The Governance Institute

BOARD BRIEFING

What a readmission penalty really measures

A payment penalty and a change in current care are different findings.

5–6 MINUTE READ

In This Briefing

Medicare is counting a broader patient group over a shorter period. The resulting penalties affect payment today, but they do not describe only today's care. Understanding the calculation helps connect financial results with the experience of patients.

About Board Briefings

Board Briefings offer deeper explanations of healthcare issues and their implications for governance. Each includes a practical example, authoritative sources, and key questions to support informed board discussion.

What Happened

On October 8, Healthcare Dive reported that 2,334 hospitals—about 80% of those assessed—face Medicare readmission penalties for fiscal 2027. The payment reductions began October 1. More hospitals were penalized than in the previous year. (1)

Medicare also changed which patients and years enter the calculation. It added patients covered through private Medicare Advantage plans and shortened the period of care being measured from three years to two. The national count does not establish how much those changes, or changes in care, contributed to the increase. (2)

The Issue, Explained

A patient leaves the hospital after treatment and returns unexpectedly a few days later. That return is a readmission. Some returns cannot be avoided. Others can reveal a problem with recovery, medication, or the transition home. A return therefore deserves attention without automatically proving that the original care was poor.

Medicare, the federal insurance program mainly for older adults, links some hospital payments to these returns. Its Hospital Readmissions Reduction Program examines unplanned readmissions within 30 days after selected conditions and procedures. Hospitals can lose part of their payment when returns exceed the level expected under the program's calculation. (3)

That calculation does more than count returning patients. It accounts for specified patient characteristics and compares hospitals with peers. The comparison groups reflect how many patients have both Medicare and Medicaid, public coverage for eligible people with limited incomes and other qualifying needs. (3)

Some Medicare patients receive traditional coverage directly through the federal program. Others receive their Medicare benefits through private plans called Medicare Advantage. Adding the latter patients broadens the group whose care is measured. Shortening the period changes which years of experience remain in the result. (2)

A broader group can produce a different overall result even when care for the previously counted patients is unchanged. Dropping an older year can change it again. Neither change determines the direction at every hospital. Real improvements or deterioration can occur at the same time.

The Issue, Explained (continued)

The penalty's financial reach is narrower than its name may suggest. It applies to traditional Medicare's base operating payments for hospital stays, with a maximum reduction of 3%. It is not a reduction of up to 3% in all hospital revenue. Including Medicare Advantage patients in the measure does not apply the same penalty to their plans' payments. (3)

There is a time gap as well. The October reporting describes fiscal 2027 results based on care delivered during 2023–2025. A penalty arriving now is not a score for only the care being delivered now. An improvement introduced later may be helping patients without yet affecting that payment result. (1)

These views answer different questions. The official calculation determines the payment reduction. Similar patients measured consistently over time help reveal changes in care. More recent outcomes describe care after the period used for the penalty. Read together, they show more than any one result alone.

A Practical Example

In this hypothetical report, one group has 100 hospital returns among 1,000 discharges in each of two years. Its raw return rate stays at 10%.

The second year's report adds another group with 75 returns among 500 discharges. Together, there are 175 returns among 1,500 discharges, or about 11.7%. The overall rate rises even though the first group's experience has not changed.

This is not Medicare's risk-adjusted formula or evidence that Medicare Advantage patients have worse outcomes. It shows why the composition of a measure matters. The broader result can reveal care needs that were previously missing, while a consistent comparison answers whether the original group's care improved or worsened.

Governance Implications

A payment reduction affects the financial plan. The experience of patients returning unexpectedly remains a quality concern. A changed calculation makes the relationship between these two results harder to read, but does not make either result unimportant.

An improvement effort follows its own timeline. A follow-up nurse may help patients understand medicines or arrange appointments. Completing more calls records activity; whether patients receive the help they need and avoid preventable returns describes the outcome. Evidence connecting those steps becomes clearer over time.

Clinical leaders and management direct improvement work. The board reviews significant quality findings, resource commitments, and evidence of progress. That discussion is better informed when the historical penalty and current outcomes are both visible. A change in the score and a change in patients' care can occur together, but neither can be inferred from the other alone.

Questions for the Board

1. **When reviewing an annual readmission result:**
   Which patients and years are included, and what has changed in the calculation?

2. **When assessing quality trends:**
   What do similar patients' outcomes measured consistently over time, alongside more recent results, show about care?

3. **When reviewing quality improvement investments:**
   How much payment is affected, and what evidence shows whether improvement investments are helping patients?

Sources & Further Reading

1. Healthcare Dive. Medicare penalizes more hospitals for readmissions. October 8, 2026. Attributed analysis of CMS data; counts not independently recalculated.
2. Centers for Medicare & Medicaid Services. FY 2026 inpatient payment final rule. July 31, 2025. Measurement changes beginning in fiscal 2027.
3. Centers for Medicare & Medicaid Services. Hospital Readmissions Reduction Program. Program scope and payment reductions.

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