

Advising the Congress on Medicare issues

MedPAC evaluation of Medicare's Hospital Readmission Reduction Program: Update

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History behind the Hospital Readmissions Reduction Program (HRRP)

- MedPAC and others suggest readmission rates were higher than necessary.
- 2009: CMS publicly reports readmission rates.
- 2010: HRRP is enacted.
- 2013: Payment rates are reduced for hospitals with high readmission rates during 2010 to 2012.

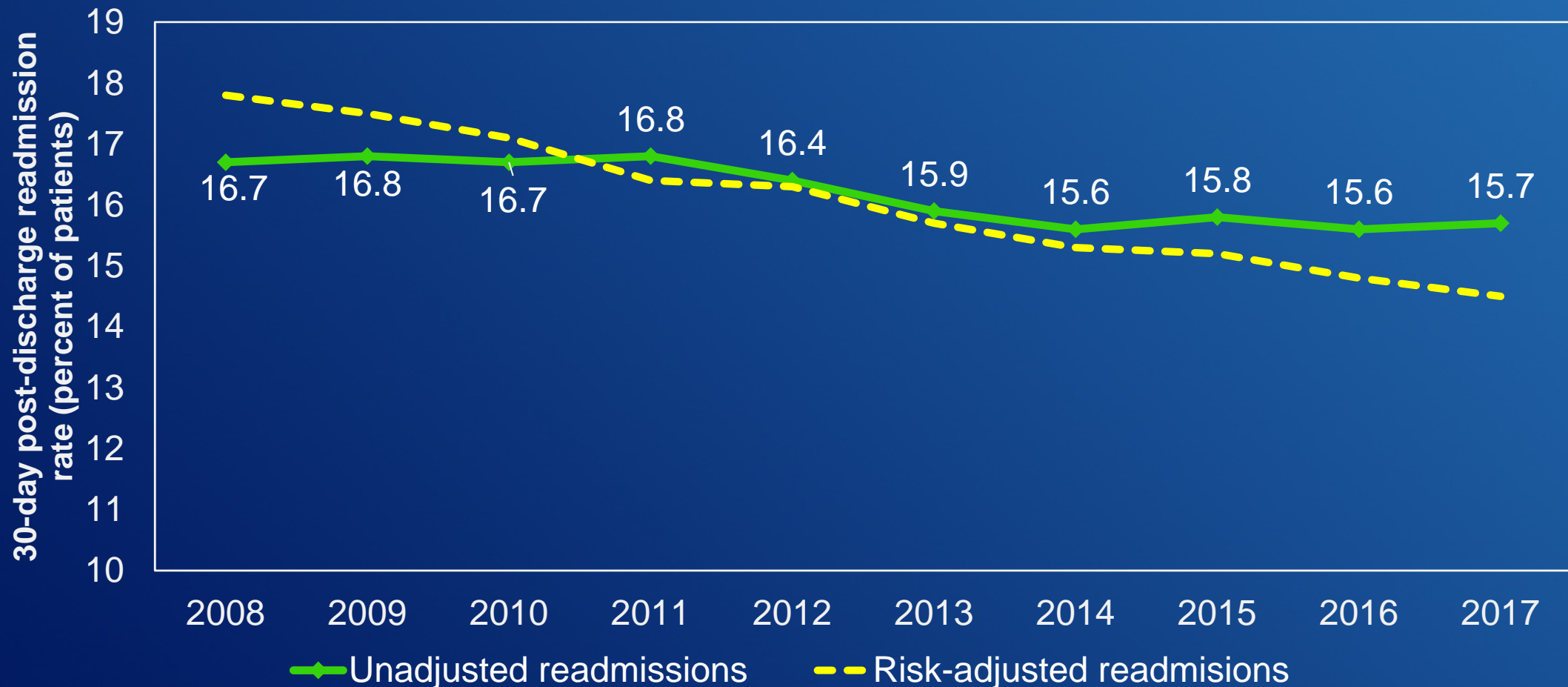
Objectives of the presentation

- Correct understatement of 2016 readmission rates
- Update readmission and mortality rates to reflect 2017 data
- Show that policy implications have not changed
 - Risk-adjusted readmission rates declined.
 - Declining readmissions did not cause an increase in risk-adjusted mortality.
 - The HRRP appears to have met its objectives.

Understatement of 2016 readmission rates

- We understated 2016 readmissions due to excluding readmissions that occurred after the end of the 2016 fiscal year. Mortality rates were not affected.
- Originally, we reported unadjusted unplanned readmission rates for all conditions declining from 16.7 percent in 2010 to 15.0 percent in 2016.
- The corrected rate of decline was from 16.7 percent in 2010 to 15.6 percent in 2016.

