JAMES B. RENACCI
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SUBCOMMITTEE ON HUMAN RESOURCES
SUBCOMMITTEE ON SOCIAL SECURITY

Congress of the United States
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June 10, 2014

Honorable Sylvia Burwell
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Dept. of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Secretary Sebelius and Administrator Tavenner:

In August 2013, Kaiser Health News reported that among the safety net hospitals with the most poor patients, 77 percent were penalized, while only 36 percent of the hospitals with the fewest poor patients were penalized. As you are well aware, the Hospital Readmission Reduction Program (HRRP) was created due to concerns that too few resources were being spent on reducing acute care hospital readmissions. Reducing avoidable readmissions should be among a hospital's top priorities. 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 people with disabilities that are eligible for both Medicare and Medicaid.

Several studies have found flaws with the current penalty methodology, which has caused concern among Congressional leaders on both sides of the aisle. Specifically, a study by the Commonwealth Fund found that readmission rates were tied to community factors more so than hospital quality. The authors argued that "penalizing hospitals with readmission rates above a certain threshold alone may not be as effective as programs that help ensure patients make a successful transition from hospital to home." The New England Journal of Medicine found that "the HRRP will penalize hospitals that care for the sickest and poorest Americans, largely because readmissions are driven by the severity of underlying illness and social instability at

home." Lastly, MedPAC recognized that hospitals serving large shares of poor patients tend to have higher readmission rates and that these hospitals will be more likely to pay readmission penalties—not due to poor quality received in the hospital, but due to certain socioeconomic factors. As new evidence emerges, policies need to be reevaluated and improved.

We appreciate that in the FY 2014 inpatient IPPS rule, CMS took an important step to improve the readmissions program by including an exclusion for planned readmissions. While the undersigned applaud this decision, the lack of a process for excluding readmissions unrelated to the initial reason for admission and other flaws still need to be addressed.

The HRRP penalty calculation jeopardizes the viability of hospitals that service our nation's most vulnerable population, which is why we the undersigned have supported H.R. 4188, 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. 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 dually-eligible beneficiaries that rely on these hospitals for their critical care needs.

Reducing readmissions cannot be placed squarely on the shoulders of the hospitals. It is a shared responsibility that involves the hospital, the patient, social services professionals, and providers across the continuum of care. With the penalty set to increase from a two percent reduction to a three percent reduction on every patient stay payment, we urge CMS to work with Congress to ensure the program is not negatively impacting hospitals that service dually-eligible beneficiaries. We look forward to your response.

Sincerely,

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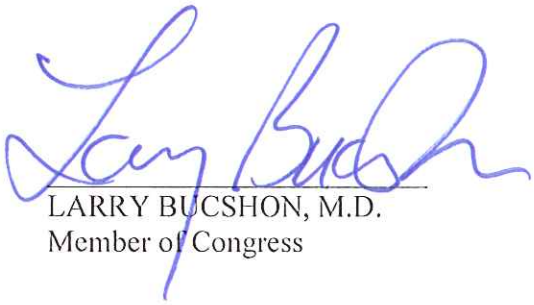

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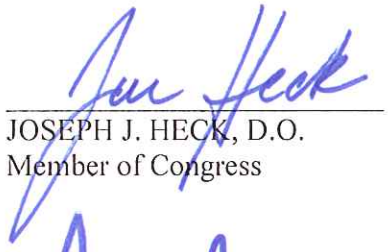

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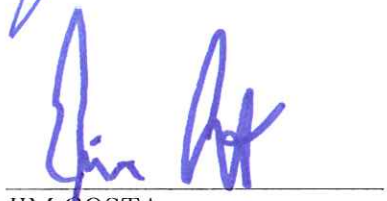

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