Hospital Readmissions and the Affordable Care Act
Paying for Coordinated Quality Care

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Hospital readmissions have been the subject of ever-increasing scrutiny. Indeed, they are an important focus of the US Patient Protection and Affordable Care Act (ACA). Identified by the Medicare Payment Advisory Commission as a major action item for some time, hospital readmissions remain prevalent, costly, and largely preventable.1 The recently updated Hospital Compare Web site reveals that the national 30-day readmission rates for acute myocardial infarction (AMI), heart failure, and pneumonia have had limited if any improvement from 2007 through 2010.2 “Payment incentives to avoid readmissions” have been cited in the Department of Health and Human Services’ strategic plan for 2010 through 2015 as an example of quality of care improvement.3 Hospital readmissions also have been singled out for improvement by the Centers for Medicare & Medicaid Services’ (CMS’s) National Strategy for Quality Improvement in Health Care.4 The goal of the CMS’s strategy is to effect a 20% reduction in hospital readmission rates by the end of 2013, thereby potentially preventing 1.6 million hospitalizations and saving an estimated $15 billion.4 We describe the various strategies embedded in the ACA that focus on this important challenge.

The first initiative launched in the effort to reduce hospital readmissions was the Community-Based Care Transitions Program (CCTP).5 This Medicare demonstration project was mandated by §3026 of the ACA and is intended to reduce hospital readmissions by targeting the quality and safety of care transitions between the inpatient and outpatient arenas. To this end, the CCTP, a nationwide 5-year $500 million program, proposes to underwrite (on a per-eligible-discharge basis) the services of partnerships between hospitals and community-based organizations focused on the reduction of hospital readmissions. Further assistance will be provided by carefully selected expert “hospital engagement” and other dedicated contractors prequalified by the Department of Health and Human Services. The premise of the CCTP is that partnerships between hospitals and community-based organizations, heretofore uncommon and non-reimbursable, will prove successful in reducing hospital readmission rates by coordinating care transitions. Effectiveness will be maximized by emphasizing high-risk beneficiaries and partnerships between hospitals with high admission rates and medically underserved communities. Unlike earlier, more-limited efforts to foster partnerships between hospitals and the community as an approach to fragmented post-acute care (eg, the 14-state Care Transitions theme of Medicare’s quality improvement organizations), the CCTP operates on a national scale that previously was unattainable. As such, the CCTP appears positioned to improve the quality of care transitions, reduce hospital readmissions, and document measurable cost savings. There is no overestimating the insights likely to be gained or the prospect of their broad dissemination and implementation.

A related initiative is the soon-to-be launched Independence At Home Demonstration Program (IAHP), authorized by §3024 of the ACA.6 Under the IAHP, a 3-year $25 million effort, primary care teams directed by physicians or nurse practitioners will evaluate service delivery models for home-bound chronically ill Medicare beneficiaries. Aiming to provide highly intense care, the IAHP is to be comprehensive, coordinated, continuous (24-hour, 7-days/week), accessible (in-home), and multidisciplinary, thereby hopefully averting readmissions. The IAHP will also be testing novel payment models wherein revenue sharing by health care teams (consisting of physicians, nurses, physician assistants, pharmacists, and other health and social services staff) can be realized subject to meeting specified quality and savings targets. The IAHP is limited to a total patient cohort of 10,000, and viewed broadly, stands out for its demanding focus on readmission-susceptible beneficiaries whose extant home-centered care is in need of intensification and coordination. The IAHP is slated to begin January 1, 2012, and may well have a salutary effect on hospital readmission rates while effecting other measurable improvements in the quality, efficiency, and cost of the care provided.

