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Andrew Logan Tobel

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Admitting the Problem with the Hospital Readmissions Reduction Program

By: Andrew Tobel[1]

Introduction

Health care reform is quickly changing the health care landscape. Over sixty-five provisions of the Patient Protection and Affordable Care Act (PPACA) have taken effect since it became law on March 23, 2010, with another fifteen to take effect in 2014.[2] The PPACA represents the biggest legislative reform to take place since enactment of the Medicare and Medicaid programs in 1965. The impact of some provisions has been more dramatic than anticipated. Hospitals argue that the "Hospital Readmission Reduction Program" (HRRP), which was implemented last year, is on the top of their list.[3] This provision hits hospitals where it really hurts: their wallet.

Under the HRRP a hospital's Medicare reimbursements are reduced when a hospital experiences excess readmission rates for certain health conditions denominated by the Secretary of Health and Human Services (HHS).[4] Hospitals, professional practitioners, and academics have criticized the the HRRP. Some argue that the HRRP unjustly places all the blame for excessive costs, presumably due to lack of quality care, on hospitals.[5] Hospitals assert that other providers

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[1] J.D. Candidate, 2014, Seton Hall University School of Law; Health Care Compliance Certified (2013); B.S. Economics, 2011, University of Arizona. The Author wishes to thank Associate Dean Kathleen Boozang, J.D. for her patience and guidance on this topic and her numerous revisions and meticulous editing; Caren Tobel, his wife , for her support and understanding; and Eileen Clifford, M.D., David Adinaro, M.D., and Susan Walsh, M.D., for their participation in a telephone interviews. Andrew Tobel can be reached at andrew.tobel@student.shu.edu.

[2] *Healthcare Reformation Implementation Timeline*, THE HENRY J. KAISER FAMILY FOUNDATION (2010), http://kff.org/interactive/implementation-timeline/ (last visited Mar. 21, 2014).

[3] *See* Jordan Rau, *Armed With Bigger Fines, Medicare To Punish 2,225 Hospitals For Excess Readmissions*, KAISER HEALTH NEWS (Aug. 2, 2013), http://www.kaiserhealthnews.org/stories/2013/august/02/readmission-penalties-medicare-hospitals-year-two.aspx.

[4] 42 U.S.C. §1395ww(q)(4)(C) (2010); 42 U.S.C. §1395ww(q)(5)(A) (2010).

[5] *See generally* Julia Berenson and Anthony Shih, *Higher Readmissions at Safety-Net Hospitals and Potential Policy Solutions*, THE COMMONWEALTH FUND (Dec. 2012) (noting that processes implemented at the hospital and community provider level, such as through ACOs and bundle payments, can reduce readmissions.)

must also provide quality health care post-discharge to reduce readmission rates and to keep costs down.[6]

Part I of this Note introduces Medicare and its reimbursement mechanisms, showing how such mechanisms affect provider behavior, thereby contributing to high or unconstrained spending. Part II of this Note discusses concerns about Medicare spending and Congress's solution to the costs of the Medicare program. Specifically, Part II discusses the HRRP, the methodology used to calculate HRRP reimbursement reduction penalty, and New Jersey's readmission rate problem. Part III of this Note looks at the economics of the HRRP, surveys how hospitals are responding, and discusses the practices New Jersey hospitals are implementing to reduce readmissions. Lastly, this Note concludes by discussing how the HRRP should be changed by redefining the Risk Adjustment Factor or converting to a peer review standard, rather than a national standard, to determine the reimbursement reduction penalty.

I. Part I

Medicare was established in 1965 under Title XVIII of the Social Security Act as a public health insurance program.[7] Medicare consists of four parts. Individuals qualify for Part A if they are sixty-five years and over, have worked for forty quarters in Medicare covered employment and are U.S. citizens or permanent legal residents, regardless of medical history, preexisting conditions, assets, or income.[8] Under limited circumstances an individual under sixty-five may qualify for Medicare Part A.[9]

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[6] Telephone Interview with Eileen Clifford, M.D., Medical Director of Care Management, Saint Joseph's Medical Regional Medical Center (Nov. 4, 2013).
[7] *Medicare: A Primer*, THE HENRY J. KAISER FAMILY FOUNDATION 1 (2010), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7615-03.pdf.
[8] *Id.* at 2.
[9] Persons under age 65 who have a permanent disability, end-stage renal disease (ESRD), or Lou Gehrig's disease (ALS) are also eligible for Medicare benefits, with certain illness specific benefit restrictions. A person with a

A qualified beneficiary under Medicare Part A receives coverage for hospital care, skilled nursing facility care, non-custodial nursing home care, hospice, and home health services.[10] In 2011 Medicare spent $552 billion on health care of which over $139.7 billion was spent on inpatient hospital stays.[11] Medicare Part A is federally funded through payroll taxes, income taxes on social security benefits, and premiums.[12] However, even with all these sources, Medicare funding is precarious for two reasons.

First, when Medicare was enacted there were four workers paying into the system for every retiree.[13] In 2010, that ratio dropped to 2.9 to 1.[14] By 2030, it is expected that only 2.3 people will be paying into public insurance programs for every beneficiary.[15] Second, Medicare spending continues to grow at a rate greater than inflation.[16]

Medicare already accounts for over 15 percent of federal spending.[17] The rise in Medicare spending will continue to put a strain on the federal budget.[18] It is estimated that at the current spending rate Medicare will become insolvent by 2026.[19]

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permanent disability must wait 24 months after receiving Social Security Disability Income (SSDI) until they qualify for receiving Medicare Benefits, notwithstanding failure to make payroll tax contributions for forty quarters. However, individuals with ESRD or ALS may begin receiving Medicare benefits as soon as they receive SSDI payments. *Id.*

[10] *What does Medicare Part A Cover?*, MEDICARE.GOV, http://www.medicare.gov/what-medicare-covers/part-a/what-part-a-covers.html (last visited Nov. 5, 2013).

[11] Medicare Payment Advisory Comm'n, Report to the Congress: A Date Book: Health Care Spending and the Medicare Program 3-5 (2013), *available at* http://www.medpac.gov/documents/Jun13DataBookEntireReport.pdf.

[12] *How is Medicare funded?*, CTRS. FOR MEDICARE AND MEDICAID SERVS., http://www.medicare.gov/about-us/how-medicare-is-funded/medicare-funding.html (last visited Sept. 29, 2013).

[13] *Frequently Asked Questions: Ratio of Covered Workers to Beneficiaries,* SSA.GOV http://www.ssa.gov/history/ratios.html (last visited Nov. 6, 2013).

[14] *Id.*

[15] Avik Roy, *Saving Medicare from Itself*, 8 NAT'L AFF. 35, 35 (2011).

[16] Robert E. Moffit & Alyene Senger, *Medicare's Rising Costs—and the Urgent Need for Reform*, 2779 THE BACKGROUNDER 1, 2 (Mar. 22, 2013); Roy, *supra* note 15, at 35.

[17] Moffit & Senger, *supra* note 16, at 2.

[18] Report to Congress: Reforming the Delivery System: Before the S. Comm. on Fin., 3 (2008) (statement of Mark Miller, Executive Director Medicare Payment Advisory Commission) [hereinafter Miller Report].

[19] Brett Norman, *Medicare Exhausted in 2026, Trustees Say*, POLITICO (May 31, 2013 11:10 AM), http://www.politico.com/story/2013/05/medicare-exhausted-2026-trustees-92066.html.

The Medicare Payment Advisory Commission (MedPAC) is an independent Congressional federal body that advises Congress on issues affecting Medicare.[20] In order to prevent insolvency, MedPAC has been determining how to reduce costs.[21] MedPAC's 2007 annual report made several suggestions on how to increase efficiency and decreases costs to help reduce Medicare spending.[22]

For example, MedPAC has recommended that reducing hospital in-patient readmissions can reduce Medicare spending.[23] Consequently, the HRRP was enacted as part of the PPACA.[24] This provision has a large impact on hospitals.[25] How hospitals receive funding under the Medicare Payment system must be reviewed to understand why the HRRP has such great consequences.

a. Medicare Payment Systems

Medicare is a major source of hospital revenues.[26] Under Medicare Part A, a hospital is reimbursed for Medicare beneficiaries admitted on an inpatient basis for medically necessary treatment.[27] Hospitals receive reimbursement for services provided to Medicare beneficiaries under a Prospective Payment System (PPS).[28] Payments are only made for the amount that

