ONLINE APPENDIXES

1

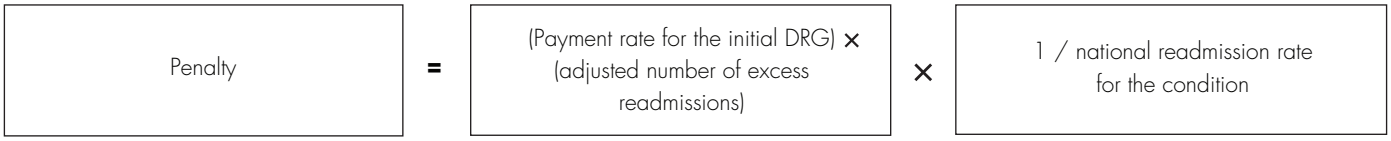
Mandated report: The effects of the Hospital Readmissions Reduction Program

ONLINE APPENDIX 1-A

Problems with the computation of HRRP penalties

FIGURE 1–A1

Current simplified computation of the HRRP readmission penalty



Note: HRRP (Hospital Readmissions Reduction Program), DRG (diagnosis related group).

In our June 2013 report on the Hospital Readmissions Reduction Program (HRRP), we described how the HRRP penalty is computed and explained that certain problems arise from this calculation. We emphasize that the direction of the incentive underpinning the penalty is correct and that it affects hospital behavior, but the penalty may not be equitable and may be too large in some cases.

Computing HRRP penalties for "excess readmissions"

Under the HRRP, hospitals that have Medicare risk-adjusted readmission rates for any of the HRRP conditions that are greater than the national average rates for those conditions (defined as "excess" readmissions) in the three most recent years available will have their current year inpatient payment rates reduced. The payment penalty will be collected by implementing a payment reduction for all Medicare discharges. The penalty is calculated as a share of a hospital's base operating payments and therefore does not reduce hospitals' indirect medical education, disproportionate share (DSH), special rural (e.g., sole community), or outlier payments.

The current readmission penalty formula is complex, but, in essence, the penalty is computed as the product of a hospital's adjusted cost of excess readmissions and a multiplier.[1] Usually, excess readmissions would be computed as the difference between a hospital's observed readmissions and its expected number of readmissions, given the riskiness of the hospital's patient population. However, the current method for computing excess readmissions does not use the actual observed number of readmissions; instead, it compares the hospital's *adjusted* number of readmissions with the expected number. The adjusted number is essentially a blend of the hospital's actual observed readmissions for a condition and the national mean readmission rate for the condition, with a larger weight placed on the national mean for smaller hospitals. The reason the current method uses the adjusted number is to limit the effect of random variation in hospitals with small numbers of cases. The method is explained in detail in the online appendix to our 2013 report on readmissions (http://www.medpac.gov/docs/default-source/reports/jun13_ch04_appendix.pdf?sfvrsn=0).

To illustrate how the magnitude of the penalty is computed, we show the readmission penalty formula, simplified, in Figure 1-A1.[2] For a condition with a high readmission of 20 percent, the multiplier would be 5, but for a condition with a low readmission rate of 4 percent, such as that for hip and knee replacement, the multiplier would be 25. The risk of distorting clinical decisions becomes greater with greater multipliers.

For illustrative purposes, consider a hospital with 100 admissions in a diagnosis related group (DRG) for which the national average rate of readmissions is 20 percent. The hospital's expected number of readmissions would be 20. If the hospital's actual number of readmissions were 24 and its adjusted number of readmissions were 22, then the number of excess readmissions would be 2. If the base DRG payment per initial admission were $10,000, the estimated cost of excess readmissions would be $20,000.[3] The right-most box in Figure 1-A1 represents a multiplier that increases the incentive to reduce readmissions. For example, given a 20 percent national average readmission rate for a condition, the multiplier would be 5 (1 / 0.20). The penalty would be equivalent to five times the cost

of the adjusted excess readmissions, or $100,000 in this example. In general, the formula produces penalties that are much higher than Medicare payments for the excess readmissions, creating a strong incentive to reduce readmissions. The multiplier will be bigger for conditions with lower readmission rates (hips and knees), and a lower multiplier will be used for conditions with higher readmission rates (heart failure). However, the full impact of the formula is limited because the penalty is applied to just six conditions, and each hospital's penalty is capped at 3 percent of base inpatient payments. The algebra showing that the penalty in law is equivalent to the simplified formula in Figure 1-A1 is shown in online Appendix 4-B to our 2013 June report available at http://www.medpac.gov/docs/default-source/reports/jun13_ch04_appendix.pdf?sfvrsn=0.

