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THE HOSPITAL READMISSION REDUCTION PROGRAM: FRAUD AND ABUSE CONCERNS

*Courtney Mathews**

INTRODUCTION

As part of the Patient Protection and Affordable Care Act of 2010 (“PPACA”), the Hospital Readmissions Reduction Program (“Program”) requires the Centers for Medicare & Medicaid Services (“CMS”) to reduce payments to Inpatient Prospective Payment System (“IPPS”) hospitals with excess readmissions, effective for Medicare discharges beginning on October 1, 2012.¹ This Program is heavily debated, receiving mostly negative attention, and it is the only CMS program that does not utilize bonuses in addition to the heavy penalties CMS imposes. Additionally, there is no opportunity for a hospital to opt out of the Program.

While critics widely argue that hospitals are not the right entity to hold accountable for readmissions; that the penalties disproportionately target academic hospitals and socioeconomically disadvantaged hospitals; and that readmissions do not reflect poor quality of care, critics very rarely voice concerns about the potential fraud and abuse concerns implicated by this Program. Thus, while this article discusses the unintended consequences brought about by the implementation of the Program, this article also adds to the literature now three years of data supporting the predictions of the unintended consequences that implementation would bring. Additionally, this article addresses an additional criticism rarely discussed: fraud and abuse concerns.

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¹ Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3025, 124 Stat. 119, 408 (codified as amended at 42 U.S.C. § 1395ww(q) (2010)).

II. BACKGROUND

A. Pre-PPACA Developments

Each year, the government agency Medicare Payment Advisory Commission (“MedPAC”) publishes two reports to Congress on its various Medicare issues. A June 2007 report warned Congress that readmissions “result[] in additional Medicare spending; 17.6 percent of admissions result in readmissions within 30 days of discharge, accounting for \$15 billion in spending.”² The report further advised Congress that while “[n]ot all of these readmissions are avoidable . . . some are.”³ In 2009, CMS began publicly reporting voluntarily provided readmission rates on its website *Hospital Compare* as an incentive for hospitals to reduce their readmissions for the following three conditions: acute myocardial infarction (heart attack) (“AMI”), heart failure (“HF”), and pneumonia (“PN”).

It has been suggested that hospitals’ reluctance to proactively reduce readmissions is attributable to the way in which Medicare pays its participating hospitals.⁴ Generally speaking, Medicare “pays hospitals a set fee for a patient’s stay, so the shorter the visit, the more revenue a hospital can keep. Hospitals also get paid when patients return.”⁵ Before PPACA made clear that hospitals are responsible for readmissions (at least financially), there was general confusion regarding a hospital’s responsibility for a patient following discharge.⁶ Also contributing to the problem were “concerns about compensation, a lack of clear institutional policies, and the absence of legal mandates that patients be properly prepared for and monitored after discharge”⁷

² MEDICARE PAYMENT ADVISORY COMM’N, *Report to the Congress: Promoting Greater Efficiency in Medicare*, 103 (2007) MEDPAC, available at http://www.medpac.gov/chapters/jun07_ch05.pdf, 103. (June 2007).

³ *Id.*

⁴ Jordan Rau, *Hospitals Face Pressure From Medicare to Avert Readmissions*, N.Y. TIMES, Nov. 27, 2012, at D1, available at http://www.nytimes.com/2012/11/27/health/hospitals-face-pressure-from-medicare-to-avert-readmissions.html?_r=0.

⁵ *Id.*

⁶ Thomas L. Hafemeister & Joshua Hinckley Porter, *Don’t Let Go of the Rope: Reducing Readmissions by Recognizing Hospitals’ Fiduciary Duties to Their Discharged Patients*, 62 AM. U. L. REV. 513, 514 (2013).

⁷ Hafemeister & Porter, *supra* note 6 at 514.

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PPACA carried lofty goals of enhancing the quality of health care, improving patient safety, and lowering overall health care spending. However, before it was enacted (and even after), PPACA faced significantly harsh opposition. One of the biggest concerns was that PPACA would bankrupt the health care industry (or even United States).⁸ Thus, to gain support, legislators included several programs that would reduce PPACA's overall cost burden, and the Program, through its use of penalties and no incentives or rewards, was estimated by the Congressional Budget Office to reduce Medicare spending by approximately \$7.1 billion between 2010 and 2019.⁹

1. Calculation of a Readmission

For purposes of the Program, a "readmission" occurs when a patient is discharged from an applicable IPPS hospital to a nonacute setting (e.g. skilled nursing facility, home health, rehabilitative center, or to the patient's home) and is then re-admitted to the same or another applicable hospital within 30 days from the date of the initial discharge.¹⁰ The Program applies to most short term acute care hospitals with exceptions for sole community hospitals, Medicare dependent hospitals, small rural hospitals, children's hospitals, certain cancer and research centers, and hospitals that provide primarily long-term, rehabilitative, or psychiatric care.¹¹ Additionally, only hospitals with at least 25 discharges for each of the three conditions are included in the readmission measures.¹²