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[20] Medicare Payment Advisory Comm'n, Report to the Congress: Promoting Greater Efficiency in Medicare ii (2007), *available at* http://www.medpac.gov/documents/Jun07_EntireReport.pdf [hereinafter MedPAC 2007 Report].
[21] *See Id.* at 103-05.
[22] Miller Report , *supra* note 18, at 4-7.
[23] *See* MedPAC 2007 Report, *supra* note 20, at 103-05.
[24] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111- 148, § 3025, 124 Stat. 119 (2010).
[25] *Id.*
[26] Symposium, *Hospital Cost Containment in Iowa: A Guide for State Public Policymakers*, 69 IOWA L. REV. 1263, 1291 (1984).
[27] 42 U.S.C. 1395f (2012); 1869 AM. JUR. 2D *Soc. Security and Medicare* § 1927 (2014).
[28] *Prospective Payment Systems - General Information*, CTRS. FOR MEDICARE AND MEDICAID SERVS., http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html (last visited Nov. 7, 2013).

reflects the reasonable cost of providing such treatment.[29] The payments are determined by diagnosis-related group (DRG) payment schedules.[30] A DRG accounts for the "principal diagnosis, complicating or comorbid conditions, surgical procedures, age/sex and discharge status."[31] Thus, in a very generalized way, hospitals are not reimbursed for the actual cost of a patient's care, but rather for what it should have cost to care for the patient based upon the assigned DRG.[32] Consequently, the hospital loses money if the cost of the actual length of the patient's stay, or quantity of services ordered by the physician, exceeds what Medicare reimburses for that specific DRG code. Thus, under the PPS system, hospitals focus on "maximizing the overall profit from each Medicare patient" by discharging patients as quickly as possible.[33]

Medicare pays doctors, on the other hand, on a fee-for-service (FFS) payment system. Under this system doctors receive funds under a "comprehensive listing of fee maximums" which "is used to reimburse a physician and/or other providers" based on the services provided.[34] Unlike hospitals, doctors are not paid based on the value of the service provided but rather on the volume of service provided.[35] "The traditional program's fee-for-service payment system … encourages an increase in the volume of services requested, which encourages excessive

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[29] Medically necessity is determined by a peer review organization that independently oversees each hospital. 1869 AM. JUR. 2D *Soc. Security and Medicare* § 1927 (2012).
[30] 42 C.F.R. 412.60 *et seq.* (2012).
[31] *Glossary of Terms*, STANFORD UNIVERSITY HOSPITAL (1998), http://med.stanford.edu/shs/update/archives/feb98/glossary.htm (last visited Sept. 20, 2013).
[32] U.S. DEP'T OF HEALTH AND HUMAN SERVS., MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM: HOW DRG RATES ARE CALCULATED AND UPDATED (2001), *available at* http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf.
[33] RICK MAYES & ROBERT A. BERENSON, MEDICARE PROSPECTIVE PAYMENT AND THE SHAPING OF U.S HEALTH CARE 48 (2006).
[34] *Fee Schedules - General Information*, CTRS. FOR MEDICARE AND MEDICAID SERVS., http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html (last visited Nov. 7, 2013).
[35] Robert E. Moffit & Alyene Senger, *Medicare's Rising Costs—and the Urgent Need for Reform*, 2779 THE BACKGROUNDER 1, 2 (Mar. 22, 2013);

spending."[36] Therefore, the reimbursement mechanisms for hospitals and doctors are misaligned – the system financially penalizes hospitals but rewards physicians for the provisions of excessive services.[37]

For this reason, Medicare's spending continues to increase not only because of the rise in health care costs but largely because of the rise in number of services provided.[38] In fact, a 2007 study by the Congressional Budget Office determined that fees paid by Medicare Part B decreased, as a result of the Sustainable Growth Rate, but that the total cost of services paid by the program increased 34.5 percent.[39] This demonstrates that doctors have been increasing the volume of services provided.

A tension exists between hospitals and doctors because of the difference in pay systems. Hospitals know the amount of reimbursement they will receive based on the DRG assigned. Therefore hospitals want to discharge Medicare beneficiaries before the cost of treatment is greater than the DRG reimbursement. However, doctors are incentivized to keep patients and provide more "services" because they are paid under a FFS system.

Some hospitals have dealt with this issue through controversial economic credentialing, whereby physicians' practice patterns are taken into account when they seek reappointment to the medical staff.[40] Some hospitals attempted to engage in profit-sharing with physicians, which the IRS quickly declared illegal for tax-exempt hospitals, as private inurement, and HHS deemed to constitute illegal remuneration under the anti-kickback statutes.[41]

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[36] *Id.*
[37] Avik Roy, *Saving Medicare from Itself*, 8 NAT'L AFF. 35, 42 (2011).
[38] *See Id.* at 41.
[39] CONGRESSIONAL BUDGET OFFICE, Pub. No. 2597, FACTORS UNDERLYING THE GROWTH IN MEDICARE'S SPENDING FOR PHYSICIANS' SERVICES 2 (2007).
[40] *See generally* Mark L. Mattioli, ECONOMIC CREDENTIALING, CONFLICT-OF-INTEREST POLICIES, AND HOSPITAL-PHYSICIAN COMPETITION: ANTITRUST ISSUES AND PITFALLS (2009) (discussing how hospitals view economic credentialling as necessary to stay competitive).
[41] *See* 42 U.S.C. § 1320a-7(b) (2012); 26 C.F.R. 1.501(c)(3)-1(c)(2) (2012).

More current schemes involve gainsharing with physicians, an arrangement where hospital gives physicians a percentage of any reduction in the hospital's costs for patient care which can be attributed to the efforts of the physician.[42] The HHS has been suspicion of these programs as well.[43] While the Office of the Inspector General (OIG) has approved some gainsharing programs, the analysis of each program is highly fact-specific.[44] The OIG believes that some programs may reduce access to services or new technology.[45] Hospitals are faced with civil monetary penalties for schemes that encourage reduction in care provided to a patient.[46]

Therefore, hospitals have few legal means to encourage changes in physician practice patterns that are not to their financial advantage. Regardless of how hospitals have developed physician cooperation, the end game is the same; hospitals seek to discharge patients as soon as possible so that the cost of care is below the DRG reimbursement.

Part of the PPACA's purpose was to address this realignment, and eliminate the financial incentives which perversely increase the cost of care. This was done by replacing past payment structures with financial incentives and penalties that reward quality care. For example, global payments, whereby all providers in the continuum of care will have to work together to provide patients with quality care in the most cost-efficient manner, is one way to transition away from FFS payments.[47] The purpose behind these programs or new payment schedules is to reduce

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[42] *Gainsharing*, AMERICAN HEALTH LAWYERS ASSOCIATION, http://www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Gainsharing.aspx (last visited Mar. 27, 2014).
[43] The Office of the Inspector General has exercised caution on whether to impose Civil Monetary Penalties for such programs. Id.
[44] Id.
[45] Id.
[46] Id.
[47] Michael Chernew & Dana Goldman, *Proposal 1: Transitioning to Bundled Payments in Medicare*, *in* 15 WAYS TO RETHINK THE FEDERAL BUDGET 12 (Michael Greenstone et al. eds., 2013)

costs. Through these bundle payment programs, provider systems are presented with new opportunities to develop systematic processes that help to avoid and reduce readmissions.[48]

The Centers for Medicare & Medicaid Services (CMS) has been serially focusing on specific practice patterns that are perceived to be particular culprits of unnecessarily high costs. CMS is concerned with readmissions because the DRG payment system encourages hospitals to discharge patients prematurely, as discuss above.[49] Under the old DRG payment system, hospitals are paid on a per admission basis.[50] Therefore, hospitals had no incentive to reduce readmissions.[51] In fact, a hospital that is not at full capacity has an incentive not to reduce readmissions because a new patient coming through the door means an increased stream of revenue.[52] The HRRP seeks to encourage hospitals to reduce readmissions or face a penalty.[53] MedPAC believes that preventing one out of every ten readmissions would save over one billion dollars annually.[54]

II. PART II

In 2007, MedPAC issued a report to Congress outlining how avoidable readmissions were adversely affecting the Medicare Program.[55] The report noted that nearly 20 percent of

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[48] Berenson, *supra* note 5, at 9-10.
[49] Becky S. Cornett, *Managing Hospital Readmissions: An Overview of the Issues*, 13 J. OF HEALTH CARE COMP. 5, 12 (2011)002E
[50] *Id.* at 13.
[51] *See* MedPAC 2007 Report, *supra* note 20, at 105; Jordan Rau, *Medicare To Penalize 2,217 Hospitals For Excess Readmissions*, KAISER HEALTH NEWS (Aug. 13, 2012), http://www.kaiserhealthnews.org/stories/2012/august/13/medicare-hospitals-readmissions-penalties.aspx.
[52] Robert Berenson et al., *Medicare's Readmissions-Reduction Program — A Positive Alternative*, 366 N. ENGL. J. MED. 1364, 1364 (2012).
[53] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111- 148, § 3025, 124 Stat. 119 (2010).
[54] Medicare Payment Advisory Comm'n, Report to the Congress: Refining the Hospital Readmissions Reduction Program 96 (2013), *available at* http://www.medpac.gov/chapters/Jun13_Ch04.pdf [hereinafter MedPAC 2013 Report].
[55] MedPAC 2007 Report, *supra* note 20, at 103.