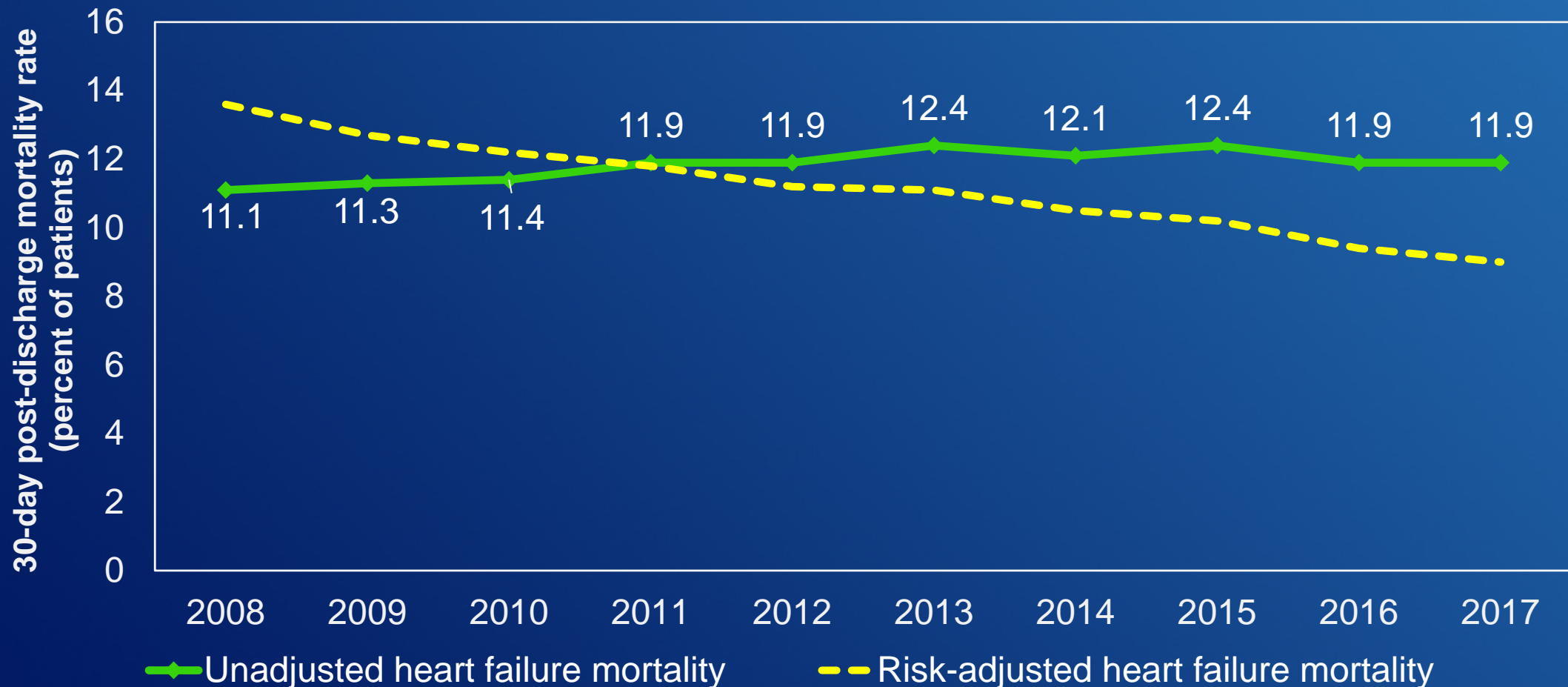
Declines in unadjusted and risk-adjusted unplanned readmissions



Drop in risk-adjusted readmissions may reflect coding, higher patient severity, and improved care

- Some of the increase in reported patient severity was due to increased coding.
- Some of increase in reported severity was real.
 - The rate of admissions per capita declined significantly.
 - Patients were increasingly discharged to hospice care or SNFs (fewer were discharged to home).
- The combination of declining and then flat unadjusted readmission rates, coupled with increasing severity of illness, suggests readmission rates have improved.

Unadjusted heart failure mortality increased, but risk-adjusted mortality declined



Relationship between changes in heart failure readmissions and mortality rates

- Some studies concluded that decreasing readmissions coincided with increasing heart failure mortality rates.
 - These studies focused on post-discharge mortality.
 - Other factors may have affected mortality time trends.
- Hospitals with above-average reductions in readmissions do not have above-average increases in mortality.
- An instrumental variables approach also led to the conclusion that the HRRP did not cause an increase in risk-adjusted mortality.

The 2017 increase in unadjusted COPD and pneumonia mortality may be an artifact of coding



Note: Risk-adjusted rates for both conditions declined (data not shown). COPD (chronic obstructive pulmonary disease).

Source: MedPAC analysis of CMS claims data and denominator file mortality data.

Results preliminary; subject to change

Summary: Under the HRRP risk-adjusted readmissions declined without causing an increase in risk-adjusted mortality

- Unadjusted readmission rates declined after the program was enacted in 2010.
- There are indicators that severity of hospitalized patients has increased.
- Hospitals with greater readmissions declines did not see increasing mortality.
- Therefore, on a risk-adjusted basis it appears that readmissions have declined from 2010 to 2017 without causing an increase in risk-adjusted mortality.

MedPAC's HVIP design

Merge programs:

**Hospital Readmissions
Reduction Program (HRRP)**

**Hospital Value-based
Purchasing (VBP) Program**

**Hospital-Acquired Condition
Reduction Program (HACRP)**

Eliminate program:

**Inpatient Quality Reporting
Program (IQRP)**

Hospital Value Incentive Program (HVIP)

- Include five outcome, patient experience and cost measure domains
 - Readmissions
 - Mortality
 - Spending (MSPB)
 - Patient experience
 - Hospital-acquired conditions
- Set clear, absolute and prospective performance targets
- Account for social risk factors by directly adjusting payment in “peer groups”
- Distribute a pool of dollars to hospitals based on their performance