The Hospital Readmission Prevention Program-
Time For a Paradigm Shift
Part-2
August 2023

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Introduction- In 2019, just before the coronavirus pandemic, I published the article "The Hospital Readmission Prevention Program - Time for a Paradigm Shift"[(1)]. May 11, 2023 marked the end of the Federal COVID-19 Public Health Emergency declaration. This crisis led to some big changes, and some for the better, such as the rise of telehealth, increased awareness of preventing the spread of disease, enhanced teamwork, emphasis on mental well-being, a brighter spotlight on healthcare disparities, and new flexibilities such as use of other wards for inpatient care[(2)]. Many of the changes have become permanent and remain in practice today. Some old issues such as high rates of avoidable, preventable, and unnecessary (APU) readmissions remain basically unchanged.

This article assesses the current status, highlights new issues related to APU readmissions, and provides a few recommendations to manage this nationwide challenge better.

Background- Readmissions have remained a painful and public health problem for hospitals and skilled facilities in financial, competitiveness, and patient care related issues. Nationwide in 2020, the all-cause 30-day readmission rate was 17.8%. For CMS beneficiaries the rates for acute care facilities, critical access hospitals, SNFs and inpatient psychiatric facilities were 14.9%, 30.0%, 31.2% and 33.1% respectively[(3)]. Other findings include wide variations for race, ethnicity, and even across CMS Hospital Star ratings[(3)]. For Medicaid recipients the 30-day readmission rate was 16% with a steady increase to 53% within a year[(4)]. APU readmissions reflect a fragmented care delivery system, divergent interests, poor focus on patient needs, lack of interoperability and care coordination, and an antiquated payment model. Over the past 15 years readmissions have resisted easy solutions and financial penalties and are perfect examples of the need for a paradigm shift with new and creative interventions.

Currently CMS posts all hospital readmission rates on its website. CMS believes that publicly reporting these measures increases the transparency of hospital care, provides useful information for consumers choosing care, and assists hospitals in their quality improvement efforts. In addition to the potential for the negative impact on public relations, public reporting of readmission rates can be detrimental to hospitals' all other lines of business and services and their overall competitiveness.

Avixena Analytical Predictions Have Been Confirmed

Avixena Population Health Solutions' (APHS) (www.avixena.com) analyses in 2014 had identified a direct relationship between the risk of readmission with the number of an

individual's social determinants of health (SDOH) risk factors, type of insurance coverage (or lack thereof), presence of disabilities, and substance abuse. Recent CMS data confirms those APHS findings. CMS and the healthcare industry now fully recognize dual-eligible beneficiaries as the proxy for the prevalence of health-related social needs correlated with twice the rate of readmissions when compared to non-duals[3].

In short, APHS' (patent pending) analyses indicate that the sum of an individual's number of chronic conditions and SDOH risk factors, presence of behavioral health diagnoses, and the type of healthcare coverage are the main elements of an accurate and predictive readmission risk assessment.

What Do We Know In 2023

Current hospital and skilled facility discharge planning processes remain mostly ineffective and fragmented. Main drivers include poor readmission risk assessment without addressing SDOH, often challenging access to care, inadequate staffing, poor information connectivity and continuity with post-discharge practitioners and providers, and the lack of a nationally recognized reimbursement model.

After fifteen years of a national program for readmission prevention, the latest data indicate the following:

- Federal health care expenditures now exceed $2 trillion per year and consume more than 20% of the GDP. National healthcare costs are projected to increase from $5 trillion to $6.8 trillion per year by 2030[5].
- Medicare enrollment is projected to increase by 10,000 per day until 2028 when the last wave of baby boomers join Medicare.
- In 2022 there were 34,011,386 inpatient admissions to U.S. hospitals[6].
- Medicare remains the primary payer for 41% of the inpatient admissions in the U.S. [7], and Medicare's readmission rate has remained unchanged at 14.9% for a decade.
- The Medicare Hospital Trust Fund is predicted to be insolvent by 2031 if no interventions are undertaken[8].
- Nationwide the average operating margin of acute care hospitals currently is 1.4%[9], and the annual operating expenses of a midsize hospital (up to 250 beds) are around $200 million per year [10].
- CMS has announced an increase of 3.1% for inpatient care for 2024 while the reported cost of care increased by 7.3% in 2023[11].
- Recent industry initiatives such as "Discharge Lounges" are focused on bed turnaround time and artificially improved patient satisfaction scores but are not really focused on readmission prevention[12].

This combination of increased number of beneficiaries, continued and unabated yearly increases in the total cost of care, and an unmanageable federal budget deficit clearly indicates that the current model is unsustainable. Furthermore, the political will to address these challenges does not appear to be on the immediate public policy timing horizon.