⁸ See *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1296-97 (N.D. Fla. 2011) ("[PPACA] will have serious negative consequences, e.g., encouraging people to forego health insurance until medical services are needed, increasing premiums and costs for everyone, and thereby bankrupting the health insurance industry."); David M. Herszenhorn, *The Road Ahead Turns Right*, N.Y. TIMES, Nov. 4, 2010, at B1, available at http://www.nytimes.com/2010/11/04/business/04outlook.html?_r=0 (statement of House Speaker John Boehner) ("I believe that the health care bill that was enacted by the current Congress will kill jobs in America, ruin the best health care system in the world, and bankrupt our country.")

⁹ CBO Letter to Nancy Pelosi (March 20, 2010), available at <http://www.cbo.gov/sites/default/files/amendreconprop.pdf>

¹⁰ 42 U.S.C. § 1395ww(q)(5)(E) (2010), amended by PL 113-185, Oct. 6, 2014, 128 Stat 1952; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and FY 2012 Rates; Hospitals' FTE Resident Caps for Graduate Medical Education Payment; Final Rule, 76 Fed. Reg. 51476, 51666 (Aug. 18, 2011).

¹¹ 42 U.S.C. § 1395ww(q)(2)(B) (2010), amended by PL 113-185, Oct. 6, 2014, 128 Stat 1952.

¹² *Id.*

In its Final Rule issued for fiscal year 2014, CMS broadened “planned readmissions” to exclude more readmissions from the Program,¹³ but CMS has yet to exclude unrelated readmissions from its calculation.¹⁴ Thus, a patient discharged for pneumonia, who is readmitted 20 days later, after a slip-and-fall accident, in the patient’s own home could serve as an additional readmission for the original admitting hospital. For including unrelated readmissions, CMS reasoned that, “readmissions not directly related to the index condition may still be a result of the care received during the index hospitalization.”¹⁵

The readmissions calculations for a given hospital are complicated, but, essentially, the prospective diagnosis related group (“DRG”) payment that Medicare typically makes to a hospital will be reduced based upon the number of readmissions from that hospital above national average readmission rates for the specified conditions.¹⁶ In fiscal year 2013, penalties were assessed at a maximum of 1% of Medicare reimbursements for patients discharged July 2008 through June 2011 (with some adjustments for gender, age, and certain medical history conditions).¹⁷ Beginning October 2013, the penalty increased from 1% to 2%, and in October 2014, the penalty increased to a cap of 3%.¹⁸ For fiscal year 2015, the expanded conditions to be included in the Program (in addition to AMI, HF, and PN) include (1) acute exacerbation of chronic obstructive pulmonary disease, (2) elective total hip arthroplasty, and (3) elective total knee arthroplasty.¹⁹

2. Years One, Two, and Three Penalties

CMS began levying penalties on October 1, 2012 (fiscal year 2013) and 2,213 hospitals were penalized approximately \$280 million in Medicare payments for excess readmissions. Thus, on average, a given

¹³ See generally *CMS Wants to Exclude More Readmissions from Penalty Program: How CMS’s FY 2014 Pay Proposal Would Change Readmissions Math*, THE DAILY BRIEFING, (May 1, 2013), <http://www.advisory.com/Daily-Briefing/2013/05/01/CMS-wants-to-exclude-more-readmissions-from-penalty-program>. (May 1, 2013).

¹⁴ Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care; Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status; Final Rule, 78 Fed. Reg. 50496, 50654–55 (Aug. 19, 2013) [hereinafter CMS Final Rule].

¹⁵ CMS Final Rule, at 50654.

¹⁶ See 42 U.S.C. § 1395ww(q)(4)(A) (2010), amended by PL 113-185, Oct. 6, 2014, 128 Stat 1952, for the precise calculation.

¹⁷ 42 U.S.C. § 1395ww(q)(3)(C)(i)-(iii) (2010).

¹⁸ *Id.*

¹⁹ CMS Final Rule, *supra* note 14, at 50657.

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hospital paid \$126,525, but some larger hospitals paid close to \$1,000,000 in penalties.²⁰ Thus, on average, a given hospital paid \$126,525, but some larger hospitals paid close to \$1,000,000 in penalties. For example, Barnes-Jewish Hospital in St. Louis, Missouri, which is well known for treating underserved populations and advanced care patients with chronic illnesses, paid about \$1.9 million.²¹ For fiscal year 2014, Medicare penalized 2,225 hospitals for excess readmissions with 18 hospitals receiving the maximum penalty of a 2% reduction in Medicare payments.²² Finally, for fiscal year 2015, Medicare penalized a record high 2,610 hospitals, with 39 hospitals receiving the maximum 3% penalty.²³

III. ANALYSIS

A. Criticisms of the Program

Despite the perceived benefits of the readmission penalty, the Program has received significant criticism. This is despite the existence of evidence from CMS that the Program has lowered readmissions. In its February 2013 report to Congress, CMS stated that “the all-cause Medicare readmission rate had dropped to 17.8 percent in the last quarter of 2012, down from the historical 19 percent; that represents 70,000 fewer readmissions in Medicare.”²⁴ Nonetheless, the criticisms outweigh the limited positive results, and the overinclusive character of the penalty harms hospitals and patients.

