A Decade of Observing the Hospital Readmission Reductions Program—Time to Retire an Ineffective Policy

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The Hospital Readmission Reductions Program (HRRP), a national value-based program that aimed to incentivize improvements in care delivery by penalizing hospitals with higher-than-expected 30-day readmission rates, has been controversial since its enactment under the Patient Protection and Affordable Care Act. Over the past decade, numerous studies have questioned the impact of the program and raised concern about unintended consequences. In a new study, Sabbatini and colleagues provide additional evidence highlighting that the HRRP has largely been ineffective.

The overarching goal of the HRRP was to encourage hospitals to improve discharge planning, care transitions, and care coordination following discharge. Early studies suggested that the program was a success, with readmissions decreasing on a national scale immediately after the program was announced in 2010. More recent evidence, however, suggests that readmission reductions initially credited to the program were overstated, and instead, primarily due to nationwide changes in the coding intensity and statistical artifact, including regression to the mean and secular decreases in index admissions, rather than changes in care delivery.

In response to the HRRP, hospitals have also changed how they triage recently discharged patients who return to the hospital, which has artificially made the policy appear successful. Currently, the 30-day readmission measure used by the Centers for Medicare and Medicaid Services (CMS) provides an incomplete picture of hospital revisits because it does not include emergency department (ED) treat-and-release encounters or observation stays that can occur within 30 days of discharge, both of which have increased substantially since the program was implemented. Evidence suggests that hospitals have raised their threshold to readmit patients presenting to the ED, and are now instead more likely to place patients in observation status or directly discharge them from the ED. In fact, one national study found that total 30-day hospital revisits—including inpatient readmissions, observation stays, and ED revisits—for conditions targeted by the HRRP actually increased under the program, highlighting that changes in triage patterns rather than widespread improvements in care are responsible for the decrease in readmissions.

The Sabbatini et al study further supports the notion that the decrease in readmissions initially observed under the HRRP was mainly due to hospitals increasing their use of observation stays. The authors reexamined the impact of HRRP after including observation stays in both the numerator (readmissions) and the denominator (index admissions). The motivation behind this decision is that observation stays are often indistinguishable from an inpatient stay or readmission. The authors found that accounting for observation stays attenuated the estimated decrease in readmission rates for targeted conditions by more than 50%, and perhaps more importantly, negated the previously reported association of the program with national decreases in readmission rates when considering only inpatient hospitalizations. The study by Sabbatini and colleagues, taken together with earlier research highlighting the role of changes in triage patterns, coding intensity, and statistical artifact, suggest that the HRRP has not been an effective policy.

These findings may not be surprising to many front-line clinicians, who have experienced the unintended effects of the HRRP for over a decade, including increased pressure from administrators to not readmit patients from the ED and nudges to increase use of observation status. Front-line clinicians, who are arguably best positioned to understand the nuances of care delivery and clinical effects of programs like the HRRP, have long argued that readmissions predominately reflect the
socioeconomic circumstances of their patients and communities. Much of the variation in readmissions across US hospitals can be explained by differences in the social determinants of health (eg, poverty) of the patient populations they serve, which CMS does not fully account for when comparing hospital performance. As a result, the HRRP has been incredibly regressive, disproportionately penalizing safety-net hospitals that care for low-income, minoritized, and marginalized populations. The inequitable nature of the HRRP was only by magnified by the COVID-19 pandemic, as low-income and minoritized communities have disproportionately shouldered worsening poverty and housing instability, which will increase readmission risk but not be captured by CMS risk-adjustment models. Although the penalties imposed by the HRRP are measurable, the short- and long-term consequences and opportunity cost of taking resources away from resource-constrained hospitals will not be.

Beyond concerns about the inequitable effects of the HRRP, front-line clinicians have also worried that incentives to avoid readmissions may lead to potentially inappropriate management of higher-risk patients with chronic conditions, such as heart failure, in the outpatient rather than inpatient setting. Although the evidence is mixed, several independent investigations have substantiated these concerns, showing that mortality within 30 days of discharge for heart failure increased under the HRRP compared with earlier trends. Given that the HRRP was not rolled out in a randomized fashion, it remains unclear whether heart failure mortality would have decreased, increased, or remained stable absent exposure to the program. Nonetheless, the bar for evidence suggesting that a policy is harmful should not be higher than the bar suggesting benefit, and therefore, any signal that suggests potential harm should be evaluated and addressed.

More than a decade has passed since the HRRP was implemented. At best, the evidence to date suggests that the HRRP has had no meaningful effect on the rate at which patients return to the hospital within 30 days of discharge. At worst, the HRRP has unfairly penalized hospitals caring for the most vulnerable populations in our country and potentially resulted in patient harm. How much more evidence will it take for policy makers to officially end this program?

The persistence of the HRRP is perhaps emblematic of the growing tension between front-line clinicians who face the effects of value-based policies and federal decision-makers who may not, but ultimately dictate their development and implementation. If policy makers are serious about enhancing patient care, they have a responsibility to iteratively improve, refine, or eliminate policies based on emerging evidence and take concerns raised by front-line clinicians seriously. After a decade of evidence that has overwhelmingly shown that the HRRP has been largely ineffective, it is time for federal policy makers to retire the program.

ARTICLE INFORMATION
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