

April 20, 2010

Key Hospital Readmission Provisions in HR 3590

Hospital Readmissions Reduction Program [Sec. 3025 (p.775 - 788)]

-Program to begin October 1, 2012

-Medicare payments for all inpatient services (DRGs) will be reduced based on an adjustment factor that is calculated based on an “excess readmission” ratio that is hospital specific. The ratio compares the actual readmission rate to the expected readmission rate for certain conditions.

-Payments will not be reduced by more than 1% in 2013, 2% in 2014, and 3% in 2015 and beyond. The reduced payments to these hospitals will be redistributed to hospitals that demonstrate certain quality standards.

-The program starts by examining the initial three conditions that were first reported on Hospital Compare (AMI, heart failure, and pneumonia), but will expand to include four additional conditions/procedures starting in 2015:

- COPD
- CABG
- Angioplasty
- Vascular Procedures

-‘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.

-Secretary shall calculate readmission rates in the same manner as used to calculate such readmission rates for hospitals posted on the CMS Hospital Compare website.

Community-Based Care Transitions Program [Section 3026 (p.789 – 795)]

-This provision allocates \$500 million over 5 years for organizations that apply to use “community-based” interventions to reduce hospital readmissions and improve care coordination among high risk Medicare beneficiaries, which are defined as those with dementia or a history of readmissions.

National Pilot Program on Payment Bundling [Section 3023 (p. 751 – 764)]

-This provision builds on ongoing work on payment bundling related to services provided in the hospital. The current Acute Care Episode demonstration bundles payments provided to physicians and hospitals but only does so over the course of a hospitalization, ending at the patient's discharge.

-This pilot expands the period for the bundle to include three days prior to admission and 30 days post discharge. This significantly increases the number of providers of care that could be subject to a bundled payment. Physician services are required to be included in the bundle.

-The bundles are limited to certain acute conditions that are to be identified by HHS including those that are common in the Medicare population and those that result in a significant number of readmissions, so both coronary heart disease/Acute Coronary Syndrome and heart failure are likely to appear on this list.

-The payment mechanisms are left to the discretion of HHS but this pilot is required to be budget neutral. Participants shall be evaluated by quality measures to ensure that appropriate care is being provided.

Ensuring the Quality of Care [Section 2717 (p. 26 – 30)]

-Private insurers will be required to offer information on efforts to reduce readmissions to those who wish to purchase their product through the insurance exchange market.

[Click Here to Access Text of HR 3590](#)