Most hospitals received HRRP penalties in 2017 because a hospital was penalized if it had above-average readmissions in any one of six conditions. Therefore, it is not unexpected that 92 percent of major teaching hospitals were penalized based on at least one of the six conditions having above-expected readmission rates. Smaller hospitals are less likely to face penalties given that 25 cases in a condition are needed to be subject to the penalty. Among hospitals with high shares of poor patients, 89 percent faced penalty. We discuss addressing the issue of socioeconomic status and readmissions in the text box on page 10 of Chapter 1. Total penalties are expected to have been $526 million in 2017, or 0.3 percent of overall Medicare payments going to hospitals (Centers for Medicare & Medicaid Services 2017).[4] ■

Endnotes

1 The formula itself is defined in the statute; thus, changing the formula would require a legislative change.

2 The actual language governing the HRRP program, including specification of the penalty formula, is shown in online Appendix 1-D, available at http://www.medpac.gov.

3 Note that excess cost is based on base operating payments for the initial admission, not payments for the readmission. For most medical diagnoses, the payment for the initial admission and readmissions are generally similar, but for surgical diagnoses, the payment for the initial admission often can be substantially greater than the payment for the readmission.

4 Twenty-two percent of hospitals avoided a penalty for one of two reasons. Seven percent were exempted because they did not have the minimum number of cases (25) over 3 years in any of the 6 conditions covered by the program. The remaining 15 percent of hospitals avoided penalties because they had better than average performance on all the conditions for which they had the minimum 25 cases.

ONLINE APPENDIX 1-B

Overview of our methods for computing readmission rates

The admissions we examine are consistent with the admissions that are subject to the Hospital Readmissions Reduction Program (HRRP) penalty. To identify the admissions subject to the HRRP, we used methods consistent with CMS in defining the elderly population (over age 65) for which readmissions rates are calculated and used the same diagnosis codes and the same criteria for identifying exclusions. The primary criteria for identifying eligible cases for each of the condition-specific measures were as follows:

- the primary diagnosis codes (International Classification of Diseases, ninth or tenth revisions) listed in the 2016 and 2017 condition-specific measures updates and specifications reports submitted to CMS by Yale's Center for Outcomes Research & Evaluation (Yale New Haven Health Services Corporation 2017a, Yale New Haven Health Services Corporation 2017b, Yale New Haven Health Services Corporation 2017c);
- beneficiaries ages 65 or older at admission;
- beneficiaries enrolled in Medicare fee-for-service Part A and Part B for 12 months before admission and enrolled in Part A during the admission;
- beneficiaries discharged alive from a nonfederal acute care hospital; and
- beneficiaries not transferred to another acute care hospital (does not apply to hip and knee replacement surgery or coronary artery bypass graft surgery).

Cases were excluded if:

- the beneficiary shifted to Medicare Advantage within 30 days postdischarge; however, beneficiaries who died during this period remained in the population evaluated;
- the beneficiary left the hospital against medical advice; and
- the beneficiary had prior admission within 30 days for the same diagnoses (e.g., admission for acute myocardial infarction (AMI) for AMI cases, admission for heart failure for heart failure cases).

Certain condition-specific exclusions were applied:

- AMI cases admitted and discharged from the hospital the same day since these cases likely were not AMIs; and
- heart failure cases where the beneficiary had a heart transplant or had a left ventricular assist device implanted during the admission or in the period 12 months before admission.

We used the above set of criteria for identifying our sample's initial admissions. We used another set of criteria, however, to identify the three different readmission measures examined: all cause, unplanned, and potentially preventable.

The all-cause measure included any readmission that occurred within 30 days of discharge. There were no exclusions for planned or potentially preventable readmissions.

Unplanned readmission methods (our primary method)

The planned readmission measure uses CMS version 4.0 of the planned readmission algorithm (Yale New Haven Health Services Corporation 2017a). The planned readmission algorithm relies on the Agency for Healthcare Research and Quality's clinical classification software to identify procedures and diagnoses. Planned readmissions include organ transplants, maintenance chemotherapy, and rehabilitation. In addition, 59 procedures that occur during a readmission are considered potentially planned. If, however, one of these potentially planned procedures is accompanied by one of a selected list of primary diagnoses, the readmission is considered unplanned and counted as such. Planned readmissions are not counted as readmissions.

