

# The Patient Readmission Rate Penalty in the Affordable Care Act

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# THE PATIENT READMISSION RATE PENALTY IN THE AFFORDABLE CARE ACT

By Yoni E. Anijar\*

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## I. INTRODUCTION

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA), which represents the most significant regulatory overhaul of the United States healthcare system since the 1965 Social Security Amendments, establishing Medicare and Medicaid.<sup>1</sup> By 2020 healthcare is expected to account for twenty percent of the Nation's economy, making it one of the most important economic issues facing Americans.<sup>2</sup> Irrespective of race, gender, or socioeconomic status, healthcare is a reality that all individuals must face at some point in their lives.

The ACA was enacted as an effort to address the overwhelming disparities that exist with regards to the access to and affordability of healthcare in the United States.<sup>3</sup> The law's provisions, including the Hospital Readmission Reduction Program (HRRP), take substantive steps that are intended to work towards mitigating these shortcomings. Using readmission rates as its metric of quality, the HRRP imposes a penalty on any hospital that exceeds the national mean readmission rate within a particular year.<sup>4</sup> These penalties are collected from hospitals through a percentage reduction in the annual Medicare payments they receive for inpatient service claims.<sup>5</sup> The expectation is that hospitals will respond to this incentive by improving operational process and patient care in a manner that will benefit all hospital patients.<sup>6</sup> This article argues, however, that this incentive system is flawed, as readmission rates are not an accurate way to evaluate a hospital's performance because they are not useful indicators of quality of care.<sup>7</sup> Moreover, in practice, the HRRP may have at least three unintended consequences: a decrease in quality of care, a decrease in access to care for minorities, and an increase in hospital financial distress.<sup>8</sup>

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<sup>1</sup> Julia Balch Samora et al., *Where the Candidates Stand on Health Care*, AM. ACAD. OF ORTHOPEDIC SURGEONS (Jan. 2014), <http://www.aaos.org/news/aaosnow/oct12/advocacy2.asp>.

<sup>2</sup> Ricardo Alonso-Zaldívar, *Health Care Costs to Account For One-Fifth Of U.S. Economy By 2020: Report*, HUFFINGTON POST (July 28, 2011, 11:17 AM), [http://www.huffingtonpost.com/2011/07/28/health-care-costs-economy-us\\_n\\_911917.html](http://www.huffingtonpost.com/2011/07/28/health-care-costs-economy-us_n_911917.html).

<sup>3</sup> See generally Mary Naylor, *Unintended Consequences of Steps to Cut Readmissions and Reform Payment May Threaten Care of Vulnerable Older Adults*, HEALTH AFF. 1623 (July 2011).

<sup>4</sup> *Id.*

<sup>5</sup> Julia James, *Medicare Hospital Readmissions Reduction Program: To Improve Care and Lower Costs, Medicare Imposes a Financial Penalty on Hospitals with Excess Readmissions*, HEALTH AFF. 3 (Apr. 2014), available at [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_102.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_102.pdf).

<sup>6</sup> Elizabeth H. Bradley, Leslie Curry, Leora I. Horwitz et al., *Hospital Strategies Associated with 30-Day Readmission Rates for Patients with Heart Failure, Circulation: Cardiovascular Quality and Outcomes* (June 2013), available at <http://www.medpagetoday.com/upload/2013/7/16/Circ%20Cardiovasc%20Qual%20Outcomes-2013-Bradley-444-50.pdf>.

<sup>7</sup> Sharon Silow-Carroll, Jennifer N. Edwards, Aimee Lashbrook et al., *Reducing Hospital Readmissions: Lessons from Top-Performing Hospitals*, THE COMMONWEALTH FUND 3 (Apr. 2011), available at [http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2011/Apr/1473\\_SilowCarroll\\_readmissions\\_synthesis\\_web\\_version.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2011/Apr/1473_SilowCarroll_readmissions_synthesis_web_version.pdf).

