

Medicare's Hospital Readmissions Reduction Program: Potential Risks for Physicians

Background

The Affordable Care Act of 2010 instructed the Center for Medicare and Medicaid



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Services ("CMS") to establish a readmission reduction program. The impetus for that instruction was CMS's historical estimate that 20% of Medicare patients (2.3 million) discharged from the hospital are readmitted

within 30 days at a cost of approximately 18 billion dollars per year. At the same time, some studies estimate that up to 75% of such readmissions are preventable. Preventing those would mean a savings for Medicare of more than 12 billion dollars.

The Hospital Readmissions Reduction Program became effective October 1, 2012. It is designed to provide "incentives" for hospitals to develop strategies to reduce the number of hospital readmissions within 30 days of discharge from an acute care, in-patient hospital. Or, rather, disincentives to allow readmissions. These take the form of escalating penalties that decrease a hospital's payments from the stays of all of its Medicare patients. For the first three years of the program, a hospital's annual readmission penalty may reduce its annual Medicare payments by up to 1% for 2012, 2% for 2013, and 3% for 2014.

A hospital's excess readmission rate (and its penalty) is determined by the frequency

of the hospital's predicted 30-day readmission for certain conditions (currently heart failure, acute heart attack, pneumonia, congestive heart failure, and elective knee and hip replacements) during a three-year look-back period. Readmissions unrelated to the subject condition nevertheless count against the hospital's index, as do admissions to another acute care hospital within the 30-day timeframe. However, for the fiscal year 2014 inpatient prospective payment system, CMS did increase the number and types of conditions that no longer count against a hospital's readmission rate. The actual methodology used to calculate the hospital readmission payment factor is complex and beyond the scope of this article.

In February 2013, CMS reported to Congress that, for all causes, the Medicare readmission rate had dropped from 19% to 17.8% and that it had dropped even more for the three conditions under study for the first year (heart attack, heart failure, and pneumonia).

So far, physician services are not affected. Yet with accountable care organizations and bundled payments for care programs and initiatives, it is only a matter of time before physician services are indirectly affected.

Mechanisms To Reduce Readmissions

Hospitals use a variety of mechanisms to decrease readmissions. The current focus is on coordination of care with post-discharge support and follow-up. Strategies include improved discharge planning, collaboration with community providers, after-hospital care plans, patient education, medication reconciliation by nurses, care access and coordination, case manager services, home care, telemedicine, home checks, including texts, internet, and phone communication, assigning staff to perform patient monitoring, improved care transitions, and in some cases even taking patients to appointments and/or picking up prescriptions or durable equipment. Most strategies emphasize improved

communication and patient-contact care throughout the process.

Potential Liability Issues

Unlike most health care services, the strategies employed by hospitals to decrease readmissions are not reimbursed by Medicare or other payers. Thus, hospitals must fund such services from their budgets. Concurrently, we can expect that some after-hospital care strategies employed by hospitals may create potential liability exposures such as:

Anti-Kickback Statute

The Anti-Kickback Statute, which makes it a criminal offense to knowingly

and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program. When reimbursement is paid to induce or reward such referrals, such payment violates the Anti-Kickback Statute. Remuneration includes the transfer of anything of value, directly or indirectly, overtly

or covertly, in cash or in kind for referrals.

In Opinion No. 13-10, the OIG recently provided an Anti-Kickback analysis issuing a favorable opinion for a vendor. The vendor was a subsidiary of a pharmaceutical manufacturer that entered into arrangements with hospitals to provide patients with certain

coordination of care services after discharge for a fee, to reduce hospital readmissions. The services were sold to the hospitals. The OIG noted that arrangement would not:

- Increase costs or utilization;
- Interfere with clinical decision-making;

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- Be used to increase drug sales by a parent company;
- Result in inappropriate patient steering (hospitals are required to give patients a choice when they need post-discharge hospital services).