Differences between clinical categorical models and regressions

For our risk adjustment methodology, we used clinical categorical models rather than regressions. Clinical categorical models, like regression models, use predictor variables to estimate the value of an outcome. Medicare severity–diagnosis related groups (MS–DRGs) are an example of a clinical categorical model. In this analysis, we used the all patient refined–DRGs with patient severity and risk of mortality values to group patients, along with age, gender, and— for readmissions—the presence or absence of a mental health condition. In clinical categorical models, patients are put into unique, mutually exclusive groups to measure the outcome of interest (in

this case, readmission rates). A clinical categorical model allows the unique effect of differences between groups to be captured. For example, while we generally find readmission rates increase with age, this relationship is reversed for patients with a mental health disorder, with higher readmission rates for younger (e.g., 70 years old) beneficiaries compared with older beneficiaries (e.g., 90 years old). Another example is the effect of age on readmission rates, which varies by patient severity within a DRG. For example, at severity level 1 for a particular DRG, the difference in expected readmission rates across beneficiaries of different ages may be larger than when the patient is at a higher severity level. In regression analysis, unless the model includes extensive interaction terms, the unique effect of these differences will not be captured.

Regression analysis can use continuous variables such as age, whereas categorical models require patients to be placed into age groups. Regression analysis can allow for the inclusion of multiple sets of patient comorbidities in models. In a clinical categorical model, patients are classified into unique groups based on selected combinations of comorbidities developed through the use of clinical panels to judge, for a particular condition, which comorbidities or combination of comorbidities will make a patient more resource intensive. These clinical hypotheses are then tested using historical data. An iterative process is used in developing the models (Fuller et al. 2016).

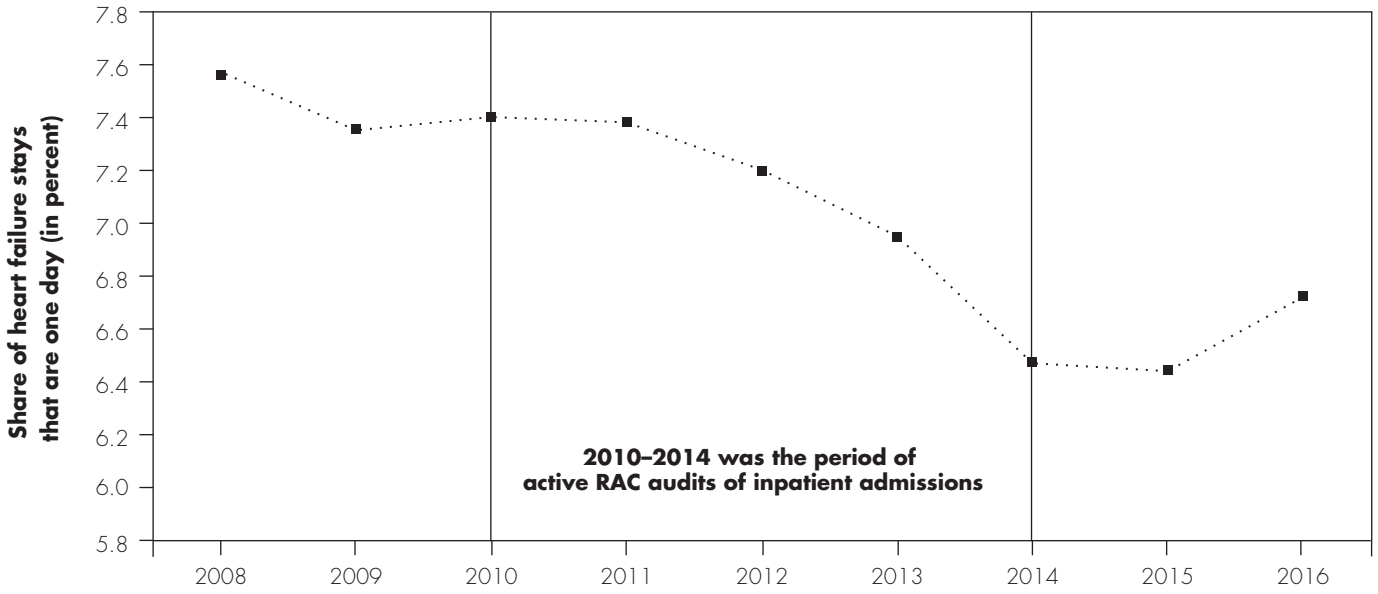
Changes to the Recovery Audit Contractor Program complicate analysis of readmission trends