²⁰ Jordan Rau, *Medicare Revises Readmissions Penalties—Again*, KAISER HEALTH NEWS, at <http://www.kaiserhealthnews.org/stories/2013/march/14/revised-readmissions-statistics-hospitals-medicare.aspx> (Mar. 14, 2013).

²¹ Jim Doyle, *Most St. Louis Area Hospitals Improve Readmissions*, ST. LOUIS POST-DISPATCH, available at http://www.stltoday.com/business/local/most-local-hospitals-improve-readmissions/article_e9d773d9-e022-5be0-944b-f255ba94358e.html (Aug. 6, 2013).

²² Jordan Rau, *Armed with Bigger Fines, Medicare to Punish 2,225 Hospitals for Excess Readmissions*, KAISER HEALTH NEWS, at <http://www.kaiserhealthnews.org/Stories/2013/August/02/readmission-penalties-medicare-hospitals-year-two.aspx> (Aug. 2, 2013).

²³ Jordan Rau, *Medicare Finds 2,610 Hospitals in Third Round of Readmission Penalties*, KAISER HEALTH NEWS, at <http://www.kaiserhealthnews.org/Stories/2014/October/02/Medicare-readmissions-penalties-2015.aspx> (Oct. 2, 2014).

²⁴ *Medicare Hospital Readmissions Reduction Program*, HEALTH POLICY BRIEFS, at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=102 (Nov. 12, 2013).

1. Hospitals Are Not the Appropriate Entity to Hold Accountable

The first criticism centers on whether hospitals are the appropriate entity to hold accountable for readmissions. Most events and circumstances preceding any given patient's readmission take place outside of the hospital.²⁵ Relatedly, one of the major problems of the Program is that it does not differentiate between related and unrelated readmissions.²⁶ This is especially concerning in light of a recent study that concludes that at least 80% of hospital readmissions were unrelated to the initial admission.²⁷ Thus, hospitals are being held accountable under this Program for patients' carelessness or recklessness that may result in a completely unrelated readmission, not reflective of a hospital's provided care.

2. The Program Disproportionately Penalizes Academic and Safety-Net Hospitals

A second and heavily voiced concern is that the Program disproportionately penalizes hospitals that treat underserved populations and patients with complex conditions. Many studies (including one from Medicare) have concluded that “. . . hospitals with the most poor and African-American patients tended to have higher readmission rates than hospitals with more affluent and Caucasian patients.”²⁸ This is likely due to their lack of access to resources important to maintaining their health post-discharge, such as social support or primary care. Evidence also suggests that patients with the most severe illnesses are at a particularly high risk for readmissions due to their underlying condition.²⁹

As a result, large academic teaching hospitals (that care for the sickest patients) and safety-net hospitals (that care for the poorest patients)

²⁵ See generally Reed Abelson, *Hospitals Question Medicare Rules on Readmissions*, N.Y. TIMES, March 30, 2013 at B1, available at <http://www.nytimes.com/2013/03/30/business/hospitals-question-fairness-of-new-medicare-rules.html> (Mar. 29, 2013) (“Because so many hospital readmissions are tied to social or economic factors, hospitals have a hard time predicting which patients are likely to return . . .”).

²⁶ Note, however, that the Program excludes some readmission measures unrelated to prior discharge, including planned readmissions and transfers to other applicable hospitals. See *supra* note 13 and accompanying text.

²⁷ See Norbert I. Goldfield et al., *Identifying Potentially Preventable Readmissions*, 30 HEALTH CARE FIN. REV. 75–91 (2008).

²⁸ Rau, *supra* note 4, at D1.

²⁹ Karen E. Joynt et al., *A Path Forward on Medicare Readmissions*, 368 NEW ENG. J. MED. 13 at 1175 (March 28, 2013).

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received substantial penalties from the Program.³⁰ Overall, 12% of hospitals treating the poorest patients received the maximum 1% reduction in Medicare payments for the first year of the program, while only 7% of hospitals treating the fewest poor patients received the maximum 1% penalty.³¹ Hospitals with a significant low-income population were more likely in general to receive a penalty of any size.³²

These hospitals will be hit doubly hard by an additional provision of PPACA. HHS will be reducing Disproportionate Share Hospital (“DSH”) payments to hospitals by 75% beginning in fiscal year 2015.³³ The year the DSH payment reduction is implemented is the same year that the maximum readmissions reduction penalty of 3% will also be implemented. Thus, because readmissions are higher in hospitals that treat socioeconomically disadvantaged patients, many of these hospitals will lose reimbursements for readmissions and, additionally, will no longer be receiving DSH payments that they have come to rely upon, putting those hospitals in a severe financial struggle.

