up to making a thorough evaluation of the winners and losers of HRRP as difficult to ascertain as the complexity of health care. Nevertheless, the impact on patients, clinicians, and health systems require best efforts to generate evidence and evolve the program. The Medicare Payment Advisory Commission (MedPAC) recently evaluated the effects of the program and found that HRRP contributed to a significant decline in readmission rates without any notable adverse effects on outcomes, resulting in a net savings to the Medicare program of approximately \$2 billion per year (3). However, there were multiple reports that suggested HRRP led to increased mortality in patients with HF, possibly by decreasing necessary admissions for HF (4,5). Although the intentions of HRRP were to improve the quality of care to limit preventable readmissions, the program did not prescribe best methods to do so because of the mixed evidence and local issues hospitals face. For the best health systems, the opportunity was seized to redesign care around the patient to improve the continuum of care from hospital to home. For others, the focus accounted for case-mix and developing methods that focused more on the readmission measure itself. Unfortunately, there were reports that care by hospitals of disadvantaged populations might unduly bear penalties under HRRP. Based on these

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reports, the clinical community called for reassessment and revision of HRRP.

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In this issue of the *Journal*, Khera et al. (6) provide a novel analysis to determine if clinicians and health systems adopted strategies that led to a change in the threshold for admissions in the 30-day period after hospital discharge for conditions affected by HRRP, including AMI and HF. The investigators used Medicare claims files from 3,256 U.S. hospitals and calculated a daily rate of readmission for post-discharge day 1 through day 60 across all index hospitalizations at that hospital for a given condition. All-cause mortality was similarly assessed at each hospital for each of the HRRP target conditions for each post-discharge day, from day 1 through day 60. In a clever analysis, using a regression discontinuity approach, there were no apparent discontinuities or sharp changes in the data for either readmission or mortality at post-discharge day 30. The investigators performed a number of sensitivity analyses, including only considering hospitals where reductions in readmissions were observed during the study period. Overall, the data suggested that, as opposed to the anecdotal reports of hospitals or clinical practices that directly intervened to prevent readmissions near the day 30 mark, there did not appear to be a systematic behavior of doing so.

These data are reassuring that clinicians did not systematically delay necessary admissions until after post-discharge day 30, but there are several caveats to consider. For one, this report focused on readmissions at any hospital. If readmissions for HF or acute MI were delayed to the nonpenalty period, they could be expected to be more common at the discharging hospital or within the same health system. Second, this report did not consider changes in other aspects of care, including the use of observational stays and emergency department visits. Data from the MedPAC report suggested both increased after implementation of HRRP. The full impact of potential substitution of observational stays and emergency department visits for readmissions is unknown (3).

Although the debate may go on regarding the benefits and harms of HRRP through countless analyses, it seems prudent to move to a more forward-looking state rather than constantly looking

back. All agree that HRRP influenced health care delivery, so why not make it better? Several steps can be taken to better align incentives with clinical outcomes. First, the HRRP should incentivize other outcomes together with readmission prevention. The current policy is unbalanced and overemphasizes readmission prevention. Previous research has shown that patients discharged from hospitals with high performance on 30-day mortality measures receive higher quality HF care and better long-term outcomes for HF and AMI (7,8). Incorporating mortality into HRRP is 1 option, as is other patient-centered outcomes (e.g., quality of life). Second, HRRP does not need to only consider care within the 30 days after hospital discharge. The period could be extended to continue to incentivize high-quality care and shared risk with graded penalties, higher penalties early after discharge, and lower penalties late after discharge. Third, HRRP needs to continuously evolve to account for safety net hospitals and areas in which underserved or under-represented populations are cared for by hospitals without the resources afforded by affluent populations. As part of the 21st Century Cures Act, a step toward this change occurred by requiring CMS to alter penalties based on a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for both Medicare and full-benefit Medicaid. However, the impact of this change is unclear and needs to be evaluated over time. Fourth, with the advent of additional data elements and networks, there is an opportunity to refine and improve risk adjustment to capture other factors (e.g., frailty) and social determinants of health that may not be apparent from claims data. It is also worth highlighting that if these changes are implemented, there will need to be ongoing assessment and opportunities for iterative improvement to develop a policy incentive that improves care and value in a patient-centered way. If all of this is done, then perhaps we can live in an era with peace, happiness, and improved patient-centered outcomes for HF.

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