Healing Medicare Hospital Recidivism: Causes and Cures

Ann Marie Marciarille

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I. INTRODUCTION: MEDICARE HOSPITAL RECIDIVISM

The role of Medicare in our national market for acute care hospital services is that of a power buyer. Medicare beneficiaries in 2008 included some 45.2 million people. Total benefits paid in 2008 were $462 billion, including 29% of all hospital spending. Medicare’s dominance in the buyer’s market for acute care hospital beds renders the program particularly well-suited to scrutinize the role of acute care hospital services in producing effective and efficient outcomes for Medicare beneficiaries. “[I]f there are to be far-reaching changes in the way medicine is practiced in this country, Medicare will have to drive them.” It is a historical irony that a program, a scaled-down version of national health insurance, could have grown to this power buyer status; but the history of Medicare is full of ironies—the greatest of which may prove to be that Medicare reforms now sit at the very center of the funding mechanisms for the 2010 Patient Protection and Affordable Care Act (PPACA).

Medicare Hospital Insurance, now known as Medicare Part A, was originally designed as a hospital inpatient insurance program. This fact demonstrates both the power of physician resistance to the inclusion of physicians’ services and the fact that, in 1965, the greatest fear for the aged

† Lecturer in Health Law, University of California at Berkeley School of Law. For thoughtful and gracious assistance, thanks to Melissa Brown, J. Bradford DeLong, Van Ellet, David Grant, Thomas L. Greaney, Elizabeth Weeks Leonard, Stephen D. Sugarman, Marjorie Shultz, Edward D. “Ned” Spurgeon, participants in the Pacific McGeorge School of Law Spring 2010 Faculty Workshops, and two anonymous referees.


uninsured was a lack of insurance for inpatient medical services. Original Medicare shaped itself to accommodate the payment system norms of the private insurance industry and the power of providers. Medicare’s pre-passage scope was expanded to include voluntary subsidized insurance as Part B’s coverage for physicians’ office visits. The program re-design acknowledged the trend toward receipt of increasing numbers of health care services in outpatient settings as well as a change of heart for the American Medical Association.

Part B coverage was added on to Part A coverage, not synthesized with it. Perhaps because Medicare, in its origins, divided provider reimbursement by the venue in which the service was provided, the conceptual divide between inpatient and outpatient services entrenched a model of health care delivery for Medicare beneficiaries that contemplated and reinforced a sharp break between inpatient services and outpatient services. This system design distinction in turn shaped the future development of services in both of these venues. The observation that Medicare’s reimbursement structure drives the shape of its delivery structure is particularly trenchant when applied to Medicare’s role in failed hospital discharges. It is at this intersection of Part A and Part B where so much is lost. The cost in human life, human suffering, and health care dollars of the continued legacy of disjointed Part A and Part B services is made manifest. Medicare’s failure to fund comprehensive acute care hospital discharge planning and services is the legacy.

Medicare acute care hospital discharge planning is often seen as offering purely clinical, financial, or legal challenges. But in reality the re-engineering of Medicare acute care hospital discharge planning requires overcoming all three: it is a legal, a financial, and a clinical delivery challenge of the utmost importance. With nearly one-fifth of Medicare patients readmitted to a hospital within thirty days of discharge, the failure of discharge and of discharge planning is multi-dimensional. It represents both a financial disaster for the Medicare program and an exacting burden that extracts a high personal toll on Medicare beneficiaries.