St. Bernard Hospital in Englewood, one of Chicago’s poorest neighborhoods, which received a five-star rating for its congestive heart failure program,³⁴ was penalized the maximum 1% reduction in its Medicare payments in the first year of the program and received a 1.42% reduction in the second year of the program.³⁵ St. Bernard received a hefty 1.43% penalty in the third year of the program.³⁶ Not only does St. Bernard treat many of the poorest patients in Chicago, but it also treats patients that “have no less than six or seven diagnoses.”³⁷ Patients who get home have “their lights and gas [] shut off,” and return to the hospital to “house them until [their] staff can help them get the utilities turned on.”³⁸ The few patients who can even afford their medicine “sometimes

³⁰ See generally Jordan Rau, *Hospitals Treating the Poor Hardest Hit By Readmissions Penalties*, KAISER HEALTH NEWS (Aug. 13, 2012) at <http://www.kaiserhealthnews.org/Stories/2012/August/13/hospitals-treating-poor-hardest-hit-readmissions-penalties.aspx>. (Aug. 13, 2012).

³¹ *Id.*

³² *Id.*

³³ 42 U.S.C. § 1395ww(d)(5)(F)(i) (2010).

³⁴ Deborah L. Shelton, *Hospitals Face Medicare Penalties for Readmissions*, CHICAGO TRIBUNE (January 30, 2012), available at http://articles.chicagotribune.com/2012-01-30/news/ct-met-readmission-rates-20120130_1_readmissions-medicare-patients-heart-failure (January 30, 2012).

³⁵ *FY 2015 IPPS Hospital Readmissions Reduction Program Supplemental Data File (Final Rule and Correction Notice)*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html> (last visited October 13, 2014).

³⁶ *Id.*

³⁷ Shelton, *supra* note 34.

³⁸ *Id.*

ration the pills, taking them less often than they are supposed to in order to make them last longer.”³⁹

An analysis of the seven academic hospitals in Illinois also reveals a disproportionate penalty levied against academic hospitals, which as previously stated, often treat the most complex medical conditions. All seven academic hospitals were penalized with the following penalties in years one, two, and three of the program, respectively: Loyola University Medical Center (0.39%/0.23%/0.16%), Northwestern Memorial Hospital (0.72%/0.38%/1.98%), Rush University Medical Center (0.24%/0.08%/1.17%), University of Chicago Medical Center (0.51%/0.50%), University of Illinois Medical Center (0.33%/0.15%/0.18%), and Saint Francis Medical Center (0.12%/0.13%/0.22%).⁴⁰ Nationally, studies show that major teaching hospitals are more likely to be highly penalized than non-teaching hospitals.⁴¹ A JAMA study found that “major teaching hospitals are more likely to be highly penalized than nonteaching hospitals . . . and less likely to not be penalized.”⁴²

3. Readmissions Are Not Tied to Hospital Quality

Critics also point out that not all readmissions reflect poor hospital quality. Specifically, “clear competing risks exist between mortality and rehospitalization. Patients who die soon after hospital discharge do not have the chance to be rehospitalized.”⁴³ Thus, hospitals with high mortality rates have low readmission rates because of these competing risks.⁴⁴ One study concluded that readmission rates are uncorrelated with mortality rates. The study showed that the best hospitals for heart failure (i.e. those with the lowest mortality rates) have high readmission rates.⁴⁵ Another study showed that when providers were more proactive with heart failure patient follow-up, including “visit reminders, education, and regular feedback,” they experienced higher twelve-month readmission

³⁹ Wes Venteicher & Jordan Rau, *Illinois Hospitals Face Fines Over Readmissions*, CHICAGO TRIBUNE (Oct. 3, 2014), available at <http://www.chicagotribune.com/business/ct-hospital-readmissions-met-20141002-story.html#page=1>.

⁴⁰ See *supra* note 35.

⁴¹ Karen E. Joynt & Ashish K. Jha, *Characteristics of Hospitals Receiving Penalties Under the Hospital Readmissions Reduction Program*, 309 JAMA 343, 343 (Jan. 2013).

⁴² *Id.* (using year 1 data, major teaching hospitals were penalized at a rate of 44% and nonteaching hospitals were penalized at a rate of 33%).

⁴³ Muthiah Vaduganathan et al., *Thirty-Day Readmissions: The Clock is Ticking*, 309 JAMA 345 (2013).