Patient Inducement

The Office of Inspector General of the Department of Health and Human Services (OIG), will initiate administrative proceedings to impose civil monetary penalties against any person who offers or transfers remuneration to a Medicare or Medicaid beneficiary that the person knows or should know is to influence the beneficiary election of a particular provider, or supplier of any item or service for which payment may be made, in whole or in part, by a federal health care program. Remuneration includes items or services provided for free or at less than fair market value.

The distinction between discharge planning, providing outreach services, and potential inducements—such as transportation to a doctor's appointment or providing a

prescription—is not a clear-cut. If services are part of a hospital DRG, there is no inducement. However, providing services for free, or at less than fair market value, may be seen as inducement for patients to continue to use the hospital or its providers.

Over the last 10 years, the OIG has issued a number of unfavorable advisory opinions that could impact such programs. For example, a pre-operative home safety assessment by a physical therapist and free safety equipment and pagers for hemophilia patients have been deemed inducements to Medicare beneficiaries. On the other hand, the OIG has provided favorable opinions to vendors that provide educational videos, medical-alert pagers for the homebound,

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and a vaccine reminder program.

In Opinion No. 13-10, discussed above, the OIG also issued a favorable opinion on the risks of patient inducement by noting that:

- The patient would designate the providers included in the software platform, and the vendor would not be permitted to select or influence the selection of providers;
- There were no rewards or incentives to the patients to influence their selection of provider.

The Stark Law

The federal physician self-referral statutes (Stark Law) provides that if a physician (or immediate family member)

has a financial relationship with an entity then, absent a Stark Law exception, the physician may not make a referral to that entity for the furnishing of a designated health service, and the entity may not submit a Medicare claim for the designated health service rendered due to a prohibited referral. Stark is a strict-liability statute so no showing of intent is necessary.

Stark may be implicated when there are agreements with providers and suppliers—including hospital-owned providers for post-discharge services, such as home health, skilled nursing, physician office visits and physical therapy—that do not meet one of the Stark exceptions. Similarly, hospitals typically have contracts with independent contractor emergency physician groups to staff their emergency departments. Such contracts may encourage hospitals to pressure physicians in the emergency department to avoid readmission for patients who present to the emergency department within 30 days of discharge. Such relationships and any subtle influence on contracted physicians could implicate a Stark Law violation.



Medical Malpractice

Physicians and hospitals owe a duty of care to patients to comply with the applicable standard of care. If providers do not meet the standard of care, the providers may be held liable for any resulting injuries and damages to the patient. Readmission strategies undertaken by hospitals will likely be used by plaintiffs' attorneys to establish new standards of care for the duties owed to patients relevant to after-hospital care plans.

At the same time, penalizing a hospital for readmissions may create a provider bias (due to the financial penalty) to discourage appropriate readmissions. Consequently, injured persons who believe

they should have been readmitted but were not due to the financial incentive to the hospitals to postpone or deny readmissions are likely to bring medical malpractice cases against the hospitals and their doctors. Such suits could assert that the physician's medical judgment was impacted by the Hospital Readmissions Reduction Program.

Finally, the Program likely gives hospitals another reason to track physician performance, as they do with infection rates and other parameters, for readmissions. In light of the Program's effects on patient care, hospital bottom lines, and their own performance, physicians may wish to familiarize themselves with the parameters of the

Hospital Readmissions Reduction Program and its potential impacts to their practices.

Conclusion

Preliminary indications are that the Hospital Readmissions Reduction Program is making a difference in the readmission rates for the selected Medicare patient population. Questions for physicians to consider regarding mechanisms to reduce readmissions are:

- Does the arrangement have the potential to interfere with my decision-making?
- Does the arrangement raise patient safety or quality of care concerns?
- Are patients being improperly induced to see me?

- Are patients being improperly steered to me?
- Would I treat the patient differently but for the Readmissions Reduction Program? **AM**

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