Part of the cause of the rise in Medicare hospital recidivism is found in the broader revolution in acute care medical procedures which have brought “sicker and quicker” acute care hospital discharges within the realm of the

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5 Id. at 31.
7 Although there is no consistent definition of preventable Medicare readmissions, this paper offers the following working definition: a Medicare beneficiary’s return to acute care within thirty days of discharge for the same or a related purpose. A Medicare beneficiary discharged after a surgical procedure who returns to a different acute care facility with a medical diagnosis of hospital acquired infection from the surgical procedure, for example, would fall within this definition. When reference is made to Medicare readmissions beyond the thirty day window, specific note is taken. One of the earliest challenges of health care reform attempts to tame preventable Medicare readmissions will be to standardize definitions.
imaginable. But it took the reformation of Medicare's reimbursement practices—especially the introduction of Medicare's prospective payment system and the rise of utilization review—to drive acute care hospital discharge planning to its current state. Contemporary Medicare hospital discharge planning's dangerous, expensive and oddly truncated emphasis on acute care utilization review averts attention from promoting successful re-entry into the pre-acute care environment for the patient.

This paper attempts to account for the history, source, and magnitude of the preventable readmissions and acute care discharge planning problems for Medicare. How did we get where we are? And how—through financial, clinical practice, and legal reforms—might we get out? What are the most promising proposals for reform?

This paper starts with the histories of hospital discharge practices and of acute care hospital utilization and then traces the development of an acute care hospital discharge practice at the Boston Psychopathic Hospital in the early nineteenth century. Well into the twentieth century, the dominant model was for patients to experience their general acute care illnesses at their homes. Alongside this model, however, a different hospitalization and post-hospitalization model had grown up in an attempt to mediate the relationships between the hospital, the family, and other social service institutions outside the hospital: the one developed for chronically-ill mental-health patients.

General acute care hospitals reinvented themselves in the second half of the twentieth century. They became increasingly dependent on government funded health programs. And so acute care discharge planning in the Medicare context turned into a reimbursement no man's land, mandated by Medicare's “Conditions of Participation” requirements, but unfunded. Simultaneously tethered to the hospital by a backward-looking historical mission and by managed care's backward-looking demand for utilization review, Medicare acute care discharge planning developed a backward-looking orientation. The introduction, in the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA), of Medicare's “Inpatient Prospective Payment System Diagnosis Related Groups”combined with the rise of managed care to create the forces that changed acute care hospital discharge planning from a mere value-added service to an essential institutional survival technique.

This paper then considers how utilization review discharge planning as an institutional survival technique has served both hospitals and Medicare's acute care services patients. It examines several proposals to re-engineer Medicare hospital discharge delivery—including the medically oriented proposals of Dr. Eric Coleman, the pharmaceutically oriented “Re-engineered Hospital Discharge” proposal from Boston Medical Center, and several narrower proposals to re-engineer Medicare hospital discharge finance, for example the bundling of acute care and rehabilitative services, and the imposition of financial penalties for Medicare rehospitalization. This article concludes that only coordinated efforts to support a forward-looking hospital

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8 Preventable acute care readmissions for Medicare beneficiaries are the symptom of the disease: the failure to integrate Part A and Part B care. This paper addresses the symptom, the disease, and possible cures.

discharge practice provide any hope at all in effectively re-engineering Medicare acute care hospital discharge for improved patient health outcomes and improved system efficiency.10

Medicare is a one size fits all health care program11 whose legal, financial, and delivery structure is particularly ill-suited to serve a diverse Medicare beneficiary population. It turns out that Medicare hospitalization recidivism is not one problem but a constellation of interlocking problems: primarily those of the failure to provide ongoing care for the chronically ill, the problem of medically inappropriate primary hospitalizations and rehospitalizations, and the failure to effectively plan and deliver the services necessary for successful community re-entry upon acute care hospital discharge. Combine these with our systemic problems of failure to deliver primary care and the standardless provision of health care and the recipe is complete.

Successfully re-engineering Medicare hospital discharge, to ameliorate Medicare hospital recidivism, will require a cross disciplinary analysis and approach. The failure to provide ongoing care for the chronically ill within the Medicare beneficiary population is intimately related to Medicare reimbursement rates for chronic care services—particularly chronic care patient self-care training—and so requires a comprehensive look at those who might provide the care, how it might be delivered, what level of chronic care support it would take to make a dent in Medicare hospital recidivism, as well as who will pay for the ongoing chronic care or who will bear the expense of hospital recidivism if ongoing chronic care is not provided.