⁴⁴ *Id.*

⁴⁵ *Id.*

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rates, but lower mortality rates.⁴⁶ Last, researchers at the Cleveland Clinic observed that with HF patients, being readmitted after an inpatient stay might actually save a patient's life. In analyzing 3,857 hospitals, the researchers discovered that higher readmission rates following an initial hospitalization for HF correlated with a lower thirty-day mortality rate.⁴⁷

In Illinois, Rush University Medical Center, which was discussed *supra*, received a significantly higher penalty in the third year of the program which the medical center's chief medical officer, David Ansell, attributes "to the new assessment of joint-replacement patients."⁴⁸ However, Rush's orthopedic program has consistently ranked as one of the best in the country.⁴⁹ But because "approximately five more people per year were readmitted than the federal Medicare standards call for," Rush University Medical Center faced a higher penalty.⁵⁰

Additionally, Massachusetts General Hospital in Boston, which was ranked as the best hospital in the country according to U.S. News & World Report,⁵¹ was penalized 0.51%, 0.25%, and 0.24% in years one through three of the Program.⁵² Among other top-ranked hospitals that received the maximum penalty in year one and penalties in year two and three of the program were Hackensack University Medical Center in New Jersey, North Shore University Hospital in New York, and Beth Israel Deaconess Medical Center in Boston (a teaching hospital of Harvard Medical School).⁵³ However, the high readmissions rates coupled with "unusually low mortality rates . . . reflect that the hospital does a good job at swiftly getting ailing patients back into care and preventing deaths."⁵⁴

⁴⁶ Alison Mudge et al., *The Paradox of Readmission: Effect of a Quality Improvement Program in Hospitalized Patients With Heart Failure*, 5 J. HOSP. MED. 148, 149 (2010).

⁴⁷ Karen Pallarito, *High Readmission Rates May Not Mean Worse Hospital Care*, U.S. NEWS & WORLD REP. (July 14, 2010), available at <http://health.usnews.com/health-news/family-health/heart/articles/2010/07/14/high-readmission-rates-may-not-mean-worse-hospital-care.html>.

⁴⁸ Venteicher & Rau, *supra* note 39.

⁴⁹ *Id.* Rush's orthopedic patients include players for the Chicago Bulls, the Chicago White Sox, and George W. Bush. Department of Orthopedic Surgery, RUSH UNIV. MED. CTR., <http://www.rush.edu/services/orthopedic-surgery> (last visited Dec. 14, 2014); see also *Top-Ranked Hospitals for Orthopedics*, U.S. NEWS & WORLD REPORT, <http://health.usnews.com/best-hospitals/rankings/orthopedics> (last visited Oct. 13, 2014) (ranking Rush University Medical Center as #6 out of 1,646 Orthopedics programs across the country).

⁵⁰ Venteicher & Rau, *supra* note 39.

⁵¹ Jordan Rau, *Government to Reduce Medicare Funding for Hospitals with High Readmittance Rates*, CHICAGO TRIBUNE, (Sept. 13, 2012), available at http://articles.chicagotribune.com/2012-09-13/business/ct-biz-0913-bf-medicare-penalties-20120913_1_high-readmission-readmission-rates-million-in-medicare-funds.

⁵² *Supra* note 35.

⁵³ Rau, *supra* note 51.

⁵⁴ *Id.*

4. The Program May Harm Individual Patients

Although readmission rates declined overall, this decrease may not be a demonstration of the success of the Program and rather may be the result of more outpatient observation status admissions, which has recently expanded significantly. Specifically, Medicare outpatient observation cases in hospitals increased by 230,000 claims in 2011 alone.⁵⁵ By handling patients on outpatient observation statuses, hospitals can at least mitigate the risk of receiving readmission penalties because, according to the Program, observational status patients are not considered admissions according to the Program.⁵⁶

However, the Center for Medicare Advocacy filed a class action lawsuit on behalf of fourteen Medicare beneficiaries on November 3, 2011 in U.S. District Court in Connecticut against CMS alleging that “Medicare policies are encouraging hospitals to put patients in observational care inappropriately, and sometimes retroactively.”⁵⁷ The increasing use of observational status forces Medicare patients to pay more out-of-pocket expenses associated with Medicare Part B, while admitted patients are covered under Medicare Part A and thus have their rehabilitative care paid for by Medicare.⁵⁸ Because many Medicare patients cannot afford the high costs for observational care, they may forgo the necessary skilled nursing.⁵⁹ While this case did not specifically reference the Program as a cause for the increasing use of observation status, researchers have consistently been connecting the two.