<sup>8</sup> Joel D. Sweider, Note, *A Dose of Reality: Unintended Consequences of Penalizing Hospital Readmissions in the PPACA*, 9 IND. HEALTH L. REV. 361, 363 (2011).

## II. BACKGROUND

Hospital readmission is a relatively broad, yet simple concept: a patient, upon initial discharge from a hospital, is shortly thereafter readmitted to the same or different hospital for the same or a different condition.<sup>9</sup> Within the context of Medicare, readmissions have generally been measured within thirty-days of initial discharge.<sup>10</sup> According to a 2009 study in the *New England Journal of Medicine*, almost one fifth of hospitalized Medicare patients are readmitted within that thirty-day window.<sup>11</sup> Furthermore, more than sixty-seven percent of patients discharged following a hospitalization for a medical condition and fifty-one percent of those discharged after undergoing surgical procedures were readmitted or died within a year.<sup>12</sup> The primary problem with readmitting a patient is that it may be indicative of poor care or an inefficient coordination of post-discharge care.<sup>13</sup> For example, research has suggested that excessive readmission can be reduced by enhanced communication between caregivers and patients and better coordination of post-discharge care.<sup>14</sup>

As an incentive based system, the intended purpose of HRRP is to encourage hospitals to adopt strategies that better improve patient services and operating practices;<sup>15</sup> however, this objective is based on the faulty premise that readmission rates are solely reflective of the quality of care provided by hospitals.<sup>16</sup> In 2000, a survey of some nineteen readmission studies, carried out over the previous ten-years, concluded that most readmissions seem to be caused by modifiable causes and that global readmission rates are not useful indicators of quality of care.<sup>17</sup> As such, using readmissions as a yardstick to evaluate the quality of healthcare provided by a hospital becomes inherently problematic. There are many factors that are not related to quality of care, such as socio-economic status of patients that nonetheless influence readmission rates.<sup>18</sup>

Indiscriminately imposing penalties on hospitals with excess readmission rates, without accounting for the contributing factors for those readmissions, may adversely impact hospitals, particularly hospitals that serve large populations of individuals from low

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<sup>9</sup> *Id.* at 365.

<sup>10</sup> *Id.* at 363.

<sup>11</sup> Stephen F. Jencks et al., *Rehospitalizations Among Patients in the Medicare Fee-for-Service Program*, 360 *NEW ENG. J. MED.* 1418, 1426 (2009).

<sup>12</sup> *Id.* at 1421.

<sup>13</sup> *See generally* Sweider, *supra* note 8, at 366 (discussing how excess readmission rates may indicate poor care or missed opportunities to better coordinate care).

<sup>14</sup> *See id.* 365 (noting that enhanced communication between caregivers and patients has a direct correlation with a reduction of readmission rates).

<sup>15</sup> *See generally* Naylor, *supra* note 3, at 1623 (discussing the overall purpose of HHRP is to improve the quality of service hospitals provide to their patients).

<sup>16</sup> *Id.*

<sup>17</sup> Jochanan Benbassat & Mark Taragin, *Hospital Readmissions as a Measure of Quality of Health Care: Advantages and Limitations*, 160 *ARCHIVES INTERNAL MED.* 1074, 1074 (2000).

<sup>18</sup> James, *supra* note 5, at 3 (arguing that an emphasis on readmission rates to improve quality of care is a flawed strategy because readmissions are tied into factors outside of a hospitals' control).

socio-economic backgrounds.<sup>19</sup> Readmissions tend to be higher in hospitals that treat a great proportion of indigent patients, since there is a direct correlation between lower socio-economic conditions and overall poor health.<sup>20</sup> Hospitals that treat primarily these types of patients are most susceptible to the financial hardships that the penalties associated with the HRRP could potentially create.<sup>21</sup> This is particularly problematic because many of these hospitals are already reliant on federal aid to maintain operation since many of their patients are uninsured.<sup>22</sup> If these hospitals are penalized for readmissions then they will experience increased financial pressure, leading to cuts in patient services and other efforts to minimize costs, harming the entire community served by the hospital.<sup>23</sup> Moreover, the need to reduce readmissions will create a conflict of interest between quality of care delivered and the hospital's bottom line.<sup>24</sup>

### **A. The HRRP Will Increase the Level of Financial Distress Experienced by Some Hospitals and in Turn Decrease Access to Care by Socio-Economically Disadvantaged Groups**

The HRRP was designed in a manner that will disproportionately impact hospitals in urban neighborhoods that treat socio-economically disadvantaged groups, including indigent and uninsured patients.<sup>25</sup> With limited funding and fewer resources, the financial implications that these penalties will have on such safety-net hospitals cannot be dismissed.

