# *Public Reporting May Not Improve Readmission Rates*

BY ALICIA AULT

Hospitals that do well on publicly reported measures on discharge planning do not necessarily have fewer readmissions, according to analysis of Medicare data.

Dr. Ashish K. Jha, E. John Orav, and Dr. Arnold M. Epstein of the Harvard School of Public Health, Boston, studied the association between hospital performance on discharge planning measures and readmission rates for congestive heart failure and pneumonia, the two most common reasons Medicare patients are readmitted (N. Engl. J. Med. 2009;361:2637-45).

The authors looked at two data sets—Medicare's Hospital Quality Alliance program and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)—as well as other Medicare information profiling patients' discharge characteristics.

Conventional wisdom assumed that hospitals documenting discharge planning (only required for congestive heart failure) likely had fewer readmissions, Dr. Jha said in an interview. "The fact that there was no relationship between the chart-based measure and readmission rates was a little bit of a surprise."

The authors compared data from 2,222 hospitals that had chart documentation and patient surveys, with 1,809 hospitals considered "nonreporting" because they did not provide data for both charts and patients.

The authors found no association between hospital size, location, or any other characteristics, and performance on the chart-based or patient-reported measures. They did find large variations in readmission rates, ranging from 17.5% to 29.6% for congestive heart failure and from 14.1% to 25.6% for pneumonia.

For heart failure readmission, unadjusted results found no difference based on a hospital's performance on chart-based discharge measures. When adjusted for institutional characteristics, hospitals in the highest quartile of performance for 30-day heart failure readmissions had rates that "were nearly identical" to those in the lowest quartile, according to the authors, the authors reported.

The authors found that, even if each facility improved performance to be on par with the hospitals in the 90th percentile on the patient-reported measure, there would be only 4,700 fewer congestive heart failure readmissions and 2,800 fewer pneumonia-related readmissions.

Public reporting has been associated with improvement in performance, but also carries a high administrative cost, said Dr. Jha. The study indicates that the chart-based measure may only be an indication of how well hospitals do in documentation, not performance, he said.

Dr. Jha reported he received consulting fees from UpToDate, which markets clinical decision support tools. ■

# 'Doughnut Hole' Affects Costs for Diabetes Drugs

BY DENISE NAPOLI

Diabetes patients without coverage of the Medicare Part D "doughnut hole" spent more out-of-pocket on their medications, compared with diabetes patients who had coverage.

Moreover, modified doughnut hole coverage of generic drugs conferred only "modest differences in out-of-pocket spending" compared with diabetes patients without any coverage at all, according to a recent study.

The study, led by Vicki Fung, Ph.D., of the Kaiser Permanente Medical Care Program in Oakland, Calif., compared diabetes patients in a staff-model, integrated HMO Medicare Advantage Prescription Drug (MAPD) plan. In the first group were 16,654 patients whose Part D plan provided no coverage in the doughnut hole; in the second were 12,126 with employer-supplemented insurance offering some coverage in the gap (Health Serv. Res. 2010 Jan. 7 [doi:10.1111/j.1475-6773.2009.01071.x]).

A total of 17% of patients without gap coverage had out-of-pocket drug expenses of at least $2,250—putting them in the doughnut hole—as did 35% of those with some gap coverage. Patients without gap coverage had lower annual total drug costs, on average: $1,750, versus $1,802 for patients with employer-supplemented gap coverage, the researchers found. However, patients without gap coverage spent significantly more out-of-pocket ($806) than their covered counterparts ($279).

MAPD plan administrators were able to review the paper but had no control over design, conduct, or interpretation of the study. ■

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