5. The Program Makes Hospitals Vulnerable to Fraud and Abuse Violations

In addition to the practical and legal consequences of the program already mentioned, the Program may make more hospitals vulnerable to violating fraud and abuse laws. Hospitals are combatting the Program in a variety of different ways in order to avoid application of the penalty, but many of these measures will implicate a variety of laws subjecting

⁵⁵ Joe Carlson, *Faulty Gauge? Readmissions Are Down, But Observational-Status Patients Are Up—And that Could Skew Medicare Numbers*, MODERN HEALTH CARE, at <http://www.modernhealthcare.com/article/20130608/MAGAZINE/306089991> (June 8, 2013).

⁵⁶ *Id.*

⁵⁷ *Id.*; Bagnall v. Sebelius (No. 3:11-cv-01703, D. Conn).

⁵⁸ *Id.*

⁵⁹ Joe Carlson, *Faulty Gauge? Readmissions Are Down, But Observational-Status Patients Are Up—And that Could Skew Medicare Numbers*, MODERN HEALTH CARE, at <http://www.modernhealthcare.com/article/20130608/MAGAZINE/306089991> (June 8, 2013).

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hospitals to even more financial hardship should their measures run afoul of fraud and abuse laws.

6. Providers Current Solutions

Many hospitals are focusing their efforts on the care at the time of the patient's discharge (or transition) at which time hospitals "can take steps to assure that patients are prepared for discharge, by improving transition communication, better managing disease, educating patients further and paying closer attention to medication management."⁶⁰ However, for safety-net hospitals with disproportionately high numbers of patients that have unsafe housing or unstable employment, "more intensive follow-up strategies will likely be necessary for patients with social risks to reduce their chance of readmission."⁶¹ In response to its efforts to improve its readmissions, Barnes-Jewish Hospital chief medical officer stated the hospital "set up follow-up appointments for patients who didn't have their own doctors. But half of the patients never showed up, he said, even after the hospital made reminder phone calls and arranged for free rides. Sending nurses to see patients at home did not significantly reduce readmission rates either, he said."⁶² These tactics are, however, potentially problematic, especially in regard to the prohibitions of Anti-Kickback and Civil Monetary Penalties Laws.

7. Implication of Anti-Kickback and Civil Monetary Penalties Law

The issue hospitals are facing in reducing their readmissions is how far they can take discharge planning before crossing the line from better care to potentially fraudulent practices. While it seems that calling patients after discharge is legally permissible, delivering prescriptions to a patient's home or providing transportation to a patient to attend a doctor's appointment may be considered a beneficiary inducement.⁶³

⁶⁰ *Hospital Readmissions in the Era of the Patient Protection and Affordable Care Act*, KINDRED HOSPITAL, at <http://www.khaurora.com/articles/hospital-readmissions-2147535483/> (Jan. 16, 2013).

⁶¹ Julia Berenson & Anthony Shih, *Higher Readmissions at Safety-Net Hospitals and Potential Policy Solutions*, THE COMMONWEALTH FUND, Dec. 2012, at 2, available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Dec/1647_Berenson_higher_readmissions_at_safety_net_hosps_ib.pdf.

⁶² Rau, *supra* note 4, at D1.

⁶³ Nina Youngstrom, *Programs to Reduce Readmissions Could Increase the Risk of Fraud and Abuse*, 21 REPORT ON MEDICARE COMPLIANCE 1 (2012).

a. The Federal Anti-Kickback Statute

Under the Anti-Kickback Statute, it is a criminal offense to knowingly offer or receive remuneration to induce referrals of items or services reimbursable by Medicare (or another federal health care benefit program).⁶⁴ Certain types of payments are excluded from the application of the statute within its safe harbors.⁶⁵ Safe harbors, however, must be strictly and precisely followed. The Statute covers any arrangement where any one purpose of the remuneration was to obtain money for the referral or to induce additional referrals.⁶⁶ According to the Anti-Kickback Statute, remuneration includes anything of value, in cash or in kind, transferred directly or indirectly.

b. The Federal Civil Monetary Penalties Law

The Civil Monetary Penalties Law, among other prohibitions, imposes civil money penalties on an entity that offers or provides remuneration to a Medicare (or another federal health care benefit program) beneficiary that is likely to influence the receipt of reimbursable services for the hospital.⁶⁷ The Act defines remuneration to include “transfers of items or services for free or for other than fair market value.”⁶⁸

c. Application

This year, OIG issued its first opinion on an arrangement implicated by the Program, which aimed to reduce a hospital’s readmission rate, Advisory Opinion No. 13-10. While the advisory opinion treated the arrangement favorably, to receive the same treatment by OIG, a hospital would have to structure its program exactly the same in order to avoid the application of fraud and abuse laws. OIG also emphasizes in its advisory opinions that they cannot be relied upon by any other entities and that the opinions are limited only to the specific arrangement described in the facts.

⁶⁴ See 42 U.S.C. § 1320a-7b.

⁶⁵ 42 U.S.C. § 1320a-7b(b)(3); 42 C.F.R. § 1001.952.

⁶⁶ See generally *United States v. Borrasi*, 639 F.3d 774 (7th Cir. 2011).