This article attempts such a multi-faceted analysis and approach.

II. THE PROBLEM: A STUDY IN DYSFUNCTION

A. Introduction to the Problem of Preventable Medicare Hospital Readmissions

Preventable Medicare hospital readmissions12 are unpopular with patients,13 with patients' families,14 and with health care analysts of all stripes.15 Yet nearly 18% of Medicare patients admitted to an acute care

10 Although there is some dispute over whether readmission rates are a better measure of quality or of outcome, there is ample reason to consider them as both.
11 Political necessity may play some role in Medicare's one size fits all design as a social insurance program.
12 Hospital readmissions are sometimes called “bounce backs” or “frequent flyers”.
14 Joe Queenan’s description of his alcoholic father’s hospital discharge travails in Closing Time: A Memoir is one for the ages: “The day after our trip to the funeral home, the hospital made the absurd announcement that my father was ready for discharge and could medicate himself at home until the situation deteriorated . . . . I responded to this lunacy by giving his doctor an earful.” Joe Queenan, Closing Time: A Memoir 326 (2009).
hospital are readmitted within thirty days of discharge, at an estimated price tag of some $15 billion in annual spending. The number of readmissions increases dramatically if the time frame is expanded to include those that occur within ninety days of discharge. Thanks, in part, to a lively ongoing public debate on all matters involving health care, these facts are becoming better known: patients who bounce back to the hospital in short order and their families are becoming aware that they are not unfortunate and unlucky exceptions but rather the rule in a broken system.

The problem of avoidable hospitalizations and rehospitalizations is larger than the Medicare program and the population of Medicare beneficiaries. At the intersection of efforts to increase quality of care and decrease costs, interest has focused on preventing avoidable primary hospitalizations and preventing rebound readmissions. The data from private insurers on the prevalence of the problem is scant, however, and often proprietary. Medicare, by contrast, collects such data on an annual basis.

Much is known about Medicare rehospitalization because Medicare’s financial arm has been tracking and studying rebound hospitalizations of Medicare funded patients for years. The Medicare Payment Advisory Commission (MedPAC) is an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission’s twice annual reports make frequent use of Medicare patient data to advise Congress on Medicare payment system topics. But the trend of increasingly costly rehospitalizations has continued remarkably unabated. It is a complex problem, and so attempts to provide a simple fix have been unsuccessful. Avoidable Medicare rehospitalization may, in short, represent a constellation of problems that produce a similar outcome.

A recent increase in Medicare claim data analysis that describes patterns of Medicare rehospitalization, the demographics of Medicare rehospitalization, and the financial structure of Medicare rehospitalization makes this paper possible. As of July 2009, The Joint Commission has

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14 See, e.g., Anderson & Steinberg, supra note 16, at 1349; see also Hector Bueno et al., Trends in Length of Stay and Short-Term Outcomes Among Medicare Patients Hospitalized for Heart Failure, 1993-2006, 303 JAMA 2141 (2010) (studying thirteen years of Medicare readmissions data on heart failure admissions); Jencks et al., supra note 17, at 1421 (examining 2004 data).
incorporated into its website the Centers for Medicare & Medicaid Services’ thirty-day readmission rates for heart attack, heart failure, and pneumonia Medicare patients.\(^{21}\) Without this background of data analysis,\(^{22}\) it would not be possible to evaluate the range of reform proposals—spanning both the Medicare financial and Medicare delivery fields—that show promise in attacking one set of the problems that lead to avoidable Medicare rehospitalization.