Our analysis examined time trends in readmission rates, which is common across almost all evaluations of the program. One complication is that the HRRP was enacted in 2010, the same year that the Medicare Recovery Audit Contractor (RAC) Program began.[1] The RACs received contingency fees ranging from 9.0 percent to 12.5 percent for recoveries from claims audits. For example, if they could argue that an admission was not medically necessary and have CMS deny the claim, the RAC auditor would receive 9 percent or more of the denied DRG payment. Because inpatient claims have high payments relative to outpatient tests and services, RACs had an incentive to target these claims. The result was that, between 2010 and 2012, claim denials increased from $60 million to $2.1 billion. Part of the response by hospitals was to use more observation stays for the less severely ill patients because of the concern that the RAC could deny payment for an inpatient claim (Medicare Payment Advisory Commission 2015). During this period, observation stays increased 14.1 percent while one-day stays fell 9.6 percent. RAC audit activity declined in 2015 to $280 million in denied claims after changes that restricted RAC denials of short inpatient stays. Thus, the RAC program had several implications for this study:

- A portion of the decrease in initial admissions from 2011 to 2013 may have been due to concerns over RAC audits.
- A portion of the increase in observation stays after 2010 may have been due to concerns over RAC audits. We found approximately equal growth in the rate of observation stays for discharges of HRRP-covered conditions and those discharged for other conditions. In earlier work, we found that the increased rate of observation stays was also similar for those never admitted to the hospital. Because the growth in observation is not centered on patients who had been discharged from the hospital, it appears that the readmission policy is not a primary driver behind growth in observation stays.
- It is important to look at risk-adjusted readmission rates rather than raw rates for pneumonia and heart failure cases. Hospitals had fewer one-day inpatient stays after introduction of the RAC program, which would have the effect of increasing the severity of remaining pneumonia and heart failure cases. For example, Figure 1-B1 shows the share of live discharges from the hospital one day after or the same day as admission from 2008 to 2016. As shown in the figure, after the ramping up of the RAC program in 2011, the share of heart failure discharges who stayed only one day declined. We therefore expect the severity of cases to be increasing, possibly in ways that are not fully accounted for with risk adjustment. Risk adjustment may be insufficient because emergency department (ED) physicians who evaluate whether an admission is necessary likely base their evaluations on more factors than are in our risk adjustment models. In fact, our analysis of risk-adjusted mortality and readmission rates found higher rates of risk-adjusted mortality for longer stay patients,

FIGURE 1–B1

Fewer one-day heart failure stays after concurrent introduction of the RAC program and passage of the Hospital Readmissions Reduction Program



Note: RAC (recovery audit contractor).

Source: MedPAC analysis of Medicare inpatient standard analytic files.

suggesting that some factors outside the risk adjusters affecting length of stay also affect readmission and mortality rates.

Why not compare hospitals subject to the policy with those not subject to the policy?

The readmissions literature generally takes two approaches to evaluating the effect of the new readmission reduction program. One approach is to look at time trends to see whether readmission rates changed after the passage of the HRRP and to look at cross-sectional comparisons to see whether there were greater reductions in readmission rates for conditions covered by the program (Zuckerman et al. 2017). The second approach is to compare readmission rates at hospitals affected by the program with a control group of hospitals not affected by the program and examine the difference in changes in readmission rates between those affected by the policy and those excepted from the policy (Ibrahim et al. 2017). Both approaches have identified reductions in readmission rates. The Ibrahim study's control group consisted of small rural critical access hospitals (CAHs) that were exempt from the HRRP. CAHs are different from acute care hospitals paid under Medicare's inpatient prospective payment system (IPPS) in three ways that make them a poor comparison group. First, about 90 percent of CAHs are "swing-bed" hospitals. Swing beds can be used for acute and post-acute care, which means that a CAH patient can move to post-acute status but stay in the same bed. Therefore, it is possible for a patient to be discharged, considered post-acute, and readmitted without ever leaving his bed. Second, CAHs are paid cost-based reimbursement. Therefore, CAHs had less incentive to fully code patients when the new MS–DRGs were initiated in 2008. Third, CAHs were not targeted by the RACs since their cost-based reimbursements would change little if a claim shifted the patient from inpatient to observation.

