3. Advancing Patient Safety and Outcomes Across the Hospital Quality Programs – Request for Comment

The Hospital Readmissions Reduction Program was implemented to reduce excess readmissions effective for discharges from applicable hospitals beginning on or after October 1, 2012. The program uses six claims-based measures to track unplanned inpatient admissions within 30 days following discharge. Using the data collected from these measures, we have observed that since the inception of the program, inpatient readmission rates for the conditions and procedures included in the program have gone down.[244]

However, studies have found a concurrent increase in patients who, after being discharged from an inpatient stay, visit the emergency department (ED) or receive observation services as an outpatient.[245] [246] [247] [248] [249] As a result, we are concerned that our hospital quality reporting and value-based purchasing programs may not be adequately incentivizing hospitals to improve quality of care by accounting for more types of post-discharge events, such as a return to the ED or the receipt of observation services.

From a patient perspective, unexpectedly returning to any acute care setting, including the ED, or receiving observation services after being discharged from an inpatient hospital stay,[250] is an undesirable outcome of care. Patients who are discharged from an inpatient stay but

---

[244] Medicare Hospital Quality Chartbook. National Rates over Time. Available at: https://www.cmshospitalchartbook.com/visualization/national-rates-over-time. Accessed March 12, 2024.
[245] Nuckols TK, Fingar KR, Barrett ML, et al. Returns to Emergency Department, Observation, or Inpatient Care Within 30 Days After Hospitalization in 4 States, 2009 and 2010 Versus 2013 and 2014. J Hosp Med. 2018;13(5):296-303.
[246] Shammas NW, Kelly R, Lemke J, et al. Assessment of Time to Hospital Encounter after an Initial Hospitalization for Heart Failure: Results from a Tertiary Medical Center. Cardiol Res Pract. 2018; 2018:6087367.
[247] Sabbatini AK, Joynt-Maddox KE, Liao JM, et al. Accounting for the growth of observation stays in the assessment of Medicare's hospital readmissions reduction program. JAMA Netw Open. 2022;5(11):e2242587.
[248] Sabbatini AK, Wright B. Excluding observation stays from readmission rates—what quality measures are missing. New Engl J Med. 2018;378(22):2062-2065.
[249] Wadhera RK, Joynt Maddox KE, Kazi DS, Shen C, Yeh RW. Hospital revisits within 30 days after discharge for medical conditions targeted by the Hospital Readmissions Reduction Program in the United States: national retrospective analysis. BMJ. 2019;366: l4563.
[250] Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. See

then make an unplanned return to the hospital may incur higher healthcare costs than those that do not return to the hospital setting due to potential out-of-pocket charges for the unplanned follow-up care. Research has found that the median out-of-pocket cost of observation services received by Medicare beneficiaries as outpatients was $448.94, with low-income beneficiaries being more likely to report being concerned about costs of follow-up care, as compared to higher income beneficiaries, and limiting health care utilization that could otherwise be deemed essential in response to higher out-of-pocket costs.[251]

While these unplanned returns to the hospital impose significant burden on patients, such visits can often be avoided with greater attention to care coordination.[252] This coordination can include addressing barriers such as poor health literacy or social determinants of health that complicate a patient's ability to follow post-discharge instructions, fill prescriptions, or alert hospital staff to new symptoms.[253] For example, in one study, nurses implemented evidence-based practices for transition care, including engaging in patient education, providing clear post-discharge instructions, and following up with patients via phone calls. The study found that 9.4 percent of patients who received such intervention were readmitted 30 days after discharge, compared to an 18.8 percent readmission rate among patients not receiving such interventions. Similarly, 19.8 percent of patients receiving evidence-based transitional care were readmitted within 90 days after discharge, compared to 31.5 percent among patients in the usual care

---

additional explanation here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf.

[251] Goldstein, J.N., Schwartz, J.S., McGraw, P. et al. "Implications of cost-sharing for observation care among Medicare beneficiaries: a pilot survey". BMC Health Serv Res 19, 149 (2019). https://doi.org/10.1186/s12913-019-3982-8.

[252] Kripalani S, Theobald CN, Anctil B, Vasilevskis EE. Reducing hospital readmission rates: current strategies and future directions. Annu Rev Med. 2014;65:471-85. doi: 10.1146/annurev-med-022613-090415. Epub 2013 Oct 21.

