American Association of Heart Failure Nurses position paper on the Hospital Readmissions Reduction Program (HRRP)

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\textbf{Introduction}

The Hospital Readmissions Reduction Program (HRRP) is a Medicare value-based purchasing program established in Section 3025 of the Patient Protection and Affordable Care Act (ACA). The 30-day risk-standardized unplanned admissions measures in the program result in reduced payments to Inpatient Prospective Payment System (IPPS) hospitals when excess readmission rates occur. Heart failure (HF) is one of the six medical conditions in the program.

The purpose of the program was to encourage communication and improve care coordination across the continuum, with the anticipated result of decreased readmission rates. The program was also aimed to support “the national goal of improving health care for Americans by linking payment to quality care”.\textsuperscript{1} Data comparing readmission rates from the period before the HRRP implementation and during the period when HRRP penalties went into effect show a decrease in readmissions. However, a concerning inverse relationship with HF mortality has also been shown.

The American Association of Heart Failure Nurses calls for a review of current health policy regarding the HRRP and heart failure mortality rates.

\textbf{Methodology}

This position paper is based on a comprehensive review of research related to readmissions of Medicare beneficiaries with HF, a literature review of the HRRP policy, and consensus opinion of healthcare leaders in HF.

\textbf{Position and recommendations}

\textbf{Historical perspective on HRRP}

Heart failure (HF) is the fastest growing cardiovascular disease in the United States: Between 2009 and 2012, 5.7 million Americans \textsuperscript{≥} 20 years of age had HF, growing to 6.2 million people between 2013 and 2016.\textsuperscript{2} Based on inpatient data collected for Medicare beneficiaries between 2005 and 2011, the mean cost of a HF related hospitalization was calculated at $14,631 per patient, largely covered by Centers for Medicare and Medicaid Services (CMS).\textsuperscript{3} Unfortunately, HF in Medicare patients was consistently among the conditions with the largest number of 30-day readmissions, with a 24.5% overall readmission rate in 2011,\textsuperscript{4} the year prior to the HRRP effective date.

In 2007, the Medicare Payment Advisory Committee (MedPAC) estimated that 76% of 30-day hospital readmissions were potentially preventable.\textsuperscript{5} Medicare spending on all-cause readmissions was $12 billion in 2005, and HF was one of the conditions with the most readmissions.\textsuperscript{5} Because CMS spending on HF was considerable and only expected to increase, focus on disease management and prevention of readmissions became a high priority.

Interventions enacted to decrease readmission were several-fold. First, the transition from hospital post-acute care settings was identified as a critical juncture with potential for improved care coordination, discharge planning, and transitional management. Secondly, a payment policy for inpatient readmission was recommended by MedPAC to encourage hospitals to reduce their readmission rates. Thirdly, in 2009, CMS began publicly reporting 30-day hospital risk-standardized readmission rates (RSRRs) for HF on its Hospital Compare Website. The measure captured readmissions for Medicare beneficiaries aged 65 and older who experienced a readmission for any reason within 30 days of a hospital inpatient discharge. However, when adjusted trends before and after implementation of public reports of readmissions were analyzed (based on Medicare claims data from 2006 to 2012), no change was noted for patients with HF.\textsuperscript{6}

In 2010, the ACA was passed, supporting the MedPAC initiatives and forging greater payment incentives. A major goal of the ACA was to shift CMS fee-for-service reimbursement to programs that link provider payment to performance of quality measures, and one quality measure identified was patient readmission following an inpatient hospitalization. The HRRP was established as a part of the ACA and reduced Medicare payments to IPPS hospitals with excess readmissions.\textsuperscript{7}
For hospitals to value declining readmission rates over higher mortality rates, there may be a need to assure no unintended harm, and any increase in mortality is cause for further study. In addition to assuring no unintended harm, there may be a need to adjust penalties assessed by the HRRP to avoid an economic impetus for hospitals to value declining readmission rates over higher mortality rates.  

Impact today

For fiscal year 2020 (based on discharges from July 1, 2015 to June 30, 2018), 3129 general hospitals in the HRRP were evaluated, and 83% received a penalty. The overwhelming number of hospitals unable to avoid imposed penalties raises concern that the overall goal of HRRP to improve quality and lower cost has not been achieved. In addition to the reimbursement losses, hospitals have expended tremendous resources to meet metrics and decrease readmission rates, but with little demonstrable return. With national trends in heart failure hospitalizations and readmissions shown to be of utmost concern. The initial analyses of the HRRP were positive during the period from October 2007 to May 2015, when readmission rates for the targeted diagnoses declined from 21.5% to 17.8%. Similarly, the 30-day RSRRs for HF decreased from 20% prior to HRRP implementation (January 1, 2006–March 31, 2010) to 18.4% during the period after HRRP penalties went into effect (October 1, 2012–December 31, 2014). However, an inverse relationship with HF mortality was also noted during the same period, with an increase in the 30-day risk-adjusted mortality rate from 7.2% before implementation to 8.6% during the penalties phase of the HRRP. While causation cannot be established between the HRRP and the increase in the mortality rates for HF, the 30-day risk adjusted mortality rate for HF had been declining steadily in the decade prior to implementation of the HRRP. Following implementation of the HRRP, the mortality rate in Medicare beneficiaries hospitalized with HF increased from 7.9% in 2008 to 9.2% in 2014. This trend is concerning and any increase in mortality is cause for further study. In addition to assuring no unintended harm, there may be a need to adjust penalties assessed by the HRRP to avoid an economic impetus for hospitals to value declining readmission rates over higher mortality rates.

Conclusion

It is therefore the position of AAHFN that the continued administration of the HRRP, and subsequent versions thereof, necessitate further study and reporting of interventions that demonstrate improved outcomes. AAHFN welcomes the opportunity to collaborate with CMS to assure policies encourage the implementation of proven multidiscipline care strategies and avoid rewarding behaviors such as inappropriate observational status or delayed readmission in any situation which clinically warrants inpatient status. Mortality rates for HF will require close monitoring in correlation to readmission reduction efforts in order to assure no harm comes to patients. AAHFN strongly advocates for expenditure control and a focus on quality improvement that promotes treatments and metrics that are meaningful to patients including patient safety, access to care, and survival. AAHFN endorses research and policy revisions that lead to equitable care for patients with HF in acute care, during transition, and in post-acute care settings.

References

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