While many readmissions can be easily avoided by implementing simple changes in patient discharge procedures, many of the underlying causes of readmissions involve factors that are beyond the hospital's control, including patient behavior, poor follow-up, and the socio-economic status of the patient population.<sup>26</sup> The computation used by the Department of Health and Human Services (DHHS) sets a readmission threshold for each hospital, and the hospital is subsequently penalized whenever they exceed this threshold.<sup>27</sup> Since the methodology used by the DHHS to compute excess readmission rates do not adjust for factors that can impact readmission rates, hospitals become victims of their surroundings.<sup>28</sup>

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<sup>19</sup> See generally Sweider, *supra* note 8, at 364 (noting that since there is a direct correlation between lower socio-economic conditions and poor population health conditions, hospitals that treat these patients will have a higher readmission rate more often than others).

<sup>20</sup> James, *supra* note 5, at 3.

<sup>21</sup> *Id.*

<sup>22</sup> Christie Provost Peters, *The Basics: Medicaid Disproportionate Share Hospital (DSH) Payments*, NAT'L HEALTH POLICY FORUM 1 (2009), available at [http://www.nhpf.org/library/the-basics/Basics\\_DSH\\_06-15-09.pdf](http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf).

<sup>23</sup> *Id.*

<sup>24</sup> Amanda Bronstad, *Suit Over Hospital's Closure Could be a Harbinger*, NAT'L L. J. (Aug. 23, 2010), <http://www.law.com/jsp/nlj/PubArticleNLJ.jsp?id=1202470936728&slreturn=1&hbxlogin=1#>.

<sup>25</sup> See generally Sweider, *supra* note 8, at 364.

<sup>26</sup> James, *supra* note 5, at 4.

<sup>27</sup> *Hospital Compare*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.hospitalcompare.hhs.gov/> (last updated Jan. 26, 2012).

<sup>28</sup> James, *supra* note 5, at 4.

*i. Many of the Readmission Reduction Strategies are Impractical or too Costly for Hospitals to Implement.*

While the ACA lays out a number of readmission reduction strategies for hospitals to implement, the success of these strategies do not necessarily translate from hospital-to-hospital.<sup>29</sup> Furthermore, a number of the strategies are simply not feasible for hospitals with limited resources and uninsured patients.<sup>30</sup> For example, many patients at large inner city hospitals are readmitted because they do not always follow the nurse's or physician's discharge instructions usually because they lack the resources to do so.<sup>31</sup> To ameliorate this phenomenon, hospitals could implement regimented follow-ups by nurses,<sup>32</sup> but this strategy is very costly and such expenditure would serve as a misappropriation of resources.

*ii. There are Underlying, Non-Care Related, Causes for Readmission.*

Hospitals that are frequented by a high proportion of uninsured patients are generally referred to as safety-net hospitals. These hospitals are typically found in low-income communities, where many of our nation's health and economic disparities are present. In adherence with federal law, a hospital must treat a patient in need of care regardless of insurance status.<sup>33</sup>

One of the reasons that many patients are readmitted to safety-net hospitals is related to an inability to afford their prescriptions, rather than the underlying care that the patient received while in that hospital.<sup>34</sup> Take for instance a patient admitted to a hospital with a laceration to the hand that requires stitches. The patient is treated and released from the hospital with a prescription for antibiotics. However, the patient is uninsured and cannot afford to fill the prescription. With no other option, the patient is forced to deviate from the recommended course of treatment. This decision makes the patient more susceptible to health complications that will later require readmission. The prior scenario is a regular occurrence in many of these safety-net hospitals. As such, these hospitals typically have higher readmissions rates than hospitals in more affluent communities.<sup>35</sup>

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<sup>29</sup> *Id.* at 3-4 (stating "CMS has made additional funding available for readmission reduction strategies through initiatives, such as the Community-based Care Transitions Program and the Partnership for Patients").