What is known is known principally from the Medicare fee-for-service data set.\(^{23}\) It is known that almost one-fifth of Medicare beneficiaries who had been discharged from a hospital were rehospitalized within thirty days.\(^{24}\) It is known that only 10% of this total—2% of hospitalized beneficiaries—planned rehospitalization\(^{25}\) (e.g., staged surgery). And a full half of the patients rehospitalized within thirty days after a medical (as opposed to a surgical) discharge to the community showed no sign of having seen a doctor in an office visit between the time of discharge and the time of rehospitalization.\(^{26}\) Even those with unplanned rehospitalizations following surgical discharge were overwhelmingly rehospitalized not for surgical complications but for a different medical condition,\(^{27}\) and those rehospitalizations were lengthier than primary hospitalizations for non-post-surgery Medicare beneficiaries with the same diagnosis.\(^{28}\) We know that, all told, unplanned rehospitalizations in 2004 cost Medicare $17.4 billion dollars and cost beneficiaries a reduced quality of life.\(^{29}\) The cost of preventable Medicare hospital readmissions may well include some cost in the loss of life itself, as newly adjusted thirty day mortality data may disclose.\(^{30}\)

A problem of the magnitude of unplanned Medicare rehospitalizations does have some broad patterns: the diagnoses for which beneficiaries are rehospitalized, the lack of outpatient follow-up care, and extraordinary regional variation across the United States.

One pattern concerns the broad outlines of the diagnoses that are most involved in Medicare rehospitalization. Certain conditions at discharge are disproportionately represented in unplanned Medicare rehospitalizations.\(^{31}\) The top five medical conditions generating the most readmissions concern: heart failure, pneumonia, chronic obstructive pulmonary disease, psychoses,


\(^{23}\) Medicare managed care data is less accessible, though a comparison of success in avoiding unnecessary Medicare rehospitalizations between it and fee for service Medicare would be a worthy enterprise.

\(^{24}\) Medicare Payment Advisory Comm’n, supra note 16, at 103; Jencks et al., supra note 17, at 1418.

\(^{25}\) Jencks et al., supra note 17, at 1418.

\(^{26}\) Id.

\(^{27}\) Id.

\(^{28}\) Id.

\(^{29}\) Id.


\(^{31}\) Anderson & Steinberg, supra note 16, at 1349.
and gastrointestinal problems.\textsuperscript{32} Four of these conditions may fairly be characterized as chronic. The top five surgical procedures most likely to require readmission concern: cardiac stent placement, major hip or knee surgery, vascular surgery, major bowel surgery, and other hip or femur surgery.\textsuperscript{33} If these are as much as 90\% of unplanned rehospitalizations, then there is a chronic-care after care as well as a surgical-care after care story to be told.

A second pattern is the lack of outpatient follow-up care for more than half of the patients with a medical discharge who were readmitted within thirty days to the community. These individuals, in short, showed no record of primary care receipt between their original hospital discharge and their rehospitalization. A corollary of this second pattern is the high number of medical rehospitalizations following a surgical discharge. If these are also as much as 90\% unplanned rehospitalizations, than there is a primary care in relation to after care story to be told.

A third pattern is the health care truism that in America geography is destiny. Readmission rates range from 13\% in Idaho to over 23\% in Washington, D.C.\textsuperscript{34} The Dartmouth Atlas of Health Care has shown that Medicare hospital admissions vary by a factor of more than two among different regions in the United States, suggesting that there are large differences in the predisposition to hospitalize that also carry over to the predisposition to rehospitalize.\textsuperscript{35} If these are as much as 90\% unplanned rehospitalizations, then there is a variability of practice and supply side after care story that needs to be told as well.

These three themes—the problem of after care for chronically ill Medicare beneficiaries, the problem of primary care follow-up for Medicare beneficiaries, and the problem of geographic variability or standardless medicine for Medicare beneficiaries—shape this look at the causes and cures of Medicare hospital recidivism. None make sense as a cause and the reform of none of them makes sense as a cure for Medicare hospital recidivism without (a) a practical understanding of how Medicare hospital discharge functions at present, and (b) an historical look at the role hospital discharge has played in acute care for Americans. How did the problem of Medicare hospital readmissions come to be laid at the door of America’s acute care hospitals?