Ibrahim and colleagues found that IPPS hospitals (those under the HRRP incentive) had greater declines than CAHs in both raw and risk-adjusted readmission rates. However, the difference was larger for the risk-adjusted

rate, suggesting that reported patient severity at IPPS hospitals increased faster than patient severity at CAHs. Increased reported patient severity at IPPS hospitals accounted for 63 percent of the reduction in risk-adjusted readmissions, and reductions in readmission rates greater than the control group (because of the HRRP and other IPPS factors) represented 37 percent of the reported reduction (Ibrahim et al. 2017). The researchers concluded, "Our findings raise a concern that a substantial portion of the estimated reductions in readmissions after implementation of the HRRP are the result of hospital documentation rather than underlying improvements in the delivery of care." What the study misses is that the RAC policy would be expected to increase severity more at IPPS hospitals than CAHs, starting in 2010. In addition, even if severity increased at both IPPS hospitals and CAHs, IPPS hospitals would be under a greater incentive to document the changes. This distinction especially held true during the Ibrahim study's time frame, which started in 2008 after the MS–DRG coding system was introduced, which was a major impetus for IPPS hospitals (but not CAHs) to increase coding intensity. It is unclear to what extent the higher coded severity at IPPS hospitals than at CAHs reflects true differences in changes in severity level, coding incentives of prospective payment system (PPS) hospitals (MS–DRGs) versus cost-based reimbursement, effects of the RACs, or other reasons for changes in reported severity. Because risk adjustment is important, and it is hard to compare risk adjustment between PPS hospitals and CAHs, we chose not to use CAHs as a comparison group. Instead, our study compared declines in readmissions for HRRP-covered conditions with noncovered conditions on a risk-adjusted and raw basis. It also looked at comparisons across hospitals to see whether hospitals with larger declines in readmission rate had differences in their growth rates of observation stays and ED visits.

Measuring mortality during the admission and 30 days postdischarge

We measured mortality over the period starting with a hospital admission and ending 30 days after discharge. We deemed that remaining alive outside of the hospital for 30 days was a good outcome and dying in the hospital or during the first 30 days after discharge was a bad outcome. By combining in-hospital and postdischarge mortality, our analysis is not distorted by shifts in practice patterns that change the site of death. For example, an expansion of hospice use may shift the site of deaths from the hospital to home, and we do not want to classify that as a worse outcome than dying in the hospital.

While our method of counting deaths differs from Dharmarajan (who looked only at mortality after discharge), our findings in our hospital-specific work are similar (Dharmarajan et al. 2017). We both found no negative correlation between changes in risk-adjusted mortality and changes in risk-adjusted readmissions over time. ■

Endnotes

1 The Tax Relief and Health Care Act of 2006 mandated that the Medicare Recovery Audit Contractor Program start in 2010.

References

Dharmarajan, K., Y. Wang, Z. Lin, et al. 2017. Association of changing hospital readmission rates with mortality rates after hospital discharge. *Journal of the American Medical Association* 318, no. 3 (July 18): 270–278.

Fuller, R. L., R. F. Averill, J. H. Muldoon, et al. 2016. Comparison of the properties of regression and categorical risk-adjustment models. *Journal of Ambulatory Care Management* 39, no. 2 (April–June): 157–165.

Ibrahim, A. M., J. B. Dimick, S. S. Sinha, et al. 2017. Association of coded severity with readmission reduction after the Hospital Readmissions Reduction Program. *JAMA Internal Medicine* (November 13).

Medicare Payment Advisory Commission. 2015. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Yale New Haven Health Services Corporation. 2017a. *2017 condition-specific measures updates and specifications report: Hospital-level 30-day risk-standardized readmission measures. Acute myocardial infarction – Version 10.0. Chronic obstructive pulmonary disease – Version 6.0. Heart failure – Version 10.0. Pneumonia – Version 10.0. Stroke – Version 6.0.* Report prepared by Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation for the Centers for Medicare & Medicaid Services. New Haven, CT: Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation.

Yale New Haven Health Services Corporation. 2017b. *2017 condition-specific measures updates and specifications report: Hospital-level 30-day risk-standardized readmission measures. Hospital-level 30-day risk-standardized readmission measure – Version 6.0.* Report prepared by Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation for the Centers for Medicare & Medicaid Services. New Haven, CT: Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation.

Yale New Haven Health Services Corporation. 2017c. *2017 condition-specific measures updates and specifications report: Hospital-level 30-day risk-standardized readmission measures. Isolated coronary artery bypass graft (CABG) surgery – Version 4.0. Elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) – Version 6.0.* Report prepared by Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation for the Centers for Medicare & Medicaid Services. New Haven, CT: Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation.