Financial Decision Making Is the Main Driver of The APU Readmissions

Financial factors now appear to be the main motivators of the delivery systems:

- In 2021, 81% of acute care hospitals paid a readmission penalty [(1)].
- Nationwide the average cost of a readmission penalty is $73 per admission while the average reimbursement for a Medicare readmission is greater than $17,000. This incentive misalignment results in many hospitals continuing the existing practices that result in high readmission rates[(1)].
- The current reimbursement model has led many hospitals, particularly the Physician-Owned Hospitals (POH), to engage in patient selection to take advantage of the system[(13)].

> A recent statement from the American Hospital Association (AHA) and the Federation of American Hospitals: "The new analysis adds to more than 15 years of research suggesting that POHs select their patients by avoiding less profitable Medicaid and uninsured patients, treat fewer medically complex patients, and provide fewer emergency services. Moreover, the recent Government Accountability Office, Health and Human Services Office of Inspector General, and the Medicare Payment Advisory Commission have reported that POHs do not treat the same scope, complexity, or acuity of patients as non-POHs within the same market. This analysis also shows that POHs have higher average penalties for readmissions compared to full-service community hospitals. In short, by choosing the healthiest and wealthiest patients, POHs pose program integrity, access, and health equity risks for the Medicare program."

Push for Artificial Intelligence - Another Misguided Financial Motivator

Reviews of healthcare news articles are replete with too-numerous-to-count planned investments, joint alliances, and deployment of Artificial Intelligence (AI) technology in healthcare. AI is now subject to FDA approval and includes deep learning, cloud computing, big data analytics, blockchain, and Generative AI including ChatGPT, and have potential positive implications for all healthcare fields. It is the author's observation that by far, the vast majority of these planned interventions in the hospital systems are focused on reduction of operating expenses mainly through staffing optimization, forecasting patient demand, and financial analytics, with little impact on or regard for care quality and outcomes. It should also be noted that most generated savings will be a one-time event and not an ongoing future savings.

This indicates that technology use and care improvement processes must be in tandem or simultaneously implemented to create continuous savings and improve care outcomes.

SECTION II- Proposed Solutions

1- Electronic Health Record Systems Need a Major Overhaul

The "Meaningful Use" provisions created in the Accountable Care Act of 2010 and enforced by CMS to promote the use of electronic health records (EHR) resulted in the use of check boxes and poor capturing of real clinical context information. The leading EHR systems have very little allowance for the capture of SDOH factors. Another unintended consequence of the Meaningful Use provision was the providers' ability to up-code with "increased" documentation. The prevailing EHR systems are specifically designed to be self-contained and inoperable with disparate systems.

Unfortunately, the current leading EHRs use the principal diagnosis and CPT codes for data collection and do not produce *patient-specific* information. External sources of information, such as reports from other systems or providers, are only saved as attachments and do not easily appear in the user's workflow. Building interfaces with other software is subject to manufacturer's approval and is a tedious, expensive and protracted process.

It is very clear that the use of EHRs has not resulted in better outcomes and reduced costs and has indirectly added to the fragmentation of healthcare delivery. EHRs must upgrade with new features to capture more clinical context, SDOH risk factors, patient-specific information, and must improve work-flow processes and interoperability.

2- New Care Model Should Move from Short Encounters to Long-Term Relationships

The central features of the U.S. healthcare system are its fragmentation and its foundation on an episodic care delivery model. This has resulted in significant challenges to provide access to care, contain costs, and achieve and maintain substantial and sustainable quality of care and service outcomes.

The pandemic dramatically transformed the U.S. healthcare landscape. New developments indicate that the future of care delivery is fundamentally evolving to become:

- Patient centric.
- Virtual.
- Ambulatory.
- In the home.
- Value based and risk bearing.
- Driven by data and analytics.
- Transparent and interoperable.
- Enabled by new medical technologies.
- Funded by private insurers.
- Integrated.

And yet care delivery still will remain stubbornly fragmented[14].

The last two years have already witnessed giant retail companies, pharmacies, payers, and big tech players devoting significant investments and acquisitions to secure their place in the new care delivery model.

It is evident that health policy and reimbursement, and investor's conflicting interests and demands, frequently move in distinct and different directions, and this discord will add more complexity and fragmentation unless addressed promptly and rationally.

3- Need for a New Financial Model

As described previously, readmission penalties are ineffective and have not produced any meaningful reductions. The national 30-day readmission rate, since inception of the readmission penalty initiative, decreased from 19.8 to 17.8% and has held steady for a decade.