Perhaps the most important program in the effort to reduce hospital readmissions is the multipronged Hospital Readmission Reduction Program (HRRP), the product of §3025 of the ACA.7,8 Identified by the Medicare Quality Strategy for Quality Improvement in Health Care as a major action item for some time, HRRP proposes to underwrite (on a per-eligible-discharge basis) the services of partnerships between hospitals and community-based organizations, heretofore uncommon and non-reimbursable, will prove successful in reducing hospital readmission rates by coordinating care transitions. Effectiveness will be maximized by emphasizing high-risk beneficiaries and partnerships between hospitals with high admission rates and medically underserved communities. Unlike earlier, more-limited efforts to foster partnerships between hospitals and the community as an approach to fragmented post-acute care (eg, the 14-state Care Transitions theme of Medicare’s quality improvement organizations), the CCTP operates on a national scale that previously was unattainable. As such, the CCTP appears positioned to improve the quality of care transitions, reduce hospital readmissions, and document measurable cost savings. There is no overestimating the insights likely to be gained or the prospect of their broad dissemination and implementation.

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See also p 1796.
of the ACA.\textsuperscript{7} Deemed to generate significant savings by the Congressional Budget Office, the HRRP is designed to drive meaningful reductions in all-cause readmissions by aligning payment with outcome. The outcome measure proposed is the hospital-specific, risk-standardized all-cause 30-day excess readmission ratio following index hospitalizations for AMI, heart failure, or pneumonia. Beginning in fiscal year 2013, underperforming hospitals will incur a reduction of 1\% or less in Medicare base reimbursements for inpatient services provided for all diagnosis related groups. Payment penalties for fiscal years 2014 and 2015 will be capped at 2\% and 3\%, respectively. Although the number of hospitals likely to incur payment penalties cannot be determined at this time, hospital-specific readmission rates reported for fiscal year 2010 would have placed half of all applicable hospitals at risk regardless of geography, bed size, or teaching status.\textsuperscript{7} After fiscal year 2015, the HRRP intends to supplement the current 30-day hospital readmission measures for AMI, heart failure, and pneumonia with yet-to-be defined measures for other discharge diagnoses. Leading candidates include acute exacerbation of chronic obstructive pulmonary disease, asthma, elective surgical procedures, or vascular procedures. The HRRP will also require (effective date yet-to-be determined) expansion of the current public reporting of readmission rates for AMI, heart failure, and pneumonia on the Hospital Compare Web site to include all patient readmissions. In addition, the HRRP establishes a patient safety organization–supported quality improvement program for hospitals with historically high readmission rates. Combining payment reform, public reporting, and a quality improvement program, the HRRP stands to play a substantial role in the national effort to decrease potentially preventable hospital readmissions.

Another initiative aimed at reducing hospital readmission rates is the National Pilot Program on Payment Bundling (NPPPB) established by §3023 of the ACA.\textsuperscript{8} This large-scale, 5-year voluntary effort (to be overseen by the CMS’s Innovation Center) will test the bundling of Medicare payments into a single comprehensive fee for an episode of care. Intended for participating health care entities, the bundled payments will constitute due reimbursement for multiple services rendered to a beneficiary by distinct health care entities before (≤3 days), during, and after (≥30 days) hospitalization. Eligible participating health care entities may include acute care hospitals and health systems, physician groups, physician and hospital organizations, and post-acute care organizations such as skilled nursing facilities and home health agencies. Under these arrangements, slated to debut by January 1, 2013, participating clinicians and health care organizations will be entitled to revenue sharing in any and all savings garnered while assuming the risk for excess costs incurred. It is the premise of the NPPPB that the global episode-based payment model will incentivize participating clinicians and health care organizations to coordinate cost-conscious care around index admissions, thereby avoiding adverse downstream outcomes including potentially preventable hospital readmissions. Properly executed, the NPPPB (presently at the application and solicitation phase) could reward beneficiaries with quality care, clinicians and health care organizations with revenue sharing, hospitals with increased efficiency, and Medicare with lower costs.

With respect to hospital readmissions, the common strategic thread that runs through the ACA is incentivized coordination of care across transitions. As such, this policy tack considers that hospital readmissions (the avoidable by-product of fragmented and ill-incentivized health care delivery) will respond to payment reform.\textsuperscript{8} Combining financial incentives and penalties, the ACA seeks to promote coordination across the continuum of care. Indeed, it is only through coordinated teamwork that the inpatient-outpatient divide will ultimately be negotiated safely and for the most part irreversibly.\textsuperscript{10}

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\textbf{REFERENCES}


