U.S. Rules Reshape Hospital Admissions --- Return-visit rate drops, but change in billing tactics skews numbers

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2 December 2015

The Wall Street Journal

At Banner Health's general hospitals, the rate of heart-failure patients who wind up admitted to the hospital again soon after leaving has been dropping significantly, according to a Wall Street Journal analysis of Medicare billing data. So has the readmission rate for patients treated for pneumonia and three other serious conditions.

The Obama administration has cast such results as a triumph of the Affordable Care Act, which penalizes hospitals that have too many readmissions within 30 days of an inpatient stay. The goal is to encourage better follow-up treatment so patients can stay out of the hospital -- keeping them in better health and whittling down the cost to the government.

But this seemingly good news isn't as encouraging as it appears. At Banner, based in Phoenix, and at hospitals around the country, more patients are entering or re-entering hospitals under something called "observation status" -- a category that keeps them out of the readmission tallies.
Patients on observation status can remain in the hospital for days, and typically receive care that is indistinguishable from inpatient stays, experts say. But under Medicare billing rules, the stays are considered outpatient visits, and as such, don't trigger penalties under the health law.

The Journal's analysis of Medicare billing data shows that increases in observation stays can skew the readmission numbers, letting hospitals avoid penalties even if patients continue to have complications and return for repeat visits. Observation stays generally are cheaper for the government, but in some cases they can lead to big bills that are the patient's responsibility.
The readmission penalties are at the forefront of a push to slash waste from the $600

billion Medicare program and improve care for the roughly 50 million seniors and disabled people it covers. Earlier this year, Health and Human Services Secretary Sylvia Burwell announced the aim of tying 90% of Medicare's payments to medical providers to quality or value measurements like the readmission rate by 2018.

The Journal's data analysis shows how differences in the ways medical providers bill for their services can skew such measures. The effect may be to burnish the apparent performance of some hospitals based on what is effectively a bookkeeping change, rather than improved care -- and leave the penalty program open to the possibility of manipulation, experts say.

"The hospitals are responding to the incentive scheme that has been established for them," said Eric Coleman, a geriatrician and University of Colorado professor. He said the Journal's findings show that observation stays are "blurring the results of what we think we're doing, and how effective we think we are." Mr. Coleman was one of six experts who reviewed the Journal's methodology and said it is valid.

A spokeswoman for the Centers for Medicare and Medicaid Services said in a written statement that the agency estimates there were 150,000 fewerreadmissions in 2012 and 2013 compared with the prior two years. "The evidence we see indicates that readmissions are declining," the spokeswoman said.

At Banner's general hospitals, the rates of readmissions following inpatient stays for conditions now in the penalty program fell to about 15.6% in 2013, from 18.5% in 2010, the Journal analysis found. Rates of observationstaysfor patients previously admitted for those conditionstripled during the period. If the share of follow-up patient stays that were labeled as observation had held fast at 2010 levels, Banner's reduction in readmissions would have been about one quarter as large, according to the Journal's analysis.

A February 2013 Banner medical policy reviewed by the Journal advised doctors to consider observation stays for heart-failure patients, in part "to prevent reimbursement penalties for greater-than-expected readmission rates."

A Banner spokesman said decisions about when to use observation stays or admissions are based on medical factors and billing rules. He said Banner'sreadmissions reduction was "the result of focused strategic initiatives" that are "consistent with goals set forth by" Medicare.

The Journal's analysis found that 319 hospitals -- about 10% of the nation's short-term acute-care hospitals, the type subject to the penalties -- contributed half of the overall increase in follow-up observation stays from 2010 to 2013. Among those hospitals, which include 10 of Banner's, readmission rates for medical conditions subject to the penalty program fell about 14% overall. At the same time, the share of follow-up visits labeled as observation stays rose 156%, accounting for nearly two-thirds of the reduction, the Journal analysis found.

Across the roughly 3,500 short-term acute-care hospitals -- often referred to as general hospitals -- that face the penalty program, the Journal identified a drop in readmission rates of about 9% from 2010 to 2013 for penalty-program conditions. Follow-up observation-stay rates increased about 48%. The rise in observation stays accounted for about 40% of the decline in readmissions, by the Journal's measure.

A 2014 report by Medicare officials acknowledged an increase in observation stays, but found declining readmission rates weren't "primarily the result" of rising observation services. The officials said they believed improvements in quality of care could be a factor.

CMS in recent years has encouraged hospitals to label more stays as observation, in part through auditors it contracts with to review claims. Hospital executives say that has contributed to the increase in observation stays.The agency rolled out changes in 2013 and 2014 meant to help better define observation stays, which hospitals say also are contributing to the increase.

Medicare typically pays lower, outpatient rates for observation stays, so the shift saves the taxpayer-funded program money.

Rebekah Gardner, an assistant professor at Brown University's medical school, said that if patients are returning to hospitals just as frequently, regardless of how their stays are labeled, it signals that patient care hasn't improved.

In some cases, observation stays can carry a financial sting for Medicare patients. Because such stays are treated as outpatient services, patients face copays that can in some cases exceed Medicare's inpatient deductibles. An even bigger bite can come when patients are referred to nursing homes: Medicare generally doesn't cover such care after an observation stay.