One potential solution is the replacement of the penalties with a new reimbursement model for inpatient admissions that would be an all-inclusive single payment that combines all the costs of care - such as the index admission and potential readmission, outpatient care, emergency department, specialty drugs, imaging, skilled nursing facility, transportation, and dialysis - for 60-90 days after the discharge date. This model will require improved information continuity, enhanced patient care and coordination of care, and the reduction - and ultimately the elimination - of the overuse, underuse and misuse of services and procedures.

4- Remote Monitoring Technologies to Improve Care Out of Office and Post-Discharge

A great variety of innovative remote monitoring technologies and algorithms are being introduced, including patient self-managed testing, wearable devices, technologies either integrated into established clinically indicated therapeutic devices, such as pacemakers and defibrillators, or as standalone to create information with clinical value and improved service delivery and clinical outcomes.

Wide gaps exist between leading and lagging countries in clinical information systems and payment incentives. U.S. physicians are among the least likely to have extensive clinical information systems or incentives targeted on quality, and the most likely to report that their patients have difficulty paying for care. Disease management capacity varies widely by payers and individual characteristics and locations in the U.S.

In short, for remote care monitoring to be effective, it requires member and caregiver engagement, access to technology (such as laptops, tablets, smart TVs), connectivity (internet, Wi-Fi, hubs), member and provider education, data integration, work-flow modifications, analytical support ("big data" collection systems, decision support, artificial intelligence), a national health policy, and a sustainable and equitable reimbursement model to be in place.

5- Provider Accountability

Currently health care professional responsibility concentrates mainly on medical malpractice. However, it is clear that it should reflect all conditions necessary for the daily delivery of high-quality health care services to the system users, which constitute rational use of the economic resources[15]. The time is ripe to offer a new technical paradigm for professional accountability that could include *competence, information accessibility, awareness,* and *gratification.*

6- Improving Quality Through External Oversight

As part of Medicare's Condition of Participation, each healthcare facility is required to have a formal process to manage and prevent readmissions. However, there are no requirements to ensure full implementation, ensure the effectiveness, or to measure and monitor compliance with that plan. This indicates that absent CMS oversight, there is a need for external entities to enforce the standards that establish parameters for structures and processes and that can set expectations for outcomes. These oversight entities could also provide incentives - financial or otherwise - for specific actions that will positively impact access to and safety of care, and the quality and service outcomes in care settings.

These oversight entities may include formal quality oversight mechanisms, purchasers of care, patients, families, and caregivers. Potential candidates include state and local governments, consumer advocacy programs, and accreditation bodies.

Conclusions

The author concludes that if Medicare, commercial payers, self-funded employers, health systems and/or providers truly were interested in an effective, immediate, and long-lasting cost saving measure that would simultaneously improve care outcomes and eliminate significant avoidable morbidity and mortality, with little implementation costs and with short ramp-up times, then the implementation of an effective and functional readmission prevention program should be their collective priority.

Implementation of a reliable readmission prevention program will undoubtedly improve care outcomes and reduce the total cost of care. Existing readmission prevention programs will become obsolete in the near future as the industry evolves. Future prevention programs must incorporate new and evolving business realities, technological advances, patient-centric initiatives, and better informed and data driven programs as described in this article.

The author thanks Mr. Allan Field and Mr. Kent Dicks for their review and critique of this article.

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Hospital Readmission Prevention Program - Time for a Paradigm Shift

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December 2019

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The Hospital Readmission Prevention Program - Time for a Paradigm Shift

Background - Section 3025 of the Accountable Care Act (ACA) outlines the details of the Hospital Readmission Reduction Program (HRRP) which limits payments to hospitals with excessive Medicare readmissions. The HRRP provides a financial incentive to hospitals to lower readmission rates. Effective Oct. 1, 2012, CMS began penalizing hospitals for what it determined to be excessive avoidable readmissions, arbitrarily set at >14%. The penalties are grounded in the belief that clinicians should and would improve transitions of care and ensure that patients and caregivers are educated about their care before they leave the hospital. Additionally, hospitals are held accountable for the collaboration and coordination with patients, caregivers, physicians and community agencies in the transition of care processes to improve patient care post discharge.

Available data at that time painted a very gloomy picture of care provided in hospitals. According to the Agency for Healthcare Research and Quality (AHRQ), 90% of readmissions within 30 days appeared to be unplanned, the result of clinical deterioration, and 75% were reported to be preventable in a MedPAC (Medicare Payment Advisory Commission) report of June 2008. The figures remain mostly unchanged as evidenced by a recent article in Annals of Internal Medicine (12/05/2018) indicating that 36% of readmissions within seven days of discharge were preventable [(1)].