Medicare patients are readmitted within a month of their initial discharge.[56] These readmissions account for over $17 billion in Medicare spending annually.[57] In an effort to curtail this ostensibly preventable spending, MedPAC recommended that Congress adopt a two-part policy to reduce Medicare spending attributable to hospital readmissions.[58]

First, MedPAC proposed that Congress require hospitals to report "hospital-specific readmission rates for a subset of conditions."[59] There are many instances in which quantifying a behavior can contribute to changing that behavior, especially where the opportunity exists for comparative analysis.[60] Congress codified this recommendation,[61] and these reports are now available for every hospital covered by the HRRP at CMS's Hospital Compare website.[62] MedPAC expects providers to use this information "to adjust their practice styles and coordinate care to reduce service use."[63]

Second, MedPAC proposed that Congress adjust the underlying payment method to financially encourage hospitals to reduce readmission rates.[64] The suggestion was that a proposed penalty scheme would reduce payments for hospitals that had "high readmissions rate[s] for select conditions."[65]

In 2008 the Executive Director of MedPAC addressed the Senate Committee on Finance noting that Medicare's FFS payment system "reward(s) providers who increase the volume of

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[56] Jordan Rau, *Medicare To Penalize 2,217 Hospitals For Excess Readmissions*, KAISER HEALTH NEWS (Aug. 13, 2012), http://www.kaiserhealthnews.org/stories/2012/august/13/medicare-hospitals-readmissions-penalties.aspx.
[57] Robert Berenson et al., *Medicare's Readmissions-Reduction Program — A Positive Alternative*, 366 N. ENGL. J. MED. 1364, 1364 (2012).
[58] MedPAC 2007 Report, *supra* note 20, at 103.
[59] MedPAC 2007 Report, *supra* note 20, at 103.
[60] *E.g.*, MAYES, *supra* note 33, at 48-53 (discussing the increased competition between hospitals as a result of the implementation of PPS system which lead to reduced costs).
[61] 42 U.S.C. §1395ww(q)(6) (2012).
[62] *Id.*; *See Hospital Readmissions Reduction Program: Overview*, QUALITYNET http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458 (last visited Sept. 19, 2013).
[63] Miller Report , *supra* note 18, at 13.
[64] MedPAC 2007 Report, *supra* note 20, at 103-04.
[65] Miller Report , *supra* note 18, at 14.

services they provide regardless of the benefit of the service."[66] These statements in conjunction with MedPAC's 2007 report sufficiently highlighted the negative effects that hospital readmissions have on the quality and cost of health care. Congress reacted by adding the "Hospital Readmissions Reduction Program" to the PPACA.[67]

a. Hospital Readmissions Reduction Program

There is a heavy cost for excessive readmissions rates under the HRRP.[68] The HRRP adjusts the Medicare payments (a.k.a. Total Base Operating DRG Payment) a hospital receives through the inpatient prospective payment system when readmission rates are higher than expected.[69] The penalties are based on the readmissions rates for Medicare patients who are readmitted into a hospital with one of three diagnoses.[70] Currently, those three conditions are pneumonia (PN), acute myocardial infarction (AMI), and heart failure (HF).[71] The statute defines a "readmission" as a patient that returns to *any* hospital within thirty days of a discharge who is readmitted as an inpatient.[72] However, readmissions "that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital)," are not considered readmission for the purpose of calculating the readmission rate.[73]

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[66] *Id.* at 4.
[67] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111- 148, § 3025, 124 Stat. 119 (2010).
[68] *See* Rau, *supra* note 3.
[69] 42 U.S.C. § 1395ww(q) (2012).
[70] 42 U.S.C. § 1395ww(q)(5)(A)(i) (2012).
[71] *Readmissions Reduction Program*, CTRS. FOR MEDICARE AND MEDICAID SERVS., http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html (last visited Feb. 1, 2014). To be selected as an applicable condition must be a condition or procedure "for which (1) readmissions are 'high volume or high expenditure'; and (2) 'measures of such readmissions' have been endorsed by the entity with a contract under section 1890(a) of the Act (currently [the National Quality Forum]) and (3) such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital)." 76 Fed. Reg. 51476, 51665 (Aug. 18, 2011).
[72] 42 U.S.C. § 1395ww(q)(5)(E) (2012).
[73] 42 U.S.C. § 1395ww(q)(5)(A)(ii)(II) (2012).

The HHS selected the three current applicable conditions for two reasons. First, according to CMS, the three diagnoses are the most common ailments among Medicare beneficiaries.[74] Reducing readmissions for these patients will create the greatest decrease in costs because these conditions are the most common. Second, these three conditions were extensively reported on from 2009 to 2012 to the Medicare Hospital Compare website.[75] CMS believes that the extensive reporting allowed hospitals adequate time to implement systems to reduce readmission rates.[76]

b. Methodology

It is important to understand the methodology for how CMS calculates the Total Base Operating DRG Payment, Readmission Adjustment Factor and Excess Readmission Ratio.[77] This section first analyzes how the HRRP adjustment factor affects the Base Operating DRG Payment a hospital receives and the results from the first two years of experience with the HRRP program. Subsequent sections will further analyze how the Readmission Adjustment Factor, its component parts, and the Excess Readmission Ratio are calculated. Through an understanding of this methodology, it becomes apparent how the government's policy goals are accomplished. Specifically, how the adopted risk adjustment methodology has a large impact on the overall Readmission Payment Adjustment.

i. Calculating Total Base Operating DRG Payment

[74] Cornett, *supra* note 49, at 5.
[75] MedPAC 2013 Report, *supra* note 54, at 97. Specifically the CMS "[e]stablished an applicable period of three years of discharge data and the use of a minimum of 25 cases to calculate a hospital's excess readmission ratio of each applicable condition." *Readmissions Reduction Program, supra* note 71.
[76] *See* 76 Fed. Reg. 51476, 51664 (Aug. 18, 2011).
[77] "DRG payments" are the IPPS payments a hospital would receive minus disproportionate share hospital payments, Indirect Medical Education, and outlier payments. This note ignores other DRG Payment calculation factors for simplicity and only assesses DRG Payments made for discharges. *See* Nikhil Sahni et al., *Will The Readmission Rate Penalties Drive Hospital Behavior Changes?*, HEALTH AFFAIRS BLOG (Feb. 14, 2013), http://healthaffairs.org/blog/2013/02/14/will-the-readmission-rate-penalties-drive-hospital-behavior-changes/.

Before the HRRP was enacted, hospitals received payments for all discharges based on reported DRGs.[78] Now the HRRP affects the Total Base Operating DRG Payment a hospital receives through a penalty, the Readmissions Payment Adjustment.[79] CMS applies a Readmission Payment Adjustment to hospitals that exhibit excessive readmissions rates for applicable conditions.[80] The fine takes the shape of a percent reduction in reimbursement – it changes each year.[81]

The Total Base Operating DRG Payment a hospital receives under the HRRP is equal to the product of the Base Operating DRG Payment Amount and the Readmission Adjustment Factor.[82] Even though CMS limits its analysis of actual readmission rates to the three applicable conditions, it assesses the penalty to *all* DRG Payments.[83] The reductions differ from hospital to hospital because each hospital's Readmission Adjustment Factor is different.[84]

ii. Calculating the Readmission Adjustment Factor

The Readmission "[A]djustment [F]actor . . . is equal to the greater of . . . the [R]atio . . . or the [F]loor [A]djustment [F]actor" for the given year.[85] The Ratio is equal to one minus the Aggregate Payments for Excess Readmissions and the Aggregate Payments for all Discharges.[86]

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[78] *See* Jane Hyatt Thorpe & Teresa Cascio, *Hospital Readmissions Reduction Program*, HEALTH REFORM GPS (Nov. 1, 2011), http://www.healthreformgps.org/resources/hospital-readmissions-reduction-program/.
[79]42 U.S.C. § 1395ww(q)(1)(A)-(B) (2012).
[80] Rau, *supra* note 3.
[81] 42 U.S.C. § 1395ww(q)(3)(C)(i)-(iii) (2012).
[82] Mathematically represented as follows: Payment = Base Operating DRG Payment Amount * Readmissions Payment Adjustment Factor). 42 U.S.C. § 1395ww(q)(1).
[83] 42 U.S.C. § 1395ww(q)(1) (2012); *See Readmissions Reduction Program, supra* note 71.
[84] *See* 42 U.S.C. § 1395ww(q)(3)(A) (2012).
[85] 42 U.S.C. § 1395ww(q)((3)(A)(i)-(ii) (2012).
[86] Aggregate Payments for Excess Readmissions is defined as "for a hospital . . . for applicable conditions . . . of the product of the base operating DRG payment . . . and the number of admissions … and the excess readmissions ratio minus one," for each applicable condition. 42 U.S.C. § 1395ww(q)(4)(A) (i)-(iii) (2012). Mathematically represented as follows: Aggregate payments for excess readmissions = [sum of base operating DRG payments for AMI x (excess readmission ratio for AMI-1)] + [sum of base operating DRG payments for HF x (excess readmission ratio for HF-1)] + [sum of base operating DRG payments for PN x (excess readmission ratio for PN-1)]. *Readmission Reductions Program, supra* note 71. Aggregate Payment for all Discharges means "the sum of the base

