Establishing Beneficiary Equity in the Hospital Readmissions Program

From: The Honorable James B. Renacci
Sent By: alex.dominguez@mail.house.gov
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Dear Colleague:

The Hospital Readmission Reduction Program (HRRP) was created due to concerns that too few resources were being spent on reducing acute care hospital readmissions. HRRP penalizes hospitals based on the last three years of available readmission data compared to the national average. Since the creation of the HRRP, hospitals have employed many techniques to reduce their readmissions to avoid penalty, such as scheduling follow-up visits, utilizing case managers, and providing better post acute care coordination. While the HRRP has incentivized hospitals to reduce readmissions, there are some factors outside of a hospital's control that make it difficult for the patient to avoid readmission.

The current penalty methodology used in the HRRP has created an unintended consequence for hospitals that service our most vulnerable population—dual-eligible beneficiaries, low-income seniors, or young people with disability that are eligible for both Medicare and Medicaid. According to MedPac, an independent Congressional agency that advises Congress on issues affecting the Medicare program, hospitals servicing large shares of lower-income patients tend to have higher readmission rates and are more likely to pay readmission penalties. A study published by the U.S. National Library of Medicine National Institutes of Health had a similar finding when it compared dual-eligible status across groups of hospitals.

The HRRP penalty calculation jeopardizes the viability of hospitals that service this vulnerable population, which is why I introduced the Establishing Beneficiary Equity in the Hospital Readmission Program. This legislation adjusts the penalty methodology for hospitals servicing larger amounts of dual-eligible beneficiaries and excludes patients with certain extenuating circumstances from the penalty calculation. Further, the legislation requires MedPac to study the appropriateness of the arbitrary 30-day readmission threshold and requires the Secretary to consider the use of V codes for potential exclusions.

Adjusting the penalty to account for certain disparities in patient population can make a big difference to hospitals across the country and the nine million dual-eligible beneficiaries that rely on these hospitals for their critical care needs. If you have any questions or would like to become an original cosponsor, please contact Alyssa Palisi in my office at 5-3876 or via email at alyssa.palisi@mail.house.gov.