The HRRP does not apply to all conditions. Rather, it focuses on specific disease conditions cited in the 2007 "Report to Congress: Promoting Better Efficiency in Medicare." MedPAC identified several conditions and procedures that accounted for 30% of potentially preventable readmissions. Currently HRRP includes: Acute Myocardial Infarction (AMI), Coronary Artery Bypass Grafting (CABG) surgery, Heart Failure (HF), Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, and Total Hip Arthroplasty/Total Knee Arthroplasty. At present, 81% of the acute care hospitals in the US are receiving readmission penalties [(2)]. It is important to note that HRRP does not include Cancer hospitals, Acute Rehabilitation hospitals, Long-Term Acute Care, Pediatric and Behavioral Health inpatient admissions.

At present, 81% of the acute care hospitals in the US are receiving readmission penalties

Definition of Readmission - "An all-cause admission to an acute care hospital within 30 days of a discharge from the same or another hospital for the same or a different diagnosis" [(3)]. Based on this definition, if a patient is readmitted but expires during the readmission, it

will be excluded from calculation. The rate of patient death during readmissions is not known.

Program Faults and Shortcomings - HRRP has several major flaws:

1- **Program Design**:
   - **A.** There is no scientific data that supports 30 days as the interval for readmissions. (Our analysis indicates that for most diagnoses, the accurate measure is between 45 and 60 days).
   - **B.** By allowing only a limited number of diagnoses, HRRP allowed potential gaming of the system such as by allocating resources to only a subsection of admissions that count rather than improve the overall delivery of care. This may have resulted in unintended consequences such as an increased rate of death following premature discharges for congestive heart failure. It should be noted that the 21st Century Cures Act asked MedPAC to assess the decline in relation to increases in observation stays and emergency department (ED) visits. MedPAC found that the penalty program did lead to lower readmission rates but was not the sole cause of increases in observation stays and ED visits [(2)]. Another factor is coding changes permitted by CMS that may have driven reductions in readmission rates by allowing an increase in reported diagnosis codes that impacted the risk-adjustment calculation CMS uses to determine changes in readmission rates [(4)].
2- The program does not require proof of continuous quality improvements.
3- There are no penalties or denied reimbursement for those physicians who inappropriately discharged patients when their care was not optimized or if patients were discharged to the wrong destination or level of care.
4- Hospitals classified as "Number of Cases Too Small" are exempt from inclusion.
5- The penalties are minimal, and most hospitals are treating them as just a cost of doing business.
6- The analysis is based on the use of raw claim-based data and with no provisions for Social Determinants of Health or Risk severity [(5)].
7- There is a major flaw in the formula that calculates the penalty. For example, this results in receiving penalties for joint replacements with penalties several time the cost of the original DRG. This is evidenced by MedPAC, who in their June 2013 Report to Congress [(6)] provided a simplified example of how the calculation overly penalizes providers.

Penalties - Attention to the readmission issue was due to its identification as a cost containment initiative, and this initial focus resulted in a brief decline in the national rate of readmissions from 19.8% in 2008 to 17.8% in 2013. The next phase of expansion included the addition of more diagnoses, increasing maximum penalties from 1% to 3%, and then changing the calculation base from an annual to a 3-year average performance [(7)]. Recent

analysis of penalty data from 2013 to 2017 for 3,229 acute care hospitals revealed that 52.4% were penalized all five years [5]. And hospitals that were penalized in the first year of the program were more likely to continue to be penalized, and to be penalized more, throughout the program. In 2017, the total financial penalty for the hospitals which received the maximum 3% penalty was approximately $11.6M, or an average of about $305K per hospital. The average penalty in 2018 was $217K [2] which indicates more hospitals are receiving penalties and the number of those with maximum penalty doubled to 6% in 2018 [2].

The reality is that the US is dealing with an inefficient and fragmented healthcare delivery system that resists regulatory and financial pressure

This abatement failure is multifactorial and may be the result of a continued lack of understanding of the root causes, lack of resources, lack of market demand or differentiation, and/or insignificant penalties. It also may signal that certain hospitals are indifferent to or non-supportive of this national initiative.

It is the authors' experience, that the current reported readmission rates are understated. Exclusion of patients who expired during readmissions artificially reduces the readmission rate. The Two-Midnight-Rule may erroneously classify an Inpatient admission as an Observation. Observation stays and prolonged care in the ED, by increasing the time interval between admissions, also results in underreporting of the incidence of readmissions. Finally, coding changes also artificially lower the readmission rate by allowing more diagnoses to be listed on inpatient claims [4].