As defined, the Ratio is capped by the statute. Therefore, for fiscal year 2012, the maximum penalty a hospital could be assessed was one percent of its Medicare DRG Payment, i.e. an adjustment factor of .99.[87] This means a hospital only received 99 percent of its Medicare DRG payments. If the Ratio, for fiscal year 2012, was greater than the .99 floor adjustment factor, then a penalty of less than 1 percent would be applied. For fiscal year 2013 and 2014 this penalty will increase to 2 and 3 percent, respectively.[88]

Over 2,225 hospitals received a reimbursement reduction for the 2012 fiscal year.[89] This totaled $280 million in penalties that Medicare collected from hospitals with excessive readmission rates.[90] It is expected that Medicare will collect $227 million for the 2013 fiscal year, when the penalty cap increases to two percent.[91]

iii. Calculating Excess Readmission Ratio

The Excessive Readmission Ratio, a key component to determine the Aggregate Payment for Excess Readmission, is defined as "the ratio (but not less than 1.0) of . . . the risk adjusted readmissions based on actual readmissions . . . to the risk adjusted expected readmissions."[92]

The most important language in this statute is that the PPACA does allow for risk adjustments for factors affecting a hospital's readmission and expected readmission rate.[93] CMS

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operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period." 42 U.S.C. § 1395ww(q)(4)(B). 42 U.S.C. § 1395ww(q)(3)(B)(i)-(ii). Therefore the Ratio is mathematically represented as follow: $Ratio = 1 - \frac{\text{aggregate payments for excess readmissions}}{\text{aggregate payments for all discharges}}$. *Readmissions Reduction Program, supra* note 71.

[87] 42 U.S.C. § 1395ww(q)(3)(C)(i)-(iii) (2012).

[88] *Readmissions Reduction Program, supra* note 71.

[89] Rau, *supra* note 3.

[90] Rau, *supra* note 56.

[91] Julia James, *Health Policy Brief: Medicare Hospital Readmissions Reduction Program*, HEALTH AFFAIRS (Nov. 12, 2013), *available at* http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_102.pdf.

[92] 42 U.S.C. § 1395ww(q)(4)(C)(i)(I)-(II) (2012). Mathematically, the excess readmission ratio is expressed as $\frac{\text{risk-adjusted predicted readmissions}}{\text{risk-adjusted expected readmissions}}$. *Readmissions Reduction Program, supra* note 71.

asserts that the risk adjustment performed "'levels the playing field' for comparing hospital performance."[94] The risk adjustment factors for each hospital's expected readmission rate currently include patient demographic characteristics, comorbidities, and patient frailty.[95] This final rate is called the Risk Adjusted Expected Readmission Rate.[96] In simplistic terms, this means that the Risk Adjusted Expected Readmission Rate is the average rate of hospitals with the same patient mix, where patient mix is determined by age, comorbidity, and patient frailty.

iv. Policy decisions for Risk Adjustment

How readmissions and expected readmissions are risk adjusted has a large impact on the Total Base Operating DRG Payment a hospital receives. The methodology for determining risk adjustment for these figures presents a key opportunity to implement government policy.[97] The National Quality Forum (NQF) is "a nonprofit, nonpartisan, public service organization" that "reviews, endorses, and recommends use of standardized healthcare performance measures."[98] CMS adopted and finalized the NQF's proposed risk-adjustment methodology in its FY 2012 IPPS Final Rule.[99]

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[93] *Readmissions Reduction Program, supra* note 71. "[T]he risk adjusted expected readmissions based on actual readmissions" are determined in a manner "consistent with a readmission measure methodology that" is endorsed by an entity under contract. The National Quality Forum (NQF) is the current entity under contract, codified at 42 U.S.C. 1395aaa(a), and has broad discretion to endorse methodologies. 42 U.S.C. § 1395ww(q)(4)(C)(i)(I)-(II) (2012); 42 U.S.C. § 1395ww(q)(5)(A)(ii)(I) (2012).

[94] 76 Fed. Reg. 51476, 51670 (Aug. 18, 2011).

[95] *Readmission Reductions Program, supra* note 71.

[96] Sahni, *supra* note 77. To calculate the adjustment factor for Fiscal Year 2014, CMS is excluding planned readmissions, which are known at the time of discharge, from the calculation of the risk-adjusted readmission rate. Jordan Rau, *Sources and Methodology: A Guide To Medicare's Readmissions Data And KHN's Analysis*, KAISER HEALTH NEWS (Aug. 2, 2013), http://www.kaiserhealthnews.org/Stories/2013/August/02/readmission-penalties-methodology.aspx.

[97] Currently, the NQF is under contract, pursuant to 42 USC 1395aaa(a), and proposes risk-standardized readmission measures for the three applicable conditions under the HRRP. 76 Fed. Reg. 51476, 51668 (Aug. 18, 2011).

[98] *Who We Are*, QUALITY FORUM, http://www.qualityforum.org/who_we_are.aspx (last visited Feb. 3, 2014).

[99] 76 Fed. Reg. 51476, 51671 (Aug. 18, 2011).

However, many commenters to the final rule argue that the risk adjustment that was proposed, and subsequently adopted, is insufficient.[100] Commenters suggest that the risk adjustment needs to include "patient race, language, life circumstances, environmental factors, and socioeconomic status" to truly level the playing field.[101] Critics are concerned that the HRRP will "disproportionately affect hospitals serving a large number of minorities," and thus "by penalizing these hospitals, the program" will disproportionately harm minority patients.[102]

CMS does not believe that the adopted risk adjustments harm minorities.[103] CMS asserts that the risk adjustments "are risk-standardized readmission measure[s] that adjust . . . age, sex, comorbid disease and indicators of patient frailty" that have a "strong relationship[] with the outcome."[104] CMS believes that other factors, such as race, socioeconomic status, and English language proficiency are not appropriate to capture in the Risk Adjustment Factor.[105] Critics of the current risk adjustment assert that socioeconomic status affects readmission rates because low-income patients lack access to primary care physicians, post-discharge medication and transportation for follow-up appointments.[106] CMS counters that the "association between such patient factors and health outcomes" is due to "differences in the quality of health care received" and that "better quality of care is achievable regardless" of such factors.[107]

Relatedly, other critics assert that the current risk adjustment structure is insufficient in regard to safety net hospitals.[108] Commenters believe such categories of hospitals are at an increased risk of receiving penalties under the HRRP because "their patients are sicker, lack

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[100] *Id.* at 51670.
[101] *Id.*
[102] *Id.*
[103] *Id.*
[104] *Id.*
[105] 76 Fed. Reg. 51476, 51670 (Aug. 18, 2011).
[106] *CMS Begins Penalizing Hospitals for Readmissions*, POLICYMED (Aug. 29, 2012), http://www.policymed.com/2012/08/cms-begins-penalizing-hospitals-for-readmissions.html.
[107] 76 Fed. Reg. 51476, 51670 (Aug. 18, 2011).
[108] *Id.* at 51671.

access to appropriate post-discharge care, may suffer numerous chronic conditions, and may have substance abuse or behavioral problems."[109] This proposition is supported by Kaiser Health News' analysis of the penalties assessed in the first year of the HRRP.[110] Kaiser Health News separated hospitals into four groups based on a CMS index which determines whether a hospital "deserves extra payments for treating large numbers of low-income patients."[111] Over 12 percent of hospitals in the group with the most low-income patients received the maximum penalty for excess readmissions compared to only 7 percent of hospitals in the group that treat the fewest poor patients.[112] Kaiser Health News' found that safety net hospitals were more likely to receive a penalty of any size than non-safety net hospitals.[113] During the HRRP's second year of penalties Kaiser Health News' analysis revealed that over 77 percent of safety net hospitals were penalized compared to only 36 percent of hospitals treating the fewest poor patients.[114] Critics of the current risk adjustment assert that socioeconomic status effect readmission rates because low-income patients lack access to primary care physicians, post-discharge medication and transportation for follow-up appointments.[115]

However, CMS does not accept that the HRRP's current risk adjustment methodology has a disparate impact on safety net hospitals.[116] CMS suggests that many safety net hospitals perform as well on readmission measures as non-safety net hospitals that have fewer at-risk

