The Hospital Readmissions Reduction Program: Inconvenient Observations

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Centers for Medicare and Medicaid Services (CMS)–promulgated quality metrics continue to attract critics. Physicians decry that many metrics are outside their control, while patient groups are frustrated that metrics lack meaning for beneficiaries. The Hospital Readmissions Reduction Program (HRRP) reduces payments for "excess" 30-day risk-standardized readmissions for six conditions and procedures, and may be less effective in reducing readmissions than previously reported due to intentional and increasing use of hospital observation stays.[1]

In this issue, Sheehy et al[2] report that nearly one in five rehospitalizations were unrecognized because either the index hospitalization or the rehospitalization was an observation stay, highlighting yet another challenge with the HRRP. Limitations of their study include the use of a single year of claims data and the exclusion of Medicare Advantage claims data, as one might expect lower readmission rates in this capitated program. Opportunities for improving the HRRP could consist of updating the HRRP metric to include observation stays and, for surgical hospitalizations, extended-stay surgical recovery, wherein patients may be observed for up to 2 days following a procedure. Unfortunately, despite the HRRP missing nearly one in five readmissions, CMS would likely need additional statutory authority from Congress in order to reinterpret the definition of readmission to include observation stays.[3]

Challenges with the HRRP metrics raise broader concerns about the program. For decades, administrators viewed readmissions as a utilization metric, only to have the Affordable Care Act re-designate and define all-cause readmissions as a quality metric. Yet hospitals and health systems control only some factors driving readmission. Readmissions occur for a variety of reasons, including not only poor quality of initial hospital care and inadequate care coordination, but also factors that are beyond the hospital's purview, such as lack of access to ambulatory services, multiple and severe chronic conditions that progress or remain unresponsive to intervention,[4] and demographic and social factors such as housing instability, health literacy, or residence in a food desert. These non-hospital factors reside within the domain of other market participants or local, state, and federal government agencies.

Challenges to the utility, validity, and appropriateness of HRRP metrics should remind policymakers of the dangers of over-legislating the details of healthcare policy and the statutory inflexibility that can ensue. Clinical care evolves, and artificial constructs—including payment categories such as observation status—may age poorly over time, exemplified best by the challenges of accessing post-acute care due to the 3-day rule.[5] Introduced as a statutory requirement in 1967, when the average length of stay was 13.8 days and observation care did not exist as a payment category, the 3-day rule requires Medicare beneficiaries to spend 3 days admitted to the hospital in order to qualify for coverage of post-acute care, creating care gaps for observation stay patients.

Observation care itself is an artificial construct of CMS payment policy. In the Medicare program, observation care falls under Part B, exposing patients to both greater financial responsibility and billing complexity through the engagement of their supplemental insurance, even though those receiving observation care experience the same care as if hospitalized— routine monitoring, nursing care, blood draws, imaging, and diagnostic tests. While CMS requires notification of observation status and explanation of the difference in patient financial responsibility, in clinical practice, patient understanding is limited. Policymakers can support both Medicare beneficiaries and hospitals by reexamining observation care as a payment category.

Sheehy and colleagues' work simultaneously challenges the face validity of the HRRP and the reasonableness of categorizing some inpatient stays as outpatient care in the hospital—issues that policymakers can and should address.

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