<sup>30</sup> *Id.* at 3.

<sup>31</sup> *Id.* at 4 (arguing that indigent patients generally lack the resources to fill their prescriptions resulting in an eventual readmission to the hospital they are initially discharged from).

<sup>32</sup> See 42 U.S.C § 2717(a)(1)(B) (2010) (noting that nurse follow-ups have typically resulted in a reduction in readmission rates because it allows hospitals to ensure that the patients are following their discharge instructions properly).

<sup>33</sup> See *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 880 (4th Cir. 1992) (stating that "all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress" and stating that Congress enacted EMTALA to address its concern with the practice of patient dumping) (quoting 131 Cong. Rec. S13904 (daily ed. Oct. 23, 1985) (statement of Sen. Durenberger)).

<sup>34</sup> James, *supra* note 5, at 4.

<sup>35</sup> Karen E. Joynt et al., *Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care*, 305 JAMA 675, 675 (2011).

*iii. Expected Disproportionate Share Hospital Cuts As Well As Costs Associated with Decreasing Readmissions May Jeopardize Access to Care.*

Medicare does not provide any direct payment for strategies that may help these hospitals reduce readmission rates.<sup>36</sup> The cost of employing these strategies, coupled with the reduced revenue from fewer readmissions, makes it less likely that attempts to reduce readmissions will be cost efficient. The financial difficulties that hospitals will face are not only tied to the HRRP of the Affordable Care Act; others provisions within the law also stand to significantly contribute to financial hardship for safety-net hospitals.<sup>37</sup>

Currently many safety-net hospitals are funded by the federal government through the Medicare Disproportionate Share Hospitals (DSH) payment program;<sup>38</sup> however, the Department of Health and Human Services (DHHS) expects a seventy-five percent reduction in DHS payments by the beginning of the 2015 fiscal year.<sup>39</sup> Through DSH payments, hospitals have been able to improve the access to care for much of the indigent population in this country.<sup>40</sup> Significant cuts to DSH payments could create more of an incentive for hospitals to alter the types of services they provide, focusing on those services that are more profitable and less often used.<sup>41</sup> The harm is that less profitable services that have proven long-term benefits to a patient's health, such as preventive screening, could be significantly cut. An emphasis on preventive care, however, is important because it will help stifle the rising healthcare costs for patients by improving the likelihood that life-threatening conditions will be detected much sooner.<sup>42</sup>

**B. Financial Strain Caused by the HRRP as well as Other Provisions of the Affordable Care Act Will Lead to Larger Problems, Including a Decrease in Services or Closure of Facilities.**

The Committee of Medicaid and Medicare Services predicted that beginning this fiscal year, at least 2,225 hospitals will be penalized \$227 million dollars because of excess readmissions.<sup>43</sup> As with any other financially strained institution, when there are added expenses, cuts must be made. While it would be difficult to speculate precisely how these hospitals will absorb the added expenses, cuts to staffing and supporting services are likely possibilities.<sup>44</sup> Although a reduction in operating costs does not necessarily

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<sup>36</sup> See Sweider, *supra* note 8, at 376 (arguing that these hospitals will be hit doubly hard, losing reimbursements for readmissions while no longer getting the Disproportionate Share Hospital (DSH) payments to which they are accustomed).

<sup>37</sup> See 42 U.S.C. § 1395ww(d)(5)(F)(i) (2010).

<sup>38</sup> See Peters, *supra* note 22, at 1.

<sup>39</sup> 42 U.S.C. § 1395ww(d)(5)(F)(i) (2010).

<sup>40</sup> See Peters, *supra* note 22, at 1.