B. History of Acute Care Hospital Discharge Planning

1. Hospital Discharge Practice in the Nineteenth Century

This history of acute care hospital discharge planning in the United States is part history of science, part history of medical and social institutions, and part history of medicine and the associated professions. But it is, most

\textsuperscript{32} Jencks et al., \textit{supra} note 17, at 1418.
\textsuperscript{33} Id.
\textsuperscript{35} Id. at 1458.
importantly, a history of the acute care hospital patient—a role whose transformation over time and in different medical contexts has seesawed between that of passive recipient of medical and social aid and that of active and self-aware health care services consumer.

It is necessary to understand the history of acute care hospital discharge planning in the United States because it is this history that shaped the form of acute care hospitalization and continues to shape it to this day. Our great hospital system is not unlike a Russian matrushka doll—containing within it, hidden deep inside, all the earlier iterations of the figure itself. The different layered historical models of acute care, of discharge, and of planning for discharge that make up this history are essential pieces of understanding current practice, so that we may consider what may or may not be worth building on going forward. Most particularly, an understanding of the history of acute care utilization and acute care after care will spare us from the error of longing for good old days that never were and help us to focus on the strengths of the systems designed to assist the chronically ill—the most expensive of Medicare beneficiaries, themselves disproportionately represented in Medicare hospital recidivism. The story of the design of systems of successful re-entry of the chronically ill to American society can be traced in the design of community re-entry programs and services for the mentally ill, and it is for that reason that a closer look at the origins of hospital discharge planning for the chronically mental ill in America is included here.

Acute care hospital discharge practice has, since its origins, been a hospital based practice. From the establishment of the first hospital “aftercare committee with a single social work-trained aftercare agent at New York’s Manhattan State Hospital” in 1906 to the present, the “what next” conversation has been understood to be the particular responsibility of the hospital. This tradition of hospital institutional responsibility—often more honored in the breech—continues to this day: discharge planning is the responsibility of the acute care hospital, and what the hospital does not do will simply not be done by anyone.

The first American hospitals grew out of almshouses oriented exclusively towards serving only those ill who lacked family and friends to nurse them at home. Only those without the social capital or the human capital to acquire status and resources to command aid were required to receive medical care outside of the home. Almshouses did not have patients. They had inmates. The terminology of the penal community was particularly apposite in a setting where the medical inmates were expected, even required, to help in the institution’s nursing, washing, ironing, and cleaning responsibilities towards fellow inmates.

From one perspective, the nineteenth century American almshouses can be understood as patient health care collectives for those too ill to self-care at home and too poor to hire paid attendants to spare them leaving their homes.

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An almshouse was a residence of last resort. And the assistance provided there was provided with as much of a moralistic objective as a medical one. The inmate was seen as more chronic than curable—at most improvable rather than curable. Anything resembling discharge planning would have been shaped around these modest expectations of recidivism.

Hospitals, as distinct from almshouses, were rare places. As Paul Starr so aptly notes:

In the early nineteenth century, there was little demand for the services of general hospitals in America. Almost no one who had a choice sought hospital care. Hospitals were regarded with dread, and rightly so. They were dangerous places; when sick, people were safer at home. The few who became patients went into hospitals because of special circumstances, which generally had to do with isolation of one kind or another from the networks of familial assistance. They might be seamen in a strange port, travelers, homeless paupers, or the solitary aged—those who, traveling or destitute, were unlucky enough to fall sick without family, friends, or servants to care for them.

