Congestive heart failure (CHF)—the inability of the heart to pump enough blood to the body—is the leading cause of hospitalization among Medicare beneficiaries. CHF hospitalizations cost Medicare more than $4 billion in 2001. Research indicates that rates of CHF hospitalizations among Medicare beneficiaries have risen markedly since the 1980s despite the fact that this is a chronic disease for which appropriate outpatient care can reduce hospitalizations. Better inpatient care might also reduce readmissions and mortality after hospitalization for CHF.

This study presents trends in CHF hospitalizations, readmissions, and mortality from 1992 through 2001 among Medicare fee-for-service (FFS) beneficiaries. Our results are based on an analysis of all Medicare claims for hospital discharges with CHF as the primary diagnosis. We calculated age-sex adjusted rates of discharges, readmissions, and mortality, and examined trends in rates over time and variation in rates across demographic groups.

RESULTS

Evidence of Improvement

CHF Hospitalizations Fell Slightly. The CHF hospitalization rate fell by 2 percent from 1992 to 2001. After peaking in 1997, rates fell by 6 percent by 2001 (Figure 1).

Mortality Rates Declined. Thirty-day mortality rates following hospitalization for CHF dropped steadily from 1992 to 2001, with a 14 percent reduction overall (Figure 2). The one-year mortality rate fell 9 percent over the period.

Opportunities for Improvement

Readmissions Rose. From 1992 through 2001, rates of 30-day readmission for CHF rose 6 percent (Figure 2). After holding steady for three years (1997-2000), rates increased by 4 percent from 2000 to 2001.

Disparities Exist. African Americans, those dually enrolled in Medicaid, and beneficiaries with ESRD were hospitalized and readmitted for heart failure at much higher rates than whites, nondual enrollees, and aged or disabled beneficiaries, respectively (Tables 1 and 2). Moreover, disparities appear to have increased for some groups over the period. From 1992 through 2001, hospitalization and readmission rates for African Americans, other minorities, and patients with ESRD rose more sharply than for their counterparts. However, these three groups had lower mortality rates following admission.2
Despite the recent drop in CHF admission rates, there is still work to be done in reducing CHF-related admissions and deaths. Indeed, Healthy People 2010 goals for heart failure admissions are roughly half the rates presented here.²

Meeting these goals means preventing CHF and treating it and associated risk factors. For Medicare beneficiaries who have developed CHF, appropriate outpatient care and disease management programs could reduce hospitalizations. Reducing race- and eligibility-related disparities in CHF hospitalizations means exploring the sources of disparities, such as differences in disease prevalence rates and differences in access to care and appropriate outpatient treatment.

More appropriate inpatient treatment could also reduce heart failure readmissions and mortality. For example, research shows and experts recommend that patients with CHF should receive ACE inhibitor drugs at discharge. But in the median state, ACE inhibitors were prescribed for only two-thirds of the eligible patients at discharge in 2000-2001.³

More appropriate inpatient treatment could also reduce heart failure readmissions and mortality. For example, research shows and experts recommend that patients with CHF should receive ACE inhibitor drugs at discharge. But in the median state, ACE inhibitors were prescribed for only two-thirds of the eligible patients at discharge in 2000-2001, a decrease from the period 1998-1999.⁴

**NOTES**


²A recent study that adjusted for differences in health conditions, illness severity, and inpatient treatment produced similar results for African Americans. See Rathore, S., et al. “Race, Quality of Care, and Outcomes of Elderly Patients Hospitalized with Heart Failure.” *JAMA*, vol. 289, no. 19, May 2003, p. 2517-2524.

³Healthy People 2010 goals are 6.5 hospitalizations/1,000 persons age 65-74; 13.5/1,000 persons age 75-84; and 26.5/1,000 persons age 85 and above. U.S. Department of Health and Human Services, Washington, DC: Government Printing Office, 2000.