<sup>41</sup> Arnold M. Epstein et al., *The Relationship between Hospital Admission Rates and Rehospitalizations*, 365 NEW ENG. J. MED. 2287, 2287 (2011) (noting that among the money saving initiatives that struggling hospitals could adopt is offering more profitable services to patients).

<sup>42</sup> See 42 U.S.C. § 300gg-13 (2010) (providing that private insurers are required to cover screening services and preventive treatments which have been given a recommendation of "A" or "B" by the U.S. Preventive Services Task Force).

<sup>43</sup> James, *supra* note 5, at 3.

<sup>44</sup> Bronstad, *supra* note 24.

imply a reduction in the quality of treatment, it does create the potential that such an outcome may occur.

Faced with mounting debts and added expenses from the new penalties associated with the HRRP, hospital that cannot compete in the readmission game will likely cut cost by offering fewer services to their patients or shedding facilities.<sup>45</sup> These hospitals may no longer have the resources to invest in innovative technology that is aimed at enhancing treatment and patient care.<sup>46</sup> Hospitals, with mounting financial pressure from HRRP penalties, may also cut critical services that could comprise the quality of care provided to patients.<sup>47</sup>

To avoid penalties hospitals may attempt to avoid treating elderly patients. The sickest and oldest patients place an increasing burden on hospitals trying to reduce their readmission rates because, generally, these patients are readmitted more often.<sup>48</sup> Currently, more than six million elderly Americans suffer from chronic medical conditions that require long-term homecare as well as frequent physician visits.<sup>49</sup> Long-term care, by its nature, involves many providers and several different types of treatment. For example, hip fractures are among the most common orthopedic injuries in the elderly population.<sup>50</sup> They are debilitating injuries that require surgical intervention and inpatient care of, what are more often than not, patients with many chronic medical issues.<sup>51</sup> These patients require orthopedic intervention for surgery, medical intervention for health status monitoring, physical therapy during and after hospital discharge, as well as regular follow-up with their primary care physician.<sup>52</sup> Such patients often require multiple readmissions for pain management, infection, and rehabilitation that arise as a result of their injury and made worse by their pre-injury healthcare status.<sup>53</sup> Fully aware of this reality, hospital may be less inclined to treat elderly patients to avoid the potential for facing readmission penalties.<sup>54</sup>

Another tactic that hospitals may employ is manipulating billing information to circumvent some key measures of readmissions in order to avoid being penalized by the HRRP.<sup>55</sup> For example, while under observational care, a patient is provided with outpatient services to determine whether hospitalization is required thereby changing

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<sup>45</sup> Suzanne Sataline, *Cash-Poor Governments Ditching Public Hospitals*, THE WALL ST. J., Aug. 29, 2010 (Health Industry Section).

<sup>46</sup> *Id.*

<sup>47</sup> Mark Levine, *St. Vincent's is the Lehman Brothers of Hospitals*, N.Y. MAG., Oct. 17, 2010, <http://nymag.com/news/features/68991/>.

<sup>48</sup> *Id.*

<sup>49</sup> H. Stephen Kaye, *Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much?*, HEALTH AFF., 11 (2010).

<sup>50</sup> *Fractures of the Pelvis & Acetabulum*, CTRS. FOR ORTHOPEDICS, <http://www.orthoassociates.com/SP11B26/> (last visited Apr. 21, 2014).

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> Levine, *supra* note 47.

<sup>55</sup> See Naylor, *supra* note 3 (discussing how coding allows hospitals to avoid or obscure measurement of some hospitalizations).



the patient's designation from an inpatient to an outpatient.<sup>56</sup> Prolonged use of this designation allows hospitals to avoid a potentially necessary hospitalization, which de facto reduces their readmission rate.<sup>57</sup> Although this tactic is illegal and would potentially compromise the quality of treatment provided to patients, this tactic would reduce a hospital's readmission rate.