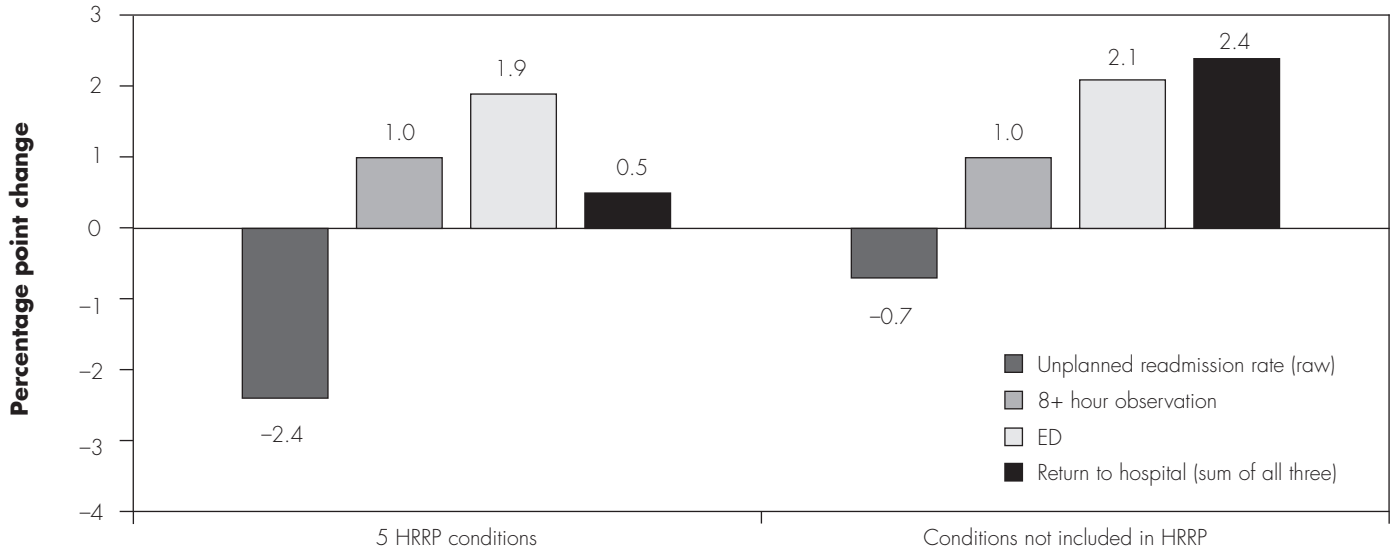
Zuckerman, R. B., K. E. Joynt Maddox, S. H. Sheingold, et al. 2017. Effect of a hospital-wide measure on the Readmissions Reduction Program. *New England Journal of Medicine* 377, no. 16 (October 19): 1551–1558.

ONLINE APPENDIX 1-C

Supplemental information comparing HRRP and non-HRRP conditions

FIGURE 1–C1

Percentage point change in use of readmissions, observation, and ED for conditions covered and not covered by the HRRP, 2010–2016 (raw rates, not risk adjusted)



Note: HRRP (Hospital Readmissions Reduction Program), ED (emergency department), AMI (acute myocardial infarction), COPD (chronic obstructive pulmonary disease). The five initial conditions include pneumonia, heart failure, AMI, COPD, and hip and knee replacement.

Source: MedPAC analysis of Medicare claims files for Medicare fee-for-service beneficiaries ages 65 or older.

In the main chapter, we compared risk-adjusted changes in readmission rates, emergency department (ED) stays, and observation stays for conditions covered by the Hospital Readmissions Reduction Program (HRRP) and conditions not covered by the program. We found modest differences in readmission rates but no differences in ED stays and observation stays, suggesting that the greater decline in readmission rates among HRRP conditions did not trigger an increase in ED and observation stays.

To demonstrate the sensitivity of those findings to risk adjustment, we present the raw differences in readmission rates, ED rates, and observation stays. Raw rates of readmission fell dramatically more for conditions covered by the HRRP (i.e., 2.4 percentage points for HRRP conditions vs. 0.7 percentage point for non-HRRP conditions). The difference is statistically significant using a Wilcoxon signed-rank test. However, changes in observation and ED visits were almost exactly the same for HRRP conditions and other conditions (Figure 1-C1). Because the greater reduction in readmission rates did not trigger a correspondingly greater growth in observation stays and ED visits, the observation growth and ED growth does not appear to be primarily a function of declining readmission rates.