The modern day version of an almshouse is, of course, found in our public hospitals. Even with the rise of the peculiarly American institution of voluntary or charitable hospitals, the poorest of the poor and the chronically ill were and are still predominantly served by public hospitals and not their voluntary hospital peers. But even the public hospitals could be easily distinguished from their precursor almshouses in important ways. Hospitals became more bureaucratized in the nineteenth century and roles were more sharply demarcated—including the rise of the sick role for patients, which by the late nineteenth century included “[a] complete dispensation from all duties.” Patients were no longer expected to be unpaid nurses’ aides and janitors as well. Average hospital length of stay decreased from something measured in weeks to something measured in days. Medical professionalism, both for doctors and for the associated profession of nurse, was on the rise. These professionals became less and less interested in charitable paternalism for the sake of the moral uplift of their patients and themselves and more and more interested in scientific management and efficiency—the ascendant values of much of a rapidly industrializing American society.

The reconstitution of American hospitals as institutions with primarily medical objectives did not occur until the late nineteenth century. This reinvention required one further element: patients willing to pay for the services of inpatient hospitals. What nineteenth century hospitals could offer that was new and payment-worthy in the eyes of the rising American middle class was twofold: (a) hygienic circumstances for (b) the performance of new

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39 Id. at 158.  
40 Id. at 72.  
41 Id. at 172.  
43 Starr, supra note 38, at 160.  
44 Id. at 158.  
45 Id. at 161.
and advanced surgical and medical procedures. The invention of modern surgery and the discovery of the germ theory of disease liberated hospitals from their “pest house” origins, enabling them to become increasingly devoted to the successful treatment of acute illness rather than the warehousing of the chronically-diseased poor. This in turn induced a revolution in the social origins of their patients. Hospitals owe these developments, in no small amount, to the hospital hygiene reforms after the American Civil War. The Civil War also introduced many Americans to the heretofore rare concepts of surgery performed outside the home and surgical and medical recovery spent outside the home. These new medically oriented institutions were also newly governed by medical masters. Physicians assumed leadership roles more powerful than the lay member governing boards associated with hospitals:

[T]he hospital became a more purely medical institution stripped of its earlier social purposes, medical control supplanted lay control of administration, the basis of funding shifted from charity to patient fees, and new reductionist medical style arose in which patients became clinical entities who were no longer understood in the context of their larger environments.

There was certainly money to be made once modern surgery and modern hygiene enticed the middle classes through the doors of late nineteenth century hospitals. There were fewer than 200 general hospitals in America in 1873. There were 4,000 by 1910. There were over 6,000 by 1920. The value of care provided by non-family members was touted as superior to home-based medical care. And the value of hospitalization in providing respite for family caregivers was noted.

The medicalization of formerly non-medical biological events such as childbirth and death no doubt played a role in the hospital boom as did a growing movement to segregate disorder and deviance—reflecting “a growing tendency to exclude pain from the public view.” Persons “diseased, deformed, maimed, and disfigured” were increasingly unwelcome on modern city streets, giving rise to a parallel increase in the use of asylums for the

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46 Pest houses or pestilence houses were popular names for quarantine hospitals, used to segregate those with small pox, cholera, tuberculosis and other diseases from the general population. See, e.g., The Pest House, St. Louis Park Historical Soc’y, http://www.slphistory.org/history/pesthouse.asp (last visited Feb. 6, 2011) (describing the history of the Minneapolis Small Pox Quarantine Hospital (“The Pest House”)).

47 Starr, supra note 38, at 159.

48 See id.

49 Id. at 75.


51 Starr, supra note 38, at 73.

52 Id. at 74.

53 Id.


55 Starr, supra note 38, at 75.

chronically ill, particularly the poor chronically ill. A culture that, in part, believed that the sight of sick people could literally make healthy people sick had every incentive to promote the removal of visible pain and suffering from both the home and the village square. This is consistent with the origins of many of the great public hospitals of the nineteenth century as “charitable asylum[s] for socially marginal invalids.”

2. Hospital Discharge Practice in the Twentieth Century

By the beginning of the twentieth century, the general hospital’s transition from “household to bureaucracy” was almost complete. And by 1913 an observable decline in home care of the sick had been noted, fueled in part as increased urbanization divorced medical care from the home. The growing popularity of hospitals produced increased pressure for admission and it was then that “hospitals began to limit care to the more acute periods of illness, rather than the full course.” This increased consumer demand reflected an increasingly American fascination with science and quick-fix technology in all realms. In the realm of the general hospital this “hampered efforts to make hospitals more responsive to the needs of the chronically ill.”