Moreover, the HRRP presumes that penalties will prompt hospitals to improve patient services and treatment facilities; however, since the penalty is capped annually at a percentage of a hospital's total Medicare payments, hospitals could bear the penalties and avoid the high costs of implementing changes in their operations and services.<sup>58</sup>

Hospitals unable to sustain the costs associated with readmission penalties will be forced to shut down.<sup>59</sup> The remaining hospitals will be overwhelmed by the flux of new, mostly indigent, patients left behind by the hospitals that shut down.<sup>60</sup> Such a wave would create overcrowded and understaffed hospitals where long waits and uneven care become the standard.<sup>61</sup>

### III. PROPOSED SOLUTIONS

To ensure that the penalty associated with the HRRP are enforced consistently and fairly, socio-economic status of patients and other patient population characteristics should be taken into consideration when computing the acceptable readmission rates for each hospital. The overall goal of the program is to eradicate the gaps that exist with patient care as a means of reducing hospital readmissions. Subjecting all hospitals to the same standards implies that all hospitals are subjected to similar patient populations and have the same resources to manage their inpatient complications. While there are legitimate concerns that adjusting for these sorts of factors may mask the potential disparities in care for the disadvantaged, it is clear that this program's intended model of enforcement is flawed and ought to be adjusted appropriately. Additionally, the HRRP should not do away with DHS payments at this time. DHS payments are vitally important for increasing and maintaining access to care, as they fund hospitals that treat indigent populations. Eliminating DHS payments creates incentive for hospitals to focus on more profitable services, despite that they might be less commonly used by needy patients. Overall, the ACA should ensure that hospitals provide the treatments that patients need, not just the ones that are more economically beneficial for the hospital.

Currently, the HRRP is trying to accomplish too much all at once.<sup>62</sup> The program simultaneously gathers uniform data among hospitals, publicizes those results, and then

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<sup>56</sup> See *id.*

<sup>57</sup> See *id.*

<sup>58</sup> See *id.* (discussing how in some cases the cost of implementing these new readmission reduction strategies would be greater than the penalty that would be imposed on them).

<sup>59</sup> See Levine, *supra* note 47 (discussing the added pressures that hospitals would have to deal with including growing costs, decreasing revenues, and unsustainable debt loads).

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> Sweider, *supra* note 8, at 382.

dispenses out penalties to various hospitals.<sup>63</sup> Given the relatively short time frame in which providers must comply with the new regulations, such a process may lead to an overextension of DHHS resources.<sup>64</sup> Gathering more data on this issue is undeniably crucial in appropriately resolving excess readmissions; however, the fact that hospital readmission data will become public will inevitably penalize hospitals that require more time to find a mechanism best suited for their particular situation. As such, a sensible solution would be to lengthen the timetable in implement the HRRP. Delaying its commencement would give Congress time to revisit and improve the program, while also allowing hospitals a sufficient period to research and formulate their individuals plans prior to placing their federal reimbursement dollars at jeopardy.

#### **IV. CONCLUSION**

Hospital readmission is an important and costly epidemic that needs to be addressed in order to improve the healthcare system in this country. A system premised on financial incentives for hospitals can be an effective solution to resolve this problem if governed and implemented properly. As currently structured, however, the HRRP will not produce the intended benefits on the delivery of healthcare in the United States. Moreover, the program has a potential to have a number of negative consequences, including a decrease in indigent access to care, a reduction in senior quality care, and increased financial strains on hospitals.

The main problem with the HRRP is that it fails to appreciate the material differences in the patient base of hospitals that contribute to disparities in readmission rates. There are often factors entirely outside of the hospital's control that, nonetheless, cause a patient to be readmitted. Rather than assessing penalties purely by readmission rates, the program ought to account for the processes and safeguards that hospitals have implemented in addressing these challenges.

Applying the same standard to each hospital, without accounting for their inherent differences, raises the potential that the existing disparities in healthcare system will be magnified. With some common sense adjustments, however, the program's implementation could affect the positive change it was intended to have on the quality of healthcare in the United States.

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<sup>63</sup> *Id.* at 385-86.

<sup>64</sup> *Id.* at 382.