We also measured changes in raw rates of readmission using percentage changes rather than percentage point changes. We found that raw readmission rates for HRRP conditions declined by 13.2 percent compared with 4.5 percent for noncovered conditions. We used each hospital as a unit of observation to test whether the difference is statistically significant. The difference is statistically significant ($p < 0.01$) using a Wilcoxon signed-rank test. We used the Wilcoxon rank test rather than a simple t-test because the distribution of readmission rates is not normally distributed.

In general, the effect of the HRRP program on readmission appears stronger without risk adjustment than with risk adjustment. This finding should reduce concerns that the reason for the decline in readmissions is coding rather than a true improvement in patient care. ■

ONLINE APPENDIX 1-D

Statutory language enacting the HRRP from the Patient Protection and Affordable Care Act

SEC. 3025. HOSPITAL READMISSIONS REDUCTION PROGRAM.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42U.S.C. 1395ww), as amended by sections 3001 and 3008, is amended by adding at the end the following new subsection:

''(q) HOSPITAL READMISSIONS REDUCTION PROGRAM.—

''(1) IN GENERAL.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (5)(C)) occurring during a fiscal year beginning on or after October 1, 2012, in order to account for excess readmissions in the hospital, the Secretary shall make payments (in addition to the payments described in paragraph (2)(A)(ii)) for such a discharge to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) in an amount equal to the product of—
''(A) the base operating DRG payment amount (as defined in paragraph (2)) for the discharge; and
''(B) the adjustment factor (described in paragraph (3)(A)) for the hospital for the fiscal year.

''(2) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—
''(A) IN GENERAL.—Except as provided in subparagraph (B), in this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year—
''(i) the payment amount that would otherwise be made under subsection (d) (determined without regard to subsection (o)) for a discharge if this subsection did not apply; reduced by ''(ii) any portion of such payment amount that
is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d).
''(B) SPECIAL RULES FOR CERTAIN HOSPITALS.—
''(i) SOLE COMMUNITY HOSPITALS AND MEDICARE DEPENDENT,
SMALL RURAL HOSPITALS.—In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

''(ii) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospitals provided that States paid under such section submit an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established herein with respect to this section.

''(3) ADJUSTMENT FACTOR.—
''(A) IN GENERAL.—For purposes of paragraph (1), the adjustment factor under this paragraph for an applicable hospital for a fiscal year is equal to the greater of—
''(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or
''(ii) the floor adjustment factor specified in subparagraph (C).
''(B) RATIO.—The ratio described in this subparagraph for a hospital for an applicable period is equal to 1 minus the ratio of—
''(i) the aggregate payments for excess readmissions (as defined in paragraph (4)(A)) with respect to an applicable hospital for the applicable period; and
''(ii) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period.
''(C) FLOOR ADJUSTMENT FACTOR.—For purposes of subparagraph (A), the floor adjustment factor specified in this subparagraph for—
''(i) fiscal year 2013 is 0.99;
''(ii) fiscal year 2014 is 0.98; or
''(iii) fiscal year 2015 and subsequent fiscal years is 0.97.

''(4) AGGREGATE PAYMENTS, EXCESS READMISSION RATIO DEFINED.—For purposes of this subsection:
''(A) AGGREGATE PAYMENTS FOR EXCESS READMISSIONS.—
The term 'aggregate payments for excess readmissions' means, for a hospital for an applicable period, the sum, for applicable conditions (as defined in paragraph (5)(A)), of the product, for each applicable condition, of—
''(i) the base operating DRG payment amount for such hospital for such applicable period for such condition;

''(ii) the number of admissions for such condition for such hospital for such applicable period; and
''(iii) the excess readmissions ratio (as defined in subparagraph (C)) for such hospital for such applicable period minus 1.
''(B) AGGREGATE PAYMENTS FOR ALL DISCHARGES.—The
term 'aggregate payments for all discharges' means, for a hospital for an applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.
''(C) EXCESS READMISSION RATIO.—
''(i) IN GENERAL.—Subject to clause (ii), the term 'excess readmissions ratio' means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—
''(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to such applicable period; to
''(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.
''(ii) EXCLUSION OF CERTAIN READMISSIONS.—For purposes of clause (i), with respect to a hospital, excess readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of discharges for such applicable condition for the applicable period and such hospital.

''(5) DEFINITIONS.—For purposes of this subsection:
''(A) APPLICABLE CONDITION.—The term 'applicable condition' means, subject to subparagraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—
''(i) readmissions (as defined in subparagraph (E)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and
''(ii) measures of such readmissions—
''(I) have been endorsed by the entity with a contract under section 1890(a); and
''(II) such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital).