"We were shocked," said Bob Wellentin, 87 years old, a retired teacher in Puyallup, Wash., who said he had never heard of observation stays before his wife spent four days in a hospital after a fall in June 2014. She recuperated for more than two months in a nursing home, costing the couple more

than $20,000, according to billing records and receipts. To pay the bills, the couple liquidated a life-insurance policy and cashed in certificates of deposit set aside to pay for their burials.
Medicare said it has recognized some problems with observation stays and has revised some policies.

The health law's penalty program dings hospitals by stripping some Medicare payments when readmission rates exceed expectations. The program initially included patients with heart failure, heart attacks and pneumonia, and has grown to include chronic obstructive pulmonary disease, known as COPD, and some joint replacements. The number of covered diagnoses is set to keep ratcheting up.

The penalties can amount to up to 3% of a hospital's main inpatient Medicare payments. The Advisory Board Co., a hospital adviser, expects Medicare to levy around $420 million in penalties next year, and congressional budget estimators projected the program could save about $7.1 billion by 2019. The health law's penalty program began in October 2012, two years after hospitals began preparing for it in the wake of the legislation.

To gauge its impact on rehospitalizations, the Journal examined inpatient and outpatient hospital bills to Medicare from 2010 to 2013 for changes in rates of both observation stays and readmissions. The analysis counted readmissions and follow-up observation stays that began with an emergency-room visit. Several experts consulted said that criterion would identify unplanned stays in both categories, though the penalty program counts some readmissions that don't begin with emergency treatment. The Journal excluded hospital stays that end in transfers to other facilities to avoid double-counting. The analysis included all medical conditions currently in the penalty program.
The Journal then calculated how many inpatient readmissions would have occurred at each hospital if the proportion of observation stays among returning patients had held steady at 2010 levels.

"There are winners and losers because of the ways hospitals are coding" their bills to Medicare, said Harlan Krumholz, a Yale cardiologist who leads the team of researchers that designed the readmission measures that are the basis of the penalty program. He said the penalty program has spurred hospitals to improve care in an effort to reduce readmissions, and even though observation stays may account for some of the reductions, the public is "much better off" overall.

Three hospitals run by Memorial Healthcare System, a public-hospital network in Broward County, Fla., were among the 319 facilities that accounted for half the increase in follow-up observations stays between 2010 and 2013. At those three hospitals, 8.4% of patients admitted for a condition in the penalty program had a follow-up observation stay within 30 days in 2013, up from 2.2% in 2010. The hospitals' readmission rate for those patients declined by 33%,and therising share of visits labeled as observation stays accounted for two-thirds of that decline, according to the Journal's analysis.

Memorial's flagship hospital, Memorial Regional Hospital, paid the maximum penalty rate in 2013, the first full year the readmission program was in effect. This year, its rate was half that.
Memorial's rising use of observation stays "is absolutely not related at all to a concerted effort to decrease readmission rates," said Stanley Marks, the system's chief medical officer. He said efforts by Medicare and private insurers to cut costs had led doctors in South Florida to order more observation services. "It is almost as if the default status moved to observation," he said.
He said patients receive "exactly the same" treatment whether they are inpatients or under observation status. "It is purely a financial consideration on the part of the payer," both Medicare and private insurers, he said.

Julius Yang, who oversees readmission-reduction efforts at Beth Israel Deaconess Medical Center in Boston, said his hospital increased use of observation stays in 2012, after Medicare scrutinized its billing practices.
Beth Israel's readmission rate declined by about 29% from 2010 to 2013, and a rise in patient visits labeled as observation stays accounts for about one-third of the decline, according to the Journal's analysis.

Dr. Yang said he was aware that rising use of observation helped reduce the hospital's readmission rates. "If they need to come back into the hospital, that's not what we really intended," said Dr. Yang, who said Beth Israel has made extensive efforts to reduce the need for repeat hospital visits of any type.

More than a dozen patient advocates and nursing-home officials interviewed by the Journal said they see the financial downside of hospital observation visits for some Medicare patients. If patients don't spend three days under formal inpatient admission in the hospital, the federal program won't pay for a subsequent nursing-home stay.

"That's always a shock, every time -- just because they were in a hospital bed doesn't mean they were admitted," said Leonna O'Neal, until recently an administrator at a Hydro, Okla., nursing home. When Medicare observation patients were referred to her facility, she said, "very few will actually stay if they have to pay" the nursing-home bills.

Mr. Wellentin's wife, Dolores, now 86, arrived in Puyallup's MultiCare Good Samaritan Hospital in an ambulance after falling down the steps of her backyard deck. In severe pain and unable to walk, she remained in the hospital for four days. The facility ended up billing for her visit as an outpatient observation stay, according to a Medicare billing document.

Mrs. Wellentin was diagnosed with a fractured shoulder and sacrum and a urinary-tract infection -- none conditions that currently trigger readmission penalties. The Wellentins paid the nursing-home bills, but they are now appealing in hopes that Medicare will cover the cost. "It was a hardship," said Mr. Wellentin.

MultiCare said doctors and a contractor determined Mrs. Wellentin's condition was appropriate for observation status. It said the Wellentins were informed that the stay wouldn't qualify for Medicare nursing-home coverage. The hospital said it is "mindful of the impact of these decisions on patients and families," but that Medicare's own rules can limit its options.