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[109] *Id.*
[110] Jordan Rau, *Hospitals Treating The Poor Hardest Hit By Readmissions Penalties*, KAISER HEALTH NEWS (Aug. 13, 2012), http://www.kaiserhealthnews.org/Stories/2012/August/13/hospitals-treating-poor-hardest-hit-readmissions-penalties.aspx.
[111] *Id.*
[112] *Id.*
[113] *Id.*
[114] Rau, *supra* note 3.
[115] *CMS Begins Penalizing Hospitals for Readmissions*, *supra* note 106.
[116] *See* 76 Fed. Reg. 51476, 51670-71 (Aug. 18, 2011).

patients.[117] For example, Denver Health Medical Center (Denver Health), a safety net hospital, has historically had low readmission rates.[118]

Denver Health has been able to obtain such low readmission rates because of its highly integrated system; which includes eight community primary care clinics.[119] Further, Denver Health operates at extremely tight margins and is usually at full capacity, creating strong financial incentives to keep readmissions low.[120] Lastly, Denver Health was an early adopter of electronic medical records which allows it to easily coordinate care post-discharge.[121] Essentially Denver Health had already positioned itself to meet HRRP requirements "through its own network of family health centers and clinics in economically disadvantaged neighborhoods;" something that many safety net hospitals cannot easily replicate.[122]

CMS asserts that the current risk adjustment measure accounts for the likelihood that certain patient groups have a greater disease burden because of their race and/or socioeconomic status. Therefore, CMS affirmatively refuses to risk adjust for race and socioeconomic status. CMS believes doing so would essentially "hold hospitals to different standards for the outcomes of their patients of low socioeconomic status."[123] CMS also believes that allowing risk adjustment for race and socioeconomic status could "mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations."[124] Despite the suggested

[117] *Id.* at 51671. CMS cites to the Medicare Hospital Quality Chartbook 2010, pages 14 through 19, which suggests, at best, "that hospitals with a higher share of lower income patients can perform at least as well on readmission measures." The analysis only looked at hospitals that disproportionately serve African-American and low-income individuals. No other races or factors were studied. *Medicare Hospital Quality Chartbook 2010*, YALE NEW HAVEN HEALTH SYSTEM CORPORATION (2010), *available at* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/downloads/HospitalChartBook.pdf.
[118] Rau, *supra* note 3.
[119] *CMS Begins Penalizing Hospitals for Readmissions*, *supra* note 106.
[120] *Id.*
[121] *Id.*
[122] *See* Berenson, *supra* note 5, at 8.
[123] 77 Fed. Reg. 53258, 53378 (Aug. 31, 2012).
[124] *Id.*

insufficient nature of the risk adjustment factors, CMS adopted the proposed NQF risk adjusted methodology which only takes age, comorbidity, and patient frailty into account.[125]

c. New Jersey's Readmission Rates Problem

New Jersey hospitals are experiencing some of the largest fines HRRP penalties. New Jersey has a wide variation of readmission rates – 15.8 percent to 25 percent of patients are readmitted within thirty days.[126] In fact, only two hospitals avoided fines in 2013 and only five are expected to have improved enough to incur no fine in 2014.[127] That means that 92 percent of hospitals in New Jersey are being assessed fines.

In fact, the average New Jersey hospital was hit with a .66 percent adjustment factor. [128] This is tied for the third worst average penalty by state.[129] The story gets worse from there. A statistically higher percentage of New Jersey hospitals were hit with the maximum penalty in fiscal year 2013 when compared to other states.[130]

CMS estimated that only 8.8 percent of hospitals nationally would receive the maximum penalty.[131] However, in New Jersey, twenty-two out of sixty-four, or 34.375 percent of hospitals, experienced the maximum penalty in 2013.[132] Whereas the next worst state, Kentucky, only

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[125] 76 Fed. Reg. 51476, 51671 (Aug. 18, 2011).
[126] Beth Fitzgerald, *Reigning in Readmissions at New Jersey Hospitals*, NJ SPOTLIGHT (April 30, 2012), http://www.njspotlight.com/stories/12/0429/2056/.
[127] *Readmissions Penalties by State: Year Two*, KAISER HEALTH NEWS (Aug. 02, 2013), http://www.kaiserhealthnews.org/Stories/2013/August/02/readmission-penalties-by-state-year-two.aspx (analyzing data from the Centers for Medicare & Medicaid Services).
[128] *Id.*
[129] Only Kentucky and Arkansas had equal or worse average penalties, however, a higher percentage of New Jersey Hospitals were penalized – ninety-two percent compared to only eighty-eight and eighty-two percent for Kentucky and Arkansas, respectively. *Id.*
[130] *Id.*
[131] Sahni, *supra* note 77.
[132] *Medicare Readmission Penalties by Hospital (Year 2)*, KAISER HEALTH NEWS, capsules.kaiserhealthnews.org/wp-content/uploads/2013/08/readmissions-year-2-data.csv (last visited Sept. 30, 2013).

26.15 percent of hospitals received the maximum penalty.[133] While only one hospital is expected to incur the 2 percent maximum fine in New Jersey in 2014, over thirteen hospitals will see their Medicare payment adjusted by greater than 1 percent.[134] Interestingly, these higher fines happened even after New Jersey had already reduced its readmission rates by 7.5 percent statewide from 2010 to 2012.[135]

New Jersey's difficulty in controlling readmission rates is partly attributable to the nature of the populations its hospitals serve. New Jersey's many safety net hospitals provide a significant level of care to low-income, uninsured, and vulnerable populations.[136] In 2012, New Jersey's unemployment rate was 9.5 percent, which is the nation's forty-seventh worst unemployment rate.[137] Statistically, hospitals that serve a large number of low-income patients are more likely to face penalties under the HRRP.[138] Because New Jersey's unemployment numbers are so high, safety net hospitals are having to provide care to a greater number of low-income, uninsured, or underinsured patients.

Nationally, a safety net hospital is 30 percent more likely to have readmission rates above the national average and thus receive a penalty.[139] In fact, 77 percent of safety net hospitals received penalties under the HRRP compared to only 36 percent of hospitals that serve the

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[133] *Readmissions Penalties by State: Year Two*, KAISER HEALTH NEWS (Aug. 02, 2013), http://www.kaiserhealthnews.org/Stories/2013/August/02/readmission-penalties-by-state-year-two.aspx (analyzing data from the Centers for Medicare & Medicaid Services).
[134] *Medicare Readmission Penalties by Hospital (Year 2)*, *supra* note 132.
[135] A study by the Healthcare Quality Strategies of East Brunswick, which was hired by the federal government specifically to help reduce readmissions in New Jersey, found that from 2010 to 2012 readmission rates were reduced from 21.6 to 19.98 (a 7.5 percent decrease). Susan K. Livio, *N.J. hospital readmission rate is down about 8 percent among Medicare patients*, NJ.COM (June 13, 2013 at 6:26 AM), http://www.nj.com/politics/index.ssf/2013/06/nj_hospital_readmissions_are_down_about_8_percent_among_medicare_patients.html.
[136] *What is a Safety Net Hospital?*, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS, http://www.naph.org/Main-Menu-Category/About-NAPH/About-Our-Members/what-is-a-safety-net-hospital.aspx (last visited Sept. 29, 2013).
[137] *Unemployment Rates for States*, BUREAU OF LAB. & STATS. (Feb. 28, 2014), http://www.bls.gov/lau/lastrk12.htm.
[138] Rau, *supra* note 3.
[139] Berenson, *supra* note 5, at 1.

fewest poor patients.[140] Safety net hospitals are in precarious financial positions before they received penalties.[141] As a result of the disproportionate application of the HRRP penalty, safety-net hospitals will receive fewer funds to attempt to reduce readmissions, thus compounding the problem.

Low-income patients are more likely to be readmitted for a variety of reasons. First, low-income patients have "higher rates of chronic health problems, disability, mental illness, and substance abuse, compared with the general population."[142] None of these factors are captured in CMS's "risk-adjusted" rate. [143] Current only patient demographic characteristics, comorbidities, and patient frailty are considered.[144] While CMS asserts that the current risk adjustment "levels the playing field" it does not do enough. CMS admits that the risk adjustment does not adjust for race, English proficiency or SES.[145]

Second, many low-income patients face adverse social factors such as homelessness, unsafe housing, and unstable employment.[146] This can result in people being over-reliant on their local emergency rooms for not only their health care, but for relief of other social problems. These factors create barriers to effective health care. Third, many low-income patients often don't have the money to pay for follow-up care post-discharge.[147] MedPAC has noted that mental illness or substance abuse problems may cause low-income patients to leave the hospital against medical advice (AMA), causing a hospital's performance to appear worse than the

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[140] Rau, *supra* note 3.
[141] *See America's Safety Net Hospitals and Health Systems, 2010: Results of the 2010 NAPH Hospital Characteristics Survey*, NAT'L ASSOC. OF PUB. HOSPITALS & HEALTH SYS. 10-15 (May 2012), *available at* www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2010-NAPH-Characteristics-Report.aspx.
[142] Berenson, *supra* note 5, at 2.
[143] *See* Karen E. Joynt &Ashish K. Jha, *A Path Forward on Medicare Readmissions*, 368 THE NEW ENGLAND J. OF MED. 1175, 1176 (Mar. 28, 2013).
[144] *Readmissions Reduction Program, supra* note 71.
[145] 76 Fed. Reg. 51476, 51670 (Aug. 18, 2011).
[146] Berenson, *supra* note 5, at 2.
[147] Rau, *supra* note 3.

national average.[148] While patients that are discharged AMA are not included in readmission rates there are many other social factors that subject low-income patients to readmission.[149] For these reasons, low-income patients are at a high-risk for being readmitted.