[253] Hoyer EH, Brotman DJ, Apfel A, Leung C, Boonyasai RT, Richardson M, Lepley D, Deutschendorf A. Improving Outcomes After Hospitalization: A Prospective Observational Multicenter Evaluation of Care Coordination Strategies for Reducing 30-Day Readmissions to Maryland Hospitals. J Gen Intern Med. 2018 May; 33(5): 621–627. Published online 2017 Nov 27. doi: 10.1007/s11606-017-4218-4.

group.[254] These findings indicate that supporting patients' discharges by proactively addressing potential barriers is effective in reducing unplanned readmissions.

Therefore, we are seeking ways to build on current measures in several quality reporting programs that account for unplanned patient hospital visits to encourage hospitals to improve discharge processes. Current measures include three Excess Days in Acute Care (EDAC) measures currently in the Hospital Inpatient Quality Reporting (IQR) Program, which estimate days spent in acute care within 30 days post discharge from an inpatient hospitalization for a principal diagnosis of the measure's specified condition. The acute care outcomes include ED visits, receipt of observation services, and unplanned readmissions.[255] The measures are:

- Excess Days in Acute Care (EDAC) after Hospitalization for Acute Myocardial Infarction (AMI), adopted in the FY 2016 IPPS/LTCH PPS final rule beginning with the FY 2018 payment determination (80 FR 49680 through 49682);
- Excess Days in Acute Care (EDAC) after Hospitalization for Heart Failure (HF), adopted in the FY 2016 IPPS/LTCH PPS final rule beginning with the FY 2018 payment determination (80 FR 49682 through 49690); and
- Excess Days in Acute Care (EDAC) after Hospitalization for Pneumonia, adopted in the FY 2017 IPPS/LTCH PPS final rule beginning with the FY 2019 payment determination (81 FR 57142 through 57148).

Another existing measure that CMS uses to assess unplanned hospital returns is the Hospital Visits After Hospital Outpatient Surgery measure. We adopted this measure into the Hospital Outpatient Quality Reporting (OQR) Program in the CY 2017 OPPS/ASC final rule beginning with the CY 2020 reporting period (81 FR 79764 through 79771) and the Rural Emergency Hospital Quality Reporting (REHQR) Program in the CY 2024 OPPS/ASC final rule

[254] Kripalani S, Chen G, Ciampa P, Theobald C, Cao A, McBride M, Dittus RS, Speroff T. A Transition Care Coordinator Model Reduces Hospital Readmissions and Costs. Contemp Clin Trials. 2019 Jun; 81: 55–61. Published online 2019 Apr 25. doi: 10.1016/j.cct.2019.04.014.
[255] Centers for Medicare & Medicaid Services. 2023 MUC List. Available at: https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.

beginning with the CY 2024 reporting period (88 FR 82064 through 82066). This measure's outcome includes any unplanned hospital visits (ED visits, receipt of observation services, or unplanned inpatient admissions) within seven days of outpatient surgery. The measure calculates facility-level measure scores based on the ratio of predicted to expected number of post-surgical hospital visits. By publicly reporting these scores, the measure encourages providers to engage in quality improvement activities to reduce unplanned follow-up visits (81 FR 79765).

While our hospital quality reporting and value-based purchasing programs currently encourage hospitals to address concerns about unplanned returns through several existing measures, we recognize that these measures, taken together, do not comprehensively capture unplanned patient returns to inpatient or outpatient care after discharge. The EDAC measures currently in the Hospital IQR Program only cover patients with a primary discharge of AMI, HF, or Pneumonia. Meanwhile, the Hospital Visits After Hospital Outpatient Surgery measure only covers patients discharged from outpatient surgeries. Furthermore, since both the Hospital IQR and Hospital OQR Programs are quality reporting programs, a hospital's performance on these measures is not tied to payment incentives.

Therefore, we invite public comment on how these programs could further encourage hospitals to improve discharge processes, such as by introducing measures currently in quality reporting programs into value-based purchasing to link outcomes to payment incentives. We are specifically interested in input on adopting measures which better represent the range of outcomes of interest to patients, including unplanned returns to the ED and receipt of observation services within 30 days of a patient's discharge from an inpatient stay.

We invite public comment on this topic.