''(B) EXPANSION OF APPLICABLE CONDITIONS.—Beginning with fiscal year 2015, the Secretary shall, to the extent practicable, expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures without such an endorsement in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.
''(C) APPLICABLE HOSPITAL.—The term 'applicable hospital' means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3), as the case may be.
''(D) APPLICABLE PERIOD.—The term 'applicable period' means, with respect to a fiscal year, such period as the Secretary shall specify.
''(E) READMISSION.—The term 'readmission' means, in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary from the date of such discharge. Insofar as the discharge relates to an applicable condition for which there is an endorsed measure described in subparagraph (A)(ii)(I), such time period (such as 30 days) shall be consistent with the time period specified for such measure.

''(6) REPORTING HOSPITAL SPECIFIC INFORMATION.—
''(A) IN GENERAL.—The Secretary shall make information available to the public regarding readmission rates of each subsection (d) hospital under the program.
''(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—
The Secretary shall ensure that a subsection (d) hospital has the opportunity to review, and submit corrections for,

the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.
''(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

''(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:
''(A) The determination of base operating DRG payment amounts.
''(B) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratio under paragraph (4)(C), aggregate payments for excess readmissions under paragraph (4)(A), and aggregate payments for all discharges under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (5).
''(C) The measures of readmissions as described in paragraph (5)(A)(ii).

''(8) READMISSION RATES FOR ALL PATIENTS.—
''(A) CALCULATION OF READMISSION.—The Secretary shall calculate readmission rates for all patients (as defined in subparagraph (D)) for a specified hospital (as defined in subparagraph (D)(ii)) for an applicable condition (as defined in paragraph (5)(B)) and other conditions deemed appropriate by the Secretary for an applicable period (as defined in paragraph (5)(D)) in the same manner as used to calculate such readmission rates for hospitals with respect to this title and posted on the CMS Hospital Compare website.
''(B) POSTING OF HOSPITAL SPECIFIC ALL PATIENT READMISSION RATES.—The Secretary shall make information on all patient readmission rates calculated under subparagraph (A) available on the CMS Hospital Compare website in a form and manner determined appropriate by the Secretary. The Secretary may also make other information determined appropriate by the Secretary available on such website.
''(C) HOSPITAL SUBMISSION OF ALL PATIENT DATA.—
''(i) Except as provided for in clause (ii), each specified hospital (as defined in subparagraph (D)(ii)) shall submit to the Secretary, in a form, manner and time specified by the Secretary, data and information determined necessary by the Secretary for the Secretary to calculate the all patient readmission rates described in subparagraph (A).
''(ii) Instead of a specified hospital submitting to the Secretary the data and information described in clause (i), such data and information may be submitted to the Secretary, on behalf of such a specified hospital, by a state or an entity determined appropriate by the Secretary.
''(D) DEFINITIONS.—For purposes of this paragraph:
''(i) The term 'all patients' means patients who are treated on an inpatient basis and discharged from a specified hospital (as defined in clause (ii)).
''(ii) The term 'specified hospital' means a subsection (d) hospital, hospitals described in clauses (i) through (v) of subsection (d)(1)(B) and, as determined feasible and appropriate by the Secretary, other hospitals not otherwise described in this subparagraph.''
(b) QUALITY IMPROVEMENT.—Part S of title III of the Public Health Service Act, as amended by section 3015, is further amended by adding at the end the following:

''SEC. 399KK. QUALITY IMPROVEMENT PROGRAM FOR HOSPITALS WITH A HIGH SEVERITY ADJUSTED READMISSION RATE.
''(a) ESTABLISHMENT.—
''(1) IN GENERAL.—Not later than 2 years after the date of enactment of this section, the Secretary shall make available a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations (as defined in section 921(4)).
''(2) ELIGIBLE HOSPITAL DEFINED.—In this subsection, the term 'eligible hospital' means a hospital that the Secretary determines has a high rate of risk adjusted readmissions for the conditions described in section 1886(q)(8)(A) of the Social Security Act and has not taken appropriate steps to reduce such readmissions and improve patient safety as evidenced through historically high rates of readmissions, as determined by the Secretary.
''(3) RISK ADJUSTMENT.—The Secretary shall utilize appropriate risk adjustment measures to determine eligible hospitals.
''(b) REPORT TO THE SECRETARY.—As determined appropriate by the Secretary, eligible hospitals and patient safety organizations working with those hospitals shall report to the Secretary on the processes employed by the hospital to improve readmission rates and the impact of such processes on readmission rates.'' ■