Most safety net hospitals have not been able to coordinate post-discharge care with low-income patients because they have limited resources, small margins and many of their patients are "high-risk." While some safety net hospitals do have access to the resources necessary, it often becomes difficult to identify the patients that are in most need of support.[150] Further, some hospitals may be choosing not to implement processes because the cost of such programs would be greater than the penalties assessed against them.[151]

Exacerbating this problem is that hospitals' readmission rates are compared to a national readmission rate standard.[152] Therefore, as safety net hospitals strive to reduce readmission rates, so are other hospitals, driving down the national average readmission rate. Safety net hospitals may be chasing an unobtainable goal. The fact that hospitals' expected readmission ratio and actual readmission rates are published on yearly, not a quarterly, basis further complicates the decision making process.[153] Hospitals only have access to their own facility's patient claims data for the prior twelve months and cannot estimate how much the national average will drop.[154] The substantial start-up cost of implementing readmission reduction processes and the unknown

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[148] MedPAC 2007 Report, supra note 20, at 118.
[149] 76 Fed. Reg. 51476, 51669 (Aug. 18, 2011); Linda Calvillo-King et al., *Impact of Social Factors on Risk of Readmission or Mortality in Pneumonia and Heart Failure: Systematic Review*, 28 J. OF GEN. INTERNAL MED. 269, 276 (Feb. 2013).
[150] *See* Elizabeth Dwelle, *Hospital Uses Data Analytics and Predictive Modeling to Identify and Allocate Scarce Resources to High-Risk Patients, Leading to Fewer Readmissions*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (Jan. 29 ,2014), http://www.innovations.ahrq.gov/content.aspx?id=3994 (noting that Parkland Health & Hospital System, in Dallas, Texas, has had some success in this area).
[151] *See infra* Part III.a.
[152] *CMS Begins Penalizing Hospitals for Readmissions*, *supra* note 106.
[153] 76 Fed. Reg. 51476, 51663 (Aug. 18, 2011).
[154] *Id.*

predictability of the national readmission rate may prohibit safety net hospitals from responding to the HRRP.

Further, safety net hospitals have struggled in the past to effectively manage post-discharge care, and few proven methods exist for these hospitals.[155] However, the CMS asserts that safety-net hospitals with limited finances can reduce readmissions, citing Denver Health Medical Center as an example.[156] Therefore, CMS does not and will not consider socioeconomic status of patients when determining an expected readmission rate for safety net hospitals.[157]

New Jersey hospitals' patient demographics vary across the state but empirical evidence shows that hospitals with some of the highest percent of low-income inpatients are receiving the maximum fines.[158] For example, Jersey City Medical Center is listed as one of the worst in the nation for readmissions and is receiving the maximum 2 percent fine this year.[159] This is occurring regardless of the fact that Jersey City Medical Center was able to reduce its HF readmission rate by over 30 percent from 2008 to 2010.[160] A simple observation shows that New Jersey is way behind the curve in reducing readmission, and, therefore is further away from being free of fines.

III. Analysis

CMS believes that readmissions can be prevented by "ensuring patients are clinically ready at discharge, by reducing the risk of infection, reconciling medications, improving

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[155] *See Medicare Hospital Readmissions Reduction Program*, HEALTH AFFAIRS (Nov. 12, 2012) https://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=102.
[156] Rau, *supra* note 3.
[157] *Id.*
[158] *Medicare Readmission Penalties by Hospital (Year 2)*, *supra* note 132.
[159] Rau, *supra* note 3.
[160] Sabrina Rodak, *Jersey City Medical Center Cuts Heart Failure Readmissions 30 percent*, BECKER'S HOSPITAL REVIEW (July 19, 2013), http://www.beckershospitalreview.com/quality/jersey-city-medical-center-cuts-heart-failure-readmissions-30.html.

communication with community providers participating in transitions of care, educating patients adequately upon discharge, and assuring patients under follow-up care upon discharge."[161] Faced with increased penalties under the HRRP, hospitals are reshaping old programs and implementing new processes during admission, discharge and post-discharge to reduce readmissions.[162] While many hospitals are implementing some or all of CMS's suggested methods, attempts to reduce readmission rates have differed from hospital to hospital.[163] This section will first look at the economic analysis that hospitals perform to determine whether any processes should be implement, then look at what processes have been implemented, and specifically what hospitals in New Jersey are doing.

a. Should hospitals respond?: A brief economic analysis

Some hospitals lost more than $2 million last year and are facing even bigger fines this year under the HRRP.[164] When the HRRP was first implemented hospitals were faced with the dilemma of whether reducing readmissions, thereby diminishing a revenue stream, would be a greater loss than the penalty they faced under the HRRP.[165] One economist poses the question as such: "assuming that hospitals are self-interested operating-margin maximizers and are strategically forward-looking, does the HRRP policy provide economic incentives for a hospital to reduce its readmissions?"[166] Hospitals have been doing extensive economic analysis to answer

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[161] 77 Fed. Reg. 53258, 53377 (Aug. 31, 2012).
[162] Tom Hubbard & Nick McNeill, *Improving Medication Adherence and Reducing Readmissions*, THE NETWORK FOR EXCELLENCE IN HEALTH INNOVATION 1 (Oct. 2012), *available at* http://www.nacds.org/pdfs/pr/2012/nehi-readmissions.pdf.
[163] Rau, *supra* note 56.
[164] Kenneth Epstein, *The Not-So-Long Goodbye*, ECI HEALTHCARE PARTNERS (Sept. 18, 2013), http://www.ecihealthcarepartners.com/blog/the-not-so-long-goodbye/.
[165] *Id.*
[166] Dennis J. Zhang et al., *Hospital Readmissions Reduction Program: An Economic and Operational Analysis* 2 (Northwestern University, Working Paper, 2013), *available at* http://ssrn.com/abstract=2366493

this question and determine whether it is cost efficient to react to the HRRP or maintain the status quo.[167]

A substantial factor in determining whether a hospital will react to the HRRP is determined by a hospital's margins.[168] Many hospitals were faced by slim margins for Medicare inpatient care before the looming threat of HRRP penalties.[169] In fact, the average hospital currently only has a 2 percent margin for Medicare inpatient care.[170] However, some hospitals will not be as affected by the HRRP and may choose not to respond because they "(i) are located in sparsely served areas, (ii) have a low fraction of revenue coming from Medicare, (iii) have currently high readmission rates, or (iv) have a high contribution margin per patient."[171] Hospitals' reactions to the HRRP will occur along a spectrum, from the "wait and see" to the aggressive implementation and renovation of processes.[172] From a purely economic perspective, hospitals must look at "the savings in penalty, the loss in contribution, and the cost of reducing readmissions."[173]

The behavioral change of a hospital is related to its fixed costs. A hospital may not change its processes even if a substantial portion of its margins are reduced by readmission penalties if the fixed costs for implementing processes to reduce readmission are high.[174] Hospitals will begin to respond to the HRRP once the penalty is greater than those fixed costs.[175] The fixed cost hurdle may be lowered by developing methods which not only respond to

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[167] *See* Diana Farrell et al., *Accounting for The Cost of US Health Care: A New Look at Why Americans Spend More*, MCKINSEY GLOBAL INSTITUTE 44 (Dec. 2008).
[168] Sahni, *supra* note 77.
[169] *See* Farrell, *supra* note 167, at 44.
[170] *See Id.*
[171] Zhang, *supra* note 166, at 1.
[172] *See* Sahni, *supra* note 77.
[173] Zhang, *supra* note 166, at 3.
[174] Sahni, *supra* note 77.
[175] *Id.*

readmission rates but that also comply with other PPACA provisions.[176] For example, the Accountable Care Collaborative has been able to jointly reduce readmissions and emergency room visit rates by creating processes that integrate services.[177]

When first suggesting readmission reduction legislation, MedPAC believed that a financial penalty-only approach would cause "structural changes in the health care delivery system."[178] MedPAC was right. After first year reimbursement reductions were assessed, many hospitals realized they are facing substantial penalties until they change their practice patterns. "Hospitals have moved past 'is this for real' or 'should we do something'" and have begun to implement systems to reduce readmissions. [179] Further, hospitals are not only concerned with the economic implications of the HRRP but also the overall quality of care. So, without regard to the economic analysis, many hospitals have begun to respond to the HRRP.

