influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act.''

J. Application of Incentives To Reduce Avoidable Readmissions to Hospitals

1. Introduction

A significant portion of Medicare spending—$15 billion each year—is related to hospital readmissions. According to a 2005 MedPAC analysis ,[17] nearly 18 percent of beneficiaries who are discharged from the hospital are readmitted within 30 days, resulting in approximately 2 million readmissions. By MedPAC's method, over 13 percent of 30-day hospital readmissions and an associated $12 billion in spending (⅘ of all Medicare spending for readmissions) were found to be potentially avoidable. Beyond cost considerations, readmissions may reflect poor quality of care and affect beneficiaries'' quality of life. Though not all readmissions are avoidable, hospitals should share accountability for readmission rates that could be much lower through the application of evidence-based best practices. Interventions that have been shown to reduce readmissions include better quality of care during the hospitalization, more complete care plans, emphasis on coordination of care at the point of transitions to home or postacute care, better use of after-hospital care, and more active involvement of patients and caregivers in decision making.

The application of incentives to reduce hospital readmissions, including payment and public reporting approaches, could promote the adoption and development of best practice interventions for averting avoidable readmissions, resulting in higher quality of care for Medicare beneficiaries and reduction in unnecessary costs for the program. Under the current payment system, readmissions are financially rewarding for hospitals. Application of payment incentives to encourage reduction of avoidable readmissions could help address unintended incentives in the current payment system.

In this section, following discussion of readmission issues related to measurement, accountability, and interventions, we are presenting three approaches to applying incentives to reduce avoidable readmissions for public comment: (1) Direct adjustment to hospital DRG payments for avoidable readmissions, (2) adjustments to hospital DRG payments through a performance-based payment methodology, and (3) public reporting of readmission rates. We note that either type of adjustment to hospital payments for readmissions would likely require new statutory authority for the Medicare program. We are seeking public comments on all of the ideas presented in this section.

2. Measurement

Routine, valid, and reliable measurement of hospital-specific rates of readmissions would be a prerequisite to any method of applying incentives for reducing hospital readmissions. Measurement data should be meaningful and actionable for hospitals and should be fair to encourage trust and engagement in the effort. Risk adjustment of measurement data is necessary to account for patientπspecific factors that influence the likelihood of readmission, such as age, disease severity, and comorbidities.

Another important consideration in measurement of readmission rates is the time period from discharge to readmission (for example, 7, 15, 30, or 90 days). In section IV.B. of the preamble of this proposed rule, measures of risk-adjusted 30-day readmission rates are proposed for the RHQDAPU program. The 9th Scope of Work for Medicare Quality Improvement Organizations (QIO 9th SOW) also includes 30-day readmission measures for communities.

Measures should be aligned across settings of care. Hospitals are not the only providers that affect the occurrence of readmissions. For example, the care delivered by SNFs and HHAs also has an important impact on whether a beneficiary is readmitted. Data from aligned readmissions measures, applicable to various settings of care, would provide better information about care coordination problems within and between settings. Alignment of readmissions measures would also facilitate more powerful application of incentives across Medicare's payment systems.

Another consideration is whether to focus on all readmissions or to focus on those that are known to be higher cost, more easily preventable, or most frequently occurring. For example, numerous hospitals have successfully implemented programs to reduce readmissions of heart failure patients, so more is known about the prevention of heart failure readmissions. Further, heart failure readmissions may be more costly than readmissions for other conditions. Another focus of efforts to prevent readmissions could be patients with multiple chronic conditions, who may be at the highest risk to experience readmissions.

3. Accountability

In the assignment of accountability for readmissions, risk adjustment of measurement data is one consideration of fairness; however, other factors must also be considered, including avoidability and shared accountability. Most clinicians would agree that a goal of zero readmissions may not be appropriate, as an extremely low rate of readmissions could indicate restricted access to needed medical services, overuse of hospital resources during the initial hospitalization (for example, prolonged length of stay), or excessive intensity of post-acute care services. Adequate risk adjustment could help to elucidate the avoidability of readmissions by identifying an expected readmission rate for a given patient or patient population.

Shared accountability is another important consideration. Hospitals are clearly accountable for the care provided during hospitalization and can also affect the quality of care provided after the hospitalization, but hospitals are not the only accountable entity. Both during and after hospitalization, physicians and other health professionals share accountability for the quality of care. Other provider entities, including skilled nursing facilities, rehabilitation facilities, home health agencies, and end-stage renal disease facilities, also share accountability for avoidable readmissions. Medicare beneficiaries themselves and their caregivers and social support systems play important roles in avoiding readmissions, particularly when beneficiaries have been discharged to home.

Assignment of accountability also requires consideration of situations where the patient presents for readmission with a different diagnosis or presents to a different hospital. If the

[17] Medicare Payment Advisory Commission: Report to Congress: Promoting Greater Efficiency in Medicare. June 2007, Chapter 5, page 103.

[18] Coleman, E.A., C. Parry, S. Chalmers, et al. 2006. The care transitions intervention: Results of a randomized controlled trial. *Archives of Internal Medicine,* 166 (September 25): 1822–1828.

[19] Coleman, E.A., J.D. Smith, R. Devbani, et al. 2005. Posthospital medication discrepancies: Prevalence and contributing factors. *Archives of Internal Medicine* 165, (September 12): 1842–1847.

[20] Coleman, E., and R. Berenson. 2004. Lost in transition: Challenges and opportunities for improving the quality of transitional care. *Annals of Internal Medicine,* 141, no. 7 (October 5): 533–536.

[21] Institute for Healthcare Improvement. 2004a. *Reducing readmissions for heart failure patients:*

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