The Patient Protection and Affordable Care Act (ACA) of 2010 represents one of the most significant regulatory overhauls of the United States healthcare system since the initial establishment of Medicare and Medicaid. While attention has largely been directed towards provisions that expanded medical coverage, the ACA also established several incentive schemes aimed at reforming the care delivery process by holding hospitals accountable for their performance in order to rein in costs and improve quality. One of the first schemes introduced was the Hospital Readmissions Reduction Program (HRRP), which requires the Centers of Medicare and Medicaid Services (CMS) to reduce payments to hospitals that exhibit higher than average 30-day risk-adjusted readmission rates. HRRP, therefore, was intended to act as an incentive device for hospitals to invest in interventions that prevented unnecessary readmissions. Such an incentive was needed as the prevailing hospital prospective payment system (PPS) paid hospitals a pre-determined fixed fee per patient episode. As a result, prior to HRRP, hospitals had absolutely no financial incentive to reduce readmissions – in fact, under PPS doing so would both reduce the revenue by reducing patient episodes, but also leave hospitals to shoulder the burden of additional costs from any intervention implemented.

Under the provisions of HRRP, CMS began imposing penalties from Oct 1st, 2012 on hospitals that exhibited above average risk-adjusted 30-day readmissions rates for acute myocardial infarction (AMI), heart failure (HF) and pneumonia (PN) patients. For hospitals that fell short, the fraction of payments made for excess readmissions in the three conditions combined, up to a maximum of 1%, was also deducted from all Medicare payments, i.e. payments were taken from all conditions even though only three are measured under HRRP. The maximum increased to 2% in FY2014 and then to 3% in FY2015. Additionally, chronic obstructive pulmonary disease (COPD) and hip/knee arthroplasty (THA/TKA) were added to the
list of conditions in FY2015 as was coronary artery bypass grafts (CABG) in FY2017. Since program implementation, several studies have shown that readmission rates have declined significantly as a result of HRRP. While these numbers seem to herald the success of the program, patients, policy analysts, and even CMS have raised concerns about potential unintended consequences. Penalties that were meant to incentivize hospitals to provide better inpatient service and transition care at discharge may also incentivize changes by hospitals at the admissions stage.

In this paper, we study one operational impact of HRRP on hospitals' admissions decisions – the choice between designating a patient for inpatient admission or outpatient observation. The admissions decision for patients that are clinically on the fence between being healthy enough to not require inpatient care and too sickly to send home is already a difficult one. As such, changes that penalize readmissions may push hospitals to seek alternative methods of care delivery that are less punitive, one of which is the use of observation status. Observation patients are classified as “outpatients” even though, like inpatients, they stay in the hospital, receive medical and nursing care, diagnostic tests, treatments, medications, and food.

Although the care delivered may not differ at all and despite the fact that observation status is usually reimbursed at a lower rate than an admission, designating a patient for observation is potentially attractive to hospitals for two reasons. For a recently discharged patient, the observation designation directly avoids a readmission. For a patient who has not been discharged in the last 30 days, observation status offers an indirect mechanism for preempting a future readmission.

Using publicly available data from CMS, covering all US-based hospitals from 2008 - 2015 subject to HRRP, we exploit variation in hospitals' financial exposure to the program due to
both readmissions performance and financial health. We compare the admissions behavior of a set of control hospitals whose readmissions performance is consistently above the national average, and therefore were not exposed to HRRP penalties, to those that fell short. We find no differences in observation bed usage between the two groups prior to program start, but a statistically significant 12.7% increase in observation bed usage after program implementation by hospitals subject to HRRP penalties relative to their high-performing (non-penalized) counterparts. Within these groups, we find further differences between financially constrained and unconstrained hospitals. We estimate that penalized hospitals experiencing short-term financial distress actually increased their usage by as much as 19.6% relative to their financially healthy but still penalized counterparts (and 31.1% relative to constrained non-penalized hospitals). Back-of-the-envelope calculations suggest that attributing just 10% of the change in observation bed usage of penalized hospitals to avoiding readmissions reduces their reported improvement in readmissions rates by 40%.

Our results suggest that while most hospitals have actually reduced their readmissions rates without using observation beds, penalized hospitals, and especially those that were financially constrained, did alter their decision-making significantly for patients on the margin, pinpointing a subset of hospitals to monitor for potential unintended consequences. Given the additional deductibles and co-pays for outpatient treatment, this behavior effectively transfers some of the financial burden of readmissions from hospitals onto their patients. Our results also have implications for the implementation of HRRP which is based on average-performance benchmarks. When hospitals use observations beds to reduce their readmission figures, they also lower the average readmission rate against which other hospitals are penalized, hurting high-performing hospitals not managing readmissions though observation beds.