Empirical evidence shows that hospitals are reacting in a variety of ways. Hospital administrators realize that "[i]t's going to take creativity and innovation and most importantly reaching outside the hospital walls" to reduce the impact of the HRRP.[180] Hospitals have recognized that the penalties can have substantial impact on Medicare payments and thus have begun to implement systems to reduce readmission rates.[181]

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[176] Rau, *supra* note 56.
[177] Erin McCann, *Colorado ACO yields big savings, reduced readmissions*, HEALTHCARE IT NEWS (Nov. 5, 2012), http://www.healthcareitnews.com/news/colorado-aco-yields-big-savings-reduced-readmissions.
[178] MedPAC 2007 Report, *supra* note 20, at 115; Miller Report , *supra* note 18, at 10.
[179] Rau, *supra* note 3.
[180] *Id.*
[181] *Id.*

b. Processes Being Implemented

Hospitals are introducing a variety of processes to reduce readmission rates. Some of these processes start when a patient is first admitted.[182] Under this process, hospitals are identifying patients that are at a high-risk for readmission.[183] A patient is identified as being high-risk for readmission based on their age, chronic condition status, race, socioeconomic status and English proficiency.[184] If a patient is at a high-risk for readmission the hospital may respond by treating the patient differently to reduce that risk. In fact, Project BOOST (Better Outcomes by Optimizing Safe Transitions), created by the Society of Hospital Medicine, has created a patient-specific risk-factor analysis that is to be completed upon admission to identify patients that are "at increased risk of adverse events post-hospitalization."[185] By identifying high-risk patients early on, hospitals believe they will reduce their readmission rates.

Also, hospitals are attempting to reduce complications during inpatient stays.[186] This includes performing medication reconciliation. Patients often don't realize that a prescription they received in the hospital is duplicative of a medication they already are taking.[187] Unlike the past, medication management is not seamless because the admitting physician, discharging physician and "receiving" physician are not the same individual.[188] Further complicating the process, an individual with comorbidity may be managed not only by a primary care physician

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[182] Telephone Interview with Susan Walsh, M.D., Vice President of Community Medicine, Jersey City Medical Center (Feb. 12, 2014).
[183] *Id.*
[184] *Id.*
[185] *Risk Assessment Tool: The 8Ps*, SOCIETY OF HOSPITAL MEDICINE, http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/06Boost/03_Assessment.cfm (last visited Mar. 23, 2014).
[186] MedPAC 2013 Report, *supra* note 54, at 95.
[187] Jordan Rau, *Hospitals Offer Wide Array of Services to Keep Patients from Needing to Return*, KAISER HEALTH NEWS (Nov. 27, 2012), http://www.kaiserhealthnews.org/stories/2012/november/28/hospital-services-to-reduce-readmissions.aspx.
[188] *See* Hubbard, *supra* note 162, at 2.

but also additional specialists.[189] Hospitals have identified this silos-within-silos phenomenon as creating difficulties in the accurate and complete compiling of patients' medications list.[190] Hospitals are attempting to reduce these difficulties by reaching outside their walls for help.

Hospitals also have been attempting to provide better transition planning by increasing and improving communication with post care providers. Hospitals that have a highly integrated medical system, like Denver Health Medical Center, are easily able to perform medication reconciliation and provide other services subsequent to discharge. Hospitals have also revamped their discharge procedures to make sure that patients are better educated about their illness and medications.[191]

Hospital readmission reduction tactics do not end once a patient has been discharged.[192] Many hospitals have started to provide support service and transition care after post-discharge.[193] This includes scheduling follow-up visits, proving transportation and assigning case managers for those with comorbidities or complex cases.[194] Hospitals believe that increased coordination with transition care providers will ensure that patients are receiving the level of care necessary to prevent readmission.[195]

Some hospitals are taking the extra steps to ensure that a patient gets follow-up care within a week after leaving the hospitals.[196] This even includes calling the patient within hours of

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[189] *See Id.*
[190] *See generally Id.* (discussing "a heightened need for communication and coordination with hospital staff and community-based physicians, particularly in the management of medications").
[191] *Medicare's Hospital Readmission Reduction Program FAQ*, AM. C. OF EMER. PHYSICIANS, https://www.acep.org/Legislation-and-Advocacy/Practice-Management-Issues/Physician-Payment-Reform/Medicare-s-Hospital-Readmission-Reduction-Program-FAQ/ (last visited Mar. 28, 2014).
[192] *See* Brian Jack, et al., *A Reengineered Hospital Discharge Program to Decrease Rehospitalization*, 150 ANNALS OF INTERNAL MEDICINE 178, 186-87 (2009).
[193] Berenson, *supra* note 7, at 7.
[194] *See* Rau, *supra* note 187.
[195] Medicare's Hospital Readmission Reduction Program FAQ, *supra* note 191.
[196] *Id.*

discharge to ensure they have the support and/or resources necessary to get care.[197] Hospitals are getting creative with the programs they are implementing. For example, Del E. Webb Medical Center, in Sun City, Arizona, has started to give bathroom scales and notepads to patients with congestive heart failure in order to record small amounts of weight gain, an indicator that a patient is retaining water because their heart isn't pumping adequately.[198] Other hospitals are implementing more expensive telemedicine home monitoring programs to reduce readmission, whereby health data is sent to nurses in real-time in order to prevent unplanned readmissions.[199] So from the simple to the complex, the cheap to the expensive, hospitals across the country are showing that they are willing to do anything to see smaller penalties under the HRRP.

c. New Jersey Hospital's Response

New Jersey hospitals have been implementing programs to reduce readmission rates in order to lower the penalty imposed by the HRRP. Specifically, a "readmissions collaborative" was assembled by the New Jersey Hospital Association (NJHA).[200] The collaborative brings together hospitals, nursing homes, home health care, and hospice providers with the realization that it takes "an entire community to reduce readmissions."[201] The NJHA realizes that reducing readmission rates is really only piece of the puzzle to reducing Medicare costs.[202] NJHA fully expects payment reductions or sanctions to be implemented for nursing homes and other providers.[203] Thus, this collaboration was formed with that possibility in mind.

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[197] *Id.*
[198] Rau, *supra* note 187.
[199] Joseph Cann, *Telehealth Reduced Readmissions, Hospital Days: Report*, MODERN HEALTHCARE (Feb. 5, 2013 3:00 P.M.), http://www.modernhealthcare.com/article/20130205/NEWS/302059954.
[200] Fitzgerald, *supra* note 126.
[201] *Id.*
[202] Cornett, *supra* note 49, at 14.
[203] Fitzgerald, *supra* note 127.

Providers have focused on the relationship between hospitals and nursing homes as a potential key to improving hospital readmission rates.[204] Essentially, hospitals want to be reassured that discharged patients sent to skilled nursing facilities are receiving the care they need. This means ensuring that skilled nursing facilities have the staff and skill set to prevent readmissions.[205] Hospitals have also begun to communicate with outside providers in advance of discharge to ensure that follow-up care is arranged specific to the particular patient's needs.[206] In some instances, hospitals are contacting local pharmacists that manage patients' medication.[207]

The Robert Wood Johnson Foundation has awarded nine grants in New Jersey to study effective ways to reduce readmissions.[208] Two successful programs have emerged. In one of the programs the hospital sends a "coach" to visit newly discharged patients.[209] The coach ensures that the patient is adhering to all discharge instructions and closely monitors the patient.[210]

The other successful program implemented intensive case management for low-income patients suffering from multiple chronic conditions.[211] This program directly targets patients who are at a high-risk of readmission.[212] Under the case management model, the most crucial step is getting to the root cause of why a patient does not have a primary care physician.[213] Often the answer was cost.[214] Jersey City Medical Center has taken a different approach. Jersey City Medical Center has focused on "enhanced assessment" of the cause behind the readmission.

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[204] *Id.*
[205] *Id.*
[206] Livio, *supra* note 135.
[207] *Id.*
[208] Fitzgerald, *supra* note 127.
[209] *Id.*
[210] *Id.*
[211] *Id.*
[212] *Id.*
[213] Fitzgerald, *supra* note 127.
[214] *Id.*

Regardless of the method used, the ultimate goal is to ensure that quality care is being provided at a lower cost. Several hospitals are attempting to implement programs to ensure that their facility is not subject to higher rates.