In fairness, as a result, it can be said that some combination of medical advancement, rise of urbanization, and social pressure combined to push hospitals toward shorter stays by the early twentieth century. What we know of eighteenth and early nineteenth century hospitalization indicates that by the late nineteenth century hospital discharge had accelerated, though perhaps not uniformly as both medical care and hospital care and procedure contrasted sharply for ward patients and private patients. Private patients paid for their stays and saw their own physicians when hospitalized, receiving their acute care from a health care provider who had some experience of their pre-acute functioning. Ward patients, by contrast, were most often charity patients who saw hospital staff physicians—precursors, in a way, to modern acute care hospitalists—who had no experience with them outside the four walls of the acute care hospital. Two models of care and two standards of care co-existed under one roof, as a result.

The early twentieth century hospital was an institution where patients literally waited upon their physicians. Doctors with hospital admitting privileges—an estimated ten percent of all physicians in 1907—were still

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37 See Starr, supra note 38, at 72.
38 Schweik, supra note 56, at 89.
39 Warner, supra note 50, at 365 (focusing on hospitals in Boston).
40 Starr, supra note 38, at 161.
41 Id. at 74.
43 Starr, supra note 38, at 157.
45 Id. at 234.
46 See Starr, supra note 38, at 159.
47 See id.
48 See id.
relatively rare and powerful. Hospitals functioned at the doctors’ convenience and as medical profit centers for physicians. Discharge from a hospital, in the early twentieth century, was, as a result, completely at the discretion of the admitting physician, tempered only by demand for open beds from patients and demand for profit-making patient turnover for physicians. General hospital patients were discharged home to the care of family, friends, or employees. Those without such connections might be discharged to that new invention, the convalescent facility, a congregate setting for the institutional provision of post-surgical and rehabilitative care. This doctor-driven model was already destined for its own transformation by the rise of third party health insurance in the not distant future.

Early twentieth century hospitals already contained within themselves the seeds of their own internal contradictions, to be played out even to the present.

The goals of American hospitals have been ambiguous throughout the century for basically four reasons: the lack of a unified social welfare policy; the social agenda of hospitals, making them multipurpose institutes (part short-term treatment stations, part educational and professional centers, and part community organizations), the dual role of hospitals as both “charities” and “businesses”; and the symbolic value placed on hospitals as instruments of the wider culture.

As the functions and standards of hospitals changed, so did the costs associated with providing hospital care. One response to the rising cost of acute hospital care was a “call for greater efficiency and stricter business methods in hospital management”—pre-figuring the third great phase of American hospital development to that of bureaucracy controlled by professional administrative staff: “Doctors . . . assumed control because of the increasing complexity and importance of their skills.”

There was, however, an alternative, parallel model of hospitalization and hospital discharge operating even in early twentieth century—the model of the mental health or psychopathic hospital. The rise of the American Progressive Era gave rise to a different model of mental illness and a different role for the mentally ill patient.

The American Mental Hygiene Movement lasted from roughly 1910 until the birth of community mental health centers in the 1960s. Abandoning an intragenic model of mental disorders, Dr. Adolf Meyers introduced the school of dynamic psychiatry to the medical field in the early twentieth century. “According to Meyer, mental illness and mental disorder were the outcome of

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69 See id. at 162.
70 Id. (citing a survey of physicians in the Bronx and Manhattan).
71 Inst. of Med., For-Profit Enterprise in Health Care 32 (Bradford H. Gray ed., 1986) (“Before the 1930s, individuals in need of long-term care outside their homes were admitted to private charitable homes.”).
72 Vadek, supra note 64, at 234.
73 Starr, supra note 38, at 160.
74 Id. at 178.
75 Id.
the dynamic interaction of individuals with their environments.” Under this new vision of mental health, the mentally ill were best understood as maladjusted, and it became the responsibility of the psychiatric hospital to help those most acutely mentally ill to become better adjusted to their environments and their environments become better adjusted to them.

