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(1) EXCLUDE HIP AND KNEE REPLACEMENTS from readmission penalties.

Medicare treats readmissions above the national average as unnecessary, but half of hospitals will always be above average on each condition. If Medicare adopts 5 conditions, then 81% of hospitals measured will pay penalties on something.

MedPAC sees that the current legal formula draws in too many hospitals, especially "*when conditions with low readmission rates are included in the policy*." Therefore MedPAC proposed changing the formula (p.103 of June 2013 Report, medpac.gov/documents/Jun13_EntireReport.pdf). **The law requires 3 conditions. It does not require 5, and conditions should not be added until the law is fixed.**

- Northwestern Memorial in Chicago is the largest hospital in Illinois. It did 1,651 elective hip and knee replacements for Medicare in 2009-2012, and will pay 46% of the revenue from those operations as a penalty.

- Froedtert Memorial Lutheran in Milwaukee did 245 replacements and will pay a 96% penalty.

- In Philadelphia, Pennsylvania Hospital of the University of Pennsylvania did 1,020 replacements and will pay 57% of that revenue as a penalty.

- The Medical Center of the University of California at Davis did 226 replacements and will pay a 27% penalty.

Hospitals cannot give up this much revenue, and would need a new business model with less treatment of Medicare patients. The simplest way to avoid penalties is creaming: taking only the easiest patients, not the neediest. Also hospitals will send more patients for 30-day stays in nursing homes, at higher cost to Medicare.

Hospitals listed here readmitted 7% to 10% of their patients after hip and knee replacements. The national average is 5%. As MedPAC implied, it is not reasonable for such slight variations to cause dire penalties.

The American College of Surgeons warned Medicare last year about "*the potential that these hospitals will decrease their care for such patients, thereby creating an access issue*." Seniors who cannot get hip and knee replacements lose the mobility they need to stay healthy (regulations.gov/contentStreamer?objectId=09000064813241d9&disposition=attachment&contentType=pdf).

The $285,000 average penalty per excess readmission is too risky for hospitals. $285,000 per excess readmission is based on:

- $15,000 average base payment for the initial DRG (#469 and #470, weighted by number of discharges)
- divided by 5.27% (national readmission rate).
- This calculation is confirmed by MedPAC, "*Payment rate for the initial DRG ... × 1 / national readmission rate for the condition*" (p.99 of June 2013 Report, medpac.gov/documents/Jun13_EntireReport.pdf), though they omit the actual numbers.
- The methodology for calculating 46%, 96% penalties etc. is at globe1234.info/medicare/category/penalty-percent.

Several studies show that readmissions prevent deaths.

- The American Hospital Association reported in *Trendwatch* September 2011, "*mortality is inversely related to readmissions*" (aha.org/research/reports/tw/11sep-tw-readmissions.pdf).
- Doctors Gorodeski, Starling and Blackstone of the Cleveland Clinic showed with a graph in the New England Journal of Medicine July 15, 2010 that hospitals with higher readmissions after heart failure treatment had significantly fewer deaths among the patients (nejm.org/doi/pdf/10.1056/NEJMc1001882).

Medicare charges these penalties 1-4 years after treatment, even though all the readmissions were fully approved by doctors and Medicare at the time of treatment, and paid for by Medicare.

Many readmissions are random and unrelated to the original hospital care. Medicare's 2014 Specifications Report gives examples of readmissions: severe flu, intestinal infections, burns, a broken arm, accidental poisoning and hundreds more (pp. 57-61). These readmissions vary randomly among hospitals, so the unlucky hospitals each year, or the ones serving fragile patients, are fined simply for being over the US average readmission rate (cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/AMI-HF-PN-COPD-and-Stroke-Readmission-Updates.zip).

(2) EXCLUDE COPD.

$33,000 average penalty is too risky for hospitals and will drive hospitals away from treating these patients, which would result in the patients not getting hospital care they need, and dying. As noted above, the law requires 3 conditions. It does not require 5, and **conditions should not be added until the law is fixed.**

(3) EXCLUDE FAR MORE READMISSIONS for the other 3 conditions.

Penalties for Pneumonia, Heart Attacks and Heart Failure are also outrageous, at $35,000 to $56,000 per excess readmission. Medicare has already shown its authority to exempt patients, such as those under 65, in Maryland or lacking Part B, so it needs to use that authority to create more justified exemptions.

(i) Calculate national readmission rates as in the past, so rates stay stable. Then:

(ii) For each hospital's rate, **EXEMPT READMISSIONS OF PATIENTS WITH ABOVE-AVERAGE RISK OF READMISSION**, according to Medicare's own model, since these are precisely the patients where readmission is expected to be needed, rather than unnecessary (readmissionscore.org).

(iii) If any hospitals remain above the national average, manually review those few readmissions, to penalize any which are medically unnecessary (and should not have been paid in the first place). **EXEMPT MEDICALLY NECESSARY READMISSIONS.** Leaving penalties on them means most of those patients would have trouble getting the care they need.

(iv) Adjusting for patient mix does not protect high-risk patients, since the adjustments are small and these patients still are likeliest to readmit, so hospitals have incentives to avoid them. Exempting them protects their ability to get care.

A list of penalties for each condition at each hospital is at Globe1234.com, based on Medicare's data.