⁶⁷ 42 U.S.C. § 1128A(a)(7).

⁶⁸ 42 U.S.C. § 1128A(a)(5).

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In the advisory opinion, the requestor was the subsidiary of a pharmaceutical manufacturer that would be paid through various fee structures (including a per patient basis) for providing services to a hospital's discharged patients to reduce readmissions. Included services are liaisons who check in with patients regarding compliance with their discharge plans, remind patients about scheduled appointments, and help patients obtain transportation (at the patient's own cost).

Although the arrangement provided referral sources for the vendor and the hospital, OIG concluded the arrangement posed a low risk of fraud and abuse under the anti-kickback statute.⁶⁹ OIG concluded that the arrangement posed a low risk of fraud and abuse under the anti-kickback statute. OIG reasoned that the services could potentially save the hospital money if the program proved to be successful; this reasoning can be criticized because under the Program, penalties are levied despite the fact that a hospital may have significantly decreased its readmissions, if the readmissions are still above the national average.⁷⁰

Additionally, under the arrangement the patients "unquestionably would receive a valuable service without cost," but OIG concluded the arrangement would not violate the Civil Monetary Penalties Law. OIG reasoned that the arrangement would not provide rewards that would be likely to influence their selection of a provider and primarily makes a person available to remind patients to follow their discharge plans.

However, should a different arrangement using these services be provided for less than fair market value, or if any company's pharmaceuticals or durable medical equipment is promoted, the hospital would be a referral source and the arrangement would implicate the Anti-Kickback statute. The arrangement at issue in Advisory Opinion 13-10 is very complex and also costly; —perhaps prohibitively costly for safety-net hospitals that need readmissions assistance more than most other hospitals. Thus, with the exception of the arrangement described in the advisory

⁶⁹ Office of Inspector Gen. Advisory Op. 13-10, page 10 (Aug. 9, 2013) *available at* <http://oig.hhs.gov/fraud/docs/advisoryopinions/2013/AdvOpn13-10.pdf> opining, "[t]he opinion specified that "The Vendor is a subsidiary of a pharmaceutical company and could provide the Services at below fair market value either to obtain data to market the Parent Company's products or to induce a hospital to purchase or prescribe the Parent Company's drugs. A hospital could also be a referral recipient under the Proposed Arrangement; it could pay above fair market value for the Services to induce the Vendor's employees or contractors to refer patients to the hospital."

⁷⁰ *Id.* at page 12; OIG also reasoned that those who would interact with the patients (liaisons and hotline staffing) would be prohibited from referring the patients to a specific provider; that fees would be consistent with the fair market value of the offered services ; and that the arrangement would not be used to increase the parent company's pharmaceutical sales.

opinion, many other solutions *would* implicate the Anti-Kickback statute and the Civil Monetary Penalties Law.

Providing transportation, for example, is viewed as suspect, and OIG has used free transportation offered to patients by drivers compensated by providers on a per-patient or per-service basis for bringing the patients to the providers' facilities as an example of an abusive arrangement.⁷¹ Additionally, some models concerning hospital readmission reductions of nursing facility patients rely on hospital-supplied nurses, which would implicate the Anti-Kickback statute "if the hospital is a referral source of the nursing facility."⁷²

IV. IMPACT

The practical and legal concerns discussed throughout this Article have pointed out an inconsistency between the policy of the Program (better health) and the likely result of the Program (cost recuperation by Medicare but worse health). This section will discuss the predictions should the Program persist and the recommendations that will, at the least, mitigate the harsh effects of the application of the Program.

A. Predictions

Because the Program disproportionately penalizes safety-net hospitals caring for the most socioeconomically disadvantaged populations in the United States, the Program will likely exacerbate disparities in caring for the most needy. The Program provides significant disincentives for hospitals to care for patients who have complex medical conditions or for patients who are unlikely to have the social and economic support to take care of themselves post-discharge. This is particularly the case if the penalties are larger than a hospital's margins for providing care for those patients, which is conceivably foreseeable given the enormity of the penalties.⁷³ The excessive nature of the penalties, which is five times

⁷¹ See Office of Inspector Gen. Advisory Op. 09-01, page 5 (Mar. 6, 2009) available at <http://oig.hhs.gov/fraud/docs/advisoryopinions/2009/AdvOpn09-01.pdf>; see generally Francis J. Serbaroli, *Offering Free Patient Transportation Poses Risks*, 240 NEW YORK LAW JOURNAL 1, 1-3 (Dec. 10, 2008).

⁷² Mark D. Choteau & Michael Crowe, *CMS' Efforts to Improve Coordination of Care Between Acute and Post-Acute Care Providers*, AHLA CONNECTIONS, at 18 (Oct. 2013) available at http://www.huschblackwell.com/~media/Files/BusinessInsights/BusinessInsights/2013/10/CMS%20Effort%20To%20Improve%20Coordination%20of%20Care/Article_AHLAConnections_Choteau_Crowe_Oct2013.pdf.