IV. Redefining the Hospital Readmissions Reduction Program

There are many critics of the Hospital Readmissions Reduction Program as it currently stands. Critics cite to the unintended consequences such as the heavy burden placed on safety net hospitals and how it may affect care for vulnerable populations.[215] One study found that safety net hospitals are 30 percent more likely to have a readmission rates above the national average.[216] However, there are opponents to redefining the HRRP to account for the burden on safety net hospitals.[217] Supporters of the HRRP, as it current stands, argue that allowing a patients' socioeconomic status to be considered would allow hospitals that serve a high proportion of vulnerable patients to be held to a lower standard of quality of care.[218] Ultimately, there are two areas of focus on how to redefine the HRRP to prevent unintended consequences. The first option is include socioeconomic status, race, ethnicity, community factors, and/or English as a primary language when determining a hospitals' risk adjusted readmission rate. The second option is to change the comparison model from a national standard to a peer review standard. This note concludes by analyzing both options.

a. Option One: Redefining the Risk Adjustment

Is HRRP working to reduce readmissions? Yes. Statistical evidence proves that from 2007 to 2011 readmission rates remained constant but after the HRRP was implemented rates

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[215] *See Medicare Hospital Readmissions Reduction Program*, *supra* note 155.
[216] Berenson, *supra* note 5, at 6.
[217] *Id.* at 7
[218] *Id.*

began to fall.[219] In fact rates fell from 19 percent to 18.5 percent and eighteen 18 percent in 2012 and 2013, respectively.[220] However, even though readmission rates are dropping, this does not mean the currently accepted methodology used to calculate the penalty is making the appropriate risk adjustments for setting a national readmission benchmark. For this reason, safety net hospitals are calling for the risk adjustment to be redefined.[221]

Many hospitals have been hypercritical of the readmission measures that CMS adopted.[222] One of the biggest critiques is that the current risk adjustment does not take into account the socioeconomic status of patients.[223] Independent research has proven that those with lower socioeconomic status lack health care resources, such as a primary care physician, money for follow-up care, and a general understanding of their illness.[224]

The CMS conceded in its FY 2012 IPPS Final Rule that socioeconomic status may need to be included as one of the factors in the risk adjustment.[225] However, CMS ultimately asserts that implementing such a policy would allow hospitals to be held to different standards and may allow for disparities in care for the disadvantaged.[226] In Contrast, MedPAC's June 2013 report suggests that CMS take into account the socioeconomic status of hospitals' patients.[227] Further studies show that readmission rates are not only correlated to patients' socioeconomic status but

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[219] *New Data Shows Affordable Care Act Reforms Are Leading to Lower Hospital Readmission Rates for Medicare Beneficiaries*, CTRS. FOR MEDICARE AND MEDICAID SERVS. (Dec. 6, 2013), http://blog.cms.gov/2013/12/06/new-data-shows-affordable-care-act-reforms-are-leading-to-lower-hospital-readmission-rates-for-medicare-beneficiaries/.
[220] *Id.*
[221] 76 Fed. Reg. 51476, 51670 (Aug. 18, 2011).
[222] *364 Hospitals Have High Rates of Overall Readmissions, New Medicare Data Show*, KAISER HEALTH NEWS (Jan. 6, 2014), http://capsules.kaiserhealthnews.org/index.php/2014/01/new-medicare-data-show-hospitals-with-high-rates-of-readmissions/.
[223] *Medicare Hospital Readmissions Reduction Program*, *supra* note 155.
[224] *364 Hospitals Have High Rates Of Overall Readmissions*, supra note 222.
[225] 76 Fed. Reg. 51476, 51671 (Aug. 18, 2011).
[226] *Medicare Hospital Readmissions Reduction Program*, *supra* note 155.
[227] *See generally* MedPAC 2013 Report, *supra* note 11, at 107 (noting that "hospitals' share of low-income patients was a stronger and more consistent predictor of readmissions…").

also to race, housing stability, social support, and community resources, and access to timely primary care resources.[228]

While CMS cites to Denver Health as an example of a safety net hospital with a low readmission rate it ignores the reality that such a highly integrated system is not easily or cheaply implemented.[229] Further, safety net hospitals are not only hit more frequently, but because a large percentage of their revenue often consists of Medicare DRG payments, they are hit with larger fines. Further, the concern that taking socioeconomic status into account will mask disparities in care for disadvantaged populations is unsupported.

Redefining the Risk Adjustment Factor to include socioeconomic status could comport with the statute as written and would require not action by Congress.[230] Since the risk adjusted readmission ratio must only be endorsed by the NQF CMs could propose, through rule making, that the Risk Adjustment Factor be redefined.[231] CMS should take this step and unburden safety net hospitals by altering the Risk Adjustment Factor to include socioeconomic status while observing hospital actions to ensure that disparities in care do not arise.

b. Option Two: Peer-Based Evaluation to Replace National Standard

Safety net hospitals patients are more vulnerable to readmission because of their higher rates of chronic health problems, disability, mental illness, substance abuse and person and social problems, such as homelessness, unsafe housing, and unstable employment.[232] A peer based evaluation rather than a national standard would recognize this burden. For this reason, MedPAC

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[228] Karen Joynt et al., *Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care*, 305 J. OF THE AM. MED. ASSOC. 675, 675; Linda Calvillo-King et al., *Impact of Social Factors on Risk of Readmission or Mortality in Pneumonia and Heart Failure: Systematic Review*, 28 J. OF GEN. INTERNAL MED. 269, 276 (Feb. 2013); Gregory J. Misky et al., *Post-Hospitalization Transitions: Examining the Effects of Timing of Primary Care Provider Follow-Up*, 5 J. OF HOSPITAL MED. 392 (June 23, 2010).

[229] *See CMS Begins Penalizing Hospitals for Readmissions*, *supra* note 106.

[230] *See* 42 U.S.C. 1395ww(q)(4)(C)(I) (2012).

[231] *Id.*

[232] Berenson, *supra* note 5, at 7.

suggests that hospitals with high shares of low-income patients be compared to hospitals with a similar patient mix for purposes of calculating the penalty assessed against a hospital.[233]

The risk adjustment would not be altered to include socioeconomic status using this methodology.[234] Under this option, CMS would still report readmission rates without regard for income, making disparities in quality of care easily identifiable, while separately assessing a financial penalty that took into account the hospitals' patient mix.[235] This would reduce disparities in the penalties being assessed at safety net hospitals and non-safety net hospitals.[236] Under this methodology, potential disparities would not be masked, which was an issue raised by opponents to Option One, discussed *supra*.[237]

Through this peer evaluation method, safety net hospitals may face reduced penalties. This would allow safety net hospitals to have more resources to address excessive readmission rates. A pure economic analysis shows this may create a disincentive to implementing readmission reduction processes, i.e. when the cost of implementing process is greater than the lowered penalty. However, it is important to remember that many safety net hospitals' end game is not profit maximization but rather the delivery of quality care.[238] In fact, many hospitals, such as Jersey City Medical Center, are trying to reduce readmission for all patients, not just patients for which the hospitals faces a penalty because their primary concern is the quality of care its patients receive.[239] MedPAC's suggested peer evaluation standard could comport with the legislation as written, requiring no action from Congress for the same reason Option One is

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[233] MedPAC 2013 Report, *supra* note 11, at 108.
[234] *Id.*
[235] *Id.*
[236] *Id.*
[237] *See supra* Part III.a.
[238] Telephone Interview with Susan Walsh, M.D., Vice President of Community Medicine, Jersey City Medical Center (Feb. 12, 2014).
[239] *Id.*

allowable, i.e. the methodology only need to be endorsed by the entity under contract (currently the NQF).[240]

MedPAC's 2013 Report to Congress simulated computation of readmission penalties based on peer evaluation using a hospital's share of SSI patients to categorize peer groups.[241] MedPAC believe that "using SSI categories to compute penalties eliminates *most of* the" disparities that exist in penalties assessed to safety net versus non-safety net hospitals.[242] MedPAC admits then even under an SSI categorization methodology that hospitals with the highest share of poor patient still have higher average penalties.[243] However, under the proposed peer evaluation methodology the disparity between safety net hospitals and non-safety net hospitals is greatly reduced.[244] So, while a peer evaluation system is not perfect it may be a move in the correct direction.

Conclusion

A general observation shows that many hospitals are reacting to the Hospital Readmissions Reduction Program. Further analysis shows that the Hospitals Readmissions Reduction Program is in fact reducing readmissions, as rates have fallen slightly over the last two years. However, this does not necessarily mean that the Hospital Readmissions Reduction Program as it stands is a total success. Many providers continue to criticize the HRRP for the unfair burden it places on safety net hospitals. MedPAC and hospitals are calling for policy decisions to be altered to reduce this burden. As the HRRP moves forward and continues to expand the penalty percentage as well as applicable conditions, CMS must continue to monitor

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[240] As currently written, the HRRP measurement standards need only be endorsed by the NQF. 42 U.S.C. 1395ww(q)(5)(ii) (2012).
[241] MedPAC 2013 Report, *supra* note 11, at 108-09.
[242] *Id.* at 110.
[243] *Id.*
[244] *Id.*

the measures and seriously consider altering the Risk Adjustment Factor to include socioeconomic status and/or move away from a national standard to a peer evaluation standard.