Medicare’s Hospital Readmissions Reduction Program (HRRP), which was launched in 2012, is a mandatory pay-for-performance program that penalizes hospitals with high 30-day readmission rates. This program has been controversial because while it adjusts performance for medical risk, it does not adjust for social risk factors such as poverty, which have been shown to affect readmission rates. Consequently, the program disproportionately penalizes safety-net hospitals. Congress passed the 21st Century Cures Act in 2016, which required Medicare to account for differences in poverty rates between hospitals when assessing hospital performance in the HRRP. Beginning in 2019, the HRRP stratifies hospitals into five “peer groups” to compare hospitals with similar proportions of patients that are poor (measured by the proportion of dually enrolled Medicare and Medicaid patients).

This research investigates the impact of stratification on hospital penalties under the HRRP.

Data and Methods

We used publicly available data on 3,049 hospitals and examined hospital characteristics, patient neighborhood characteristics and state Medicaid eligibility to estimate HRRP penalties before and after stratification. We calculated penalty amounts under both the old and new (stratified) HRRP formulae to compare the projected penalties during the first year of stratification to what they would have been under the old system. We estimated the difference in HRRP penalties in relative (percent change) and absolute (dollars) terms between 2018 and 2019.

Results

In total, hospitals in the lowest quintile of dually enrolled Medicare and Medicaid patients will see an increase of more than $12 million in penalties, while hospitals in the highest quintile—who serve the highest proportion of poor patients—will see a decrease of more than $22 million in penalties.

The average penalty per hospital will be about $176,400 under both stratification and traditional policy specifications due to the overall budget-neutrality of the program. Changes in penalties for hospitals ranged from an increase

Figure 1: HRRP Penalty Change (by Percent)
Results (cont’d)

of just over $225,000 to a decrease of more than $436,000 and varied significantly by stratum.

Similarly, the average penalty at the state level will be $21,094,000 under both stratification and traditional policy specifications. The changes in penalties differed significantly state by state.

On a relative basis, California is projected to have the greatest reduction in penalties (-14.2%), while South Dakota is projected to have the greatest increase in penalties (+37.3%). Missouri is projected to have an 0.8% increase in penalties (Figure 1).

On an absolute basis, California is also projected to have the greatest reduction in penalties ($6,587,964 lower), while Florida is projected to have the greatest increase in penalties ($2,524,904 higher). Missouri is projected to nearly break even, with a $103,036 increase in penalties (Figure 2).

The state-level shifts are correlated with state Medicaid generosity, with states with more generous eligibility criteria having a greater reduction in penalties than those in less generous states, likely because the proportion of a hospital’s population that is dually eligible is a better proxy for the overall safety net population in such states.

Policy Implications

Stratification of the HRRP is associated with a significant shift in penalties. Hospitals serving the poorest patient populations will see the greatest shift in penalties. Penalties are projected to drop by over $22 million for safety-net hospitals. This could mean that these hospitals have more money to provide services to vulnerable patient populations.

At the state level, the projected shift in dollars is also large, and it particularly benefited hospitals in states that have more generous Medicaid eligibility. Because hospitals are assigned to “peer groups” based on their proportion Medicaid, they get more credit for having a high proportion of poor patients if more of those patients are on Medicaid.

There is still debate about the ideal way to account for social risk in the readmissions program. Some have argued that direct adjustment (giving each hospital credit for their exact proportion of patients who are poor), rather than breaking hospitals into five groups, would have been a better approach. Some have argued that adjusting for social risk may reduce hospitals’ incentive to improve and lead to widening disparities in readmissions.

Overall, the new HRRP program is a fairer way of judging hospital performance on readmissions. Policymakers should monitor the impact of this change on trends in readmission rates as well as hospital financial performance as the policy is fully implemented.