⁷³ Mark D. Choteau & Michael Crowe, *CMS' Efforts to Improve Coordination of Care Between Acute and Post-Acute Care Providers*, AHLA CONNECTIONS, at 18 (Oct. 2013) available at

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more than Medicare paid hospitals for the excess readmissions,⁷⁴ takes money away from other essential services that hospitals, and especially safety-net hospitals, already struggle to fund.⁷⁵

Practically, the application of the Program may lead to increased personal injury lawsuits due to hospitals' increasing unwillingness to admit patients in order to avoid excess readmissions. The unwillingness to admit patients may lead to oversight in signs and symptoms with delayed presentation, causing misdiagnosis and undertreatment. This is particularly problematic with symptoms accompanying complex heart conditions, which may subside temporarily with emergency treatment, but reappear within a short period of time.

B. Recommendations

While better health care is a worthy cause, the Program's means are insufficient to accomplish its goals. Instead of penalizing hospitals, especially for readmissions that cannot be prevented regardless of the quality of care received, a program that funded strategies for hospitals that need the assistance the most would be better received. At the very least, however, the program should be amended to first, exclude readmissions unrelated to the initial reason for the admission. This ensures that hospitals are only held accountable for readmissions that they could *potentially* prevent.

Second, the Program should be amended to incorporate an adjustment for various factors, including: dual eligibility status or income, frailty, and limited English proficiency.⁷⁶ These factors acknowledge the

http://www.huschblackwell.com/~media/Files/BusinessInsights/BusinessInsights/2013/10/CMS%20Efforts%20To%20Improve%20Coordination%20of%20Care/Article_AHLAConnections_Chouteau_Crowe_Oct2013.pdf

⁷⁴ *Factsheet: Hospital Readmissions Reduction Program*, AMERICAN HOSPITAL ASSOCIATION, Sept. 9, 2013, at 1. For this source, I think the website is updated periodically and the older versions are no longer available. The current factsheet by the AHA is: *Factsheet: Outpatient Evaluation & Management Services*, AMERICAN HOSPITAL ASSOCIATION, page 2 (Aug. 27, 2014) available at <http://www.aha.org/content/14/combinedfactsheets.pdf>.

⁷⁵ See Rau, *supra* note 4, at D1, ("Some researchers fear the Medicare penalties are so steep, they will distract hospitals from other pressing issues, like reducing infections and surgical mistakes and ensuring patients' needs are met promptly. 'It should not be our top priority,' said Dr. Ashish Jha, a professor at the Harvard School of Public Health who has studied readmissions. 'If you think of all the things in the Affordable Care Act, this is the one that has the biggest penalties, and that's just crazy.'").

⁷⁶ *Examining the Drivers of Readmissions and Reducing Unnecessary Readmissions for Better Patient Care*, AMERICAN HOSPITAL ASSOCIATION, Sept. 2011, at 3. Currently included in the risk adjustment are: age, gender, history of coronary artery bypass graft, and condition categories including history of infection, cancer, hematological disorders, malnutrition, drug or alcohol abuse, paraplegia or paralysis, stroke and vascular disease, asthma, end stage renal disease or dialysis, urinary tract infection, vertebral fractures, septicemia or shock, diabetes, gastrointestinal disorders, dementia and senility, psychiatric disorders,

reality that hospitals are not in control of structural barriers that prevent patients from accessing important resources needed to combat readmissions. The dual eligibility status is a good indicator that a patient lacks important post-discharge resources to take care of herself, and the limited English proficiency risk adjustment ensures that hospitals are not held accountable for language barriers that prevent a patient from fully understanding discharge or medication instructions. Being able to take account of frailty accepts the inevitability of readmissions for elderly patients with complex conditions. No matter how adequate care is provided, patients will be readmitted for their own health and safety.

V. CONCLUSION

The Hospital Readmissions Reduction Program unwisely penalizes hospitals for admissions mostly out of their control. Armed with evidence that “some” readmissions could be preventable, CMS disproportionately penalizes hospitals that care for the sickest and neediest.⁷⁷ While criticisms of the Program have been voiced for years, only now after three years of data can these fears be brought to fruition. Aside from the most commonly voiced opinions of the Program is a criticism that has received little attention despite the serious penalties potentially involved—fraud and abuse concerns. With hospitals trying to combat the occurrence of excess readmissions, fraud and abuse laws will be implicated more and more, and at the very least should be considered by hospitals in addition to the improvements that should be considered by policymakers.

congestive heart failure and other heart diseases, chronic obstructive pulmonary disease and lung disorders, pneumonia, renal failure, skin ulcers, or other injuries. *Id.*

⁷⁷ See *supra* note 3.