Surprisingly, there has been very little focus on best practices and sharing those best practices that have resulted in better readmission rates for the 19% of the acute care hospitals that are not penalized. It should also be noted that there is no additional reimbursement for best-in-class (lowest) readmission rates. There has been little valid information made available not only to the public but also to patients deciding on where or where not to receive care at a selected hospital.

Over the past decade, readmissions have refused easy solutions and resisted penalties. This is a perfect example of a need for a paradigm shift

More troubling is the fact that in 2018, CMS implemented a similar program for Skilled Nursing Facilities (SNFs) [8]. The program impacts 73% of SNFs, or roughly 11,000 facilities nationwide, and may have more deleterious effects on SNFs as their operating margins are lower than those of hospitals and the potential cost reduction activities needed to mitigate the losses from the penalties may further impact care delivery and outcomes.

In summary, readmissions have become an increasingly painful and public problem for hospitals in financial, competitiveness and patient care related issues. Nationwide, in 2017 the all-cause 30-day readmission rate for acute care facilities and SNFs was 17.8% and 28.2% respectively**.** While no easy fix exists to prevent readmissions, hospitals and health systems must take a proactive approach by accepting readmissions as a real problem and allocating the appropriate resources needed to fully understand the problem at hand, as well as enlisting the involvement of the many different groups that can contribute to a successful readmission prevention initiative. As a public policy matter, the readmission problem remains a disturbing national issue, one that reflects a fragmented care delivery system with divergent interests, misaligned incentives, lack of focus on patient needs, absence of information sharing and interoperability, as well as an antiquated, ineffective payment model. Over the past seven years HRRP has failed to achieve its desired goals, warranting the need for a paradigm shift [(9)]**.**

Potential Solution - In a recently published article in NEJM, it was suggested that HRRP needs rebooting [(14)]. However, while the NEJMs findings and recommendations have merit and deserve some consideration, HRRP needs to be overhauled, not rebooted. Rebooting will bring us to the same starting point and will not improve outcomes nor lower readmission rates. What is needed is a new system based on two fundamental components: **patient-centered care** and a **new financial model** for hospitals.

- **Patient-centered Approach -** CMS should require hospitals to readily demonstrate a readmission prevention and quality program based on continuous quality improvement. This may include implementation of new tools to identify individuals who are at high risk, proof of a fully implemented and functional Transition of Care Program [(10)], and ensuring that every single person is discharged with an evidence-based, real-time, readmission prevention plan that provides care and information continuity. New performance measures focused on APU (avoidable / preventable / unnecessary) readmissions, individuals with multiple readmissions within a 12- month period, and the correct calculation of readmission rates should all be included. Creation of new partnerships is critical for the success of the program [(11)]. New technologies, such as Artificial Intelligence, Mobile Platforms, Virtual Healthcare**,** Nanomedicine, Decision Support, Virtual Reality, 3D Printing and Robot-Assisted Surgery, will revolutionize care delivery and will be major partners in the coming years. In addition, technology companies such as Amazon, Google,

Rebooting will bring us to the same starting point and eliminating the program will neither improve outcomes nor lower readmission rates. What is needed is a new system based on two fundamental components: patient-centered care and a new financial model.

Apple and Facebook will play a major role in providing technology solutions and provision of direct care to consumer care.

- **Replacement of the penalties with a new reimbursement model for readmissions** - An all-inclusive single payment that combines all the costs (the index admission and readmission, OP surgery, ASC, ED, specialty drugs, imaging, SNF, transportation, dialysis, professional fees, etc.) for 60 days after the discharge day and for every single discharge. The new model would make the hospital the PAP (Principal Accountable Provider), the one who is responsible to pay all other costs anywhere after a discharge. This approach will be geared towards what matters, drive the use of proven and evidence-based care, and ultimately will result in the elimination of waste and inefficiencies, utilization and overutilization of less effective treatments (e.g., duplicative imaging, low yield procedures), and confront underutilization of effective but less used techniques (e.g., patient and caregiver engagement, home-based care). It should be noted that this proposed model is very different than the abandoned CMS bundled payment model [12] [13].

Few industries are as complex as healthcare, and at the same time, many healthcare organizations are run by a culture that is not geared to collaboration and integration. There is a very high likelihood that the new approach will make hospitals and their staff physicians more attentive, cooperative and focused on improving quality of care and satisfaction which will result in improved health outcomes and lower readmissions.

Authors would like to thank Mr. Allan Field and Mr. Thomas Lescault for their review of this article.

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