But it was not until a dynamic former psychiatric hospital patient named Clifford Beers founded the movement with the publication of his memoir, A Mind that Found Itself, in 1908 that Dr. Meyer’s principles began to be implemented on a large scale in American hospitals. Mental hygiene, interestingly and revealingly, was a consumer-driven movement eventually adopted by the medical establishment of the day. But it was more than the arrival of an articulate spokesman that made the time right for such a change in approach. Rather, the dismal overcrowded conditions of psychiatric hospitals in America had been a public scandal for some time. Inpatient psychiatric care had changed little in decades. The public psychiatric hospitals were essentially warehouses for the chronically mentally ill, not overly distant from their almshouse roots. Adolf Meyer’s principles at least gave hope that early identification and treatment of mental illness were the keys to preventing growth in the population of these grim facilities.

The 1913 Handbook of Mental Hygiene Society outlines a theory of mental health:

Life is a process of adjustment; of the individual to the environment. Health is a state of mind and body in which the adjustments are relatively good, while in disease, of which insanity is a special form, they are insufficient or imperfect.

Lest this begin to sound too much like the theory of Aristotelian humors, the 1913 Mental Hygiene Society statement of goals included a plan to assist the mentally ill in making the necessary adjustments to enable them to live outside the state mental hospitals. Prominent in their 1913 call to reform was “[e]stablishment of after-care and social service work under the direction or with the full co-operation of state institutions.” With this, the American psychiatric hospital and the American psychiatric establishment began a decades long embrace of the Mental Hygiene Movement’s insistence that the mentally ill be understood in familial and social context and aided in returning to that context.

Who would aid psychiatric patients in their adjustments was less clear. Nurses were an obvious choice for the role, until it was acknowledged that these adjustment helpers might have to assume a more activist advocacy role both vis-a-vis patients’ families and vis-a-vis other social institutions such as community based health care providers. Nurses could not do this. Though they had long been powerful patient advocates in some health care settings,

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78 2 Encyclopedia of Children and Childhood, supra note 76, at 595.
79 Nat’l Comm. for Mental Hygiene, Hand Book of the Mental Hygiene Movement and Exhibit, at 11-12 (1913).
80 Id. at 20.
they had been trained in the early twentieth century to act as the handmaidens of doctors in the acute care hospital setting. By 1921, one doctor observed:

> It may be said with truth that the training of a nurse, as we know it in America, at any rate, really unfits a woman in some respects for the work of a social worker, since it accustoms her to habitual obedience and subordination.  

Social workers, or those who acted in that role, had been around the medically needy for a long time. Although the formal term “social worker” itself was not coined until the second decade of the twentieth century, counselors serving the social problems of the sick had been around much longer—achieving particular prominence in the aftermath of the Civil War, when so many physically and psychically damaged by the war returned to civilian life. But it was in the early twentieth century that social work was professionalized and, not coincidentally, began to find a place in the newly professionalized and bureaucratized hospitals of the day.

Mary Cromwell Jarrett, the formidable founder of the psychiatric social worker movement in America, helped to shape the role these hospital-based social workers would play in mental health hospitals.

Jarrett was initially interested in how the properly trained social worker might facilitate the work of the psychiatrist, first by obtaining a detailed history from the patient’s community (as an aid to correct diagnosis) and later by helping to bring about changes in the patient’s environment necessary to his or her mental well-being.

Jarrett’s psychiatric social worker took an environmentalist approach to social work, acknowledging individual changes could be made to improve health only if the individual’s environment was improved as well.

Exemplified by the work of Dr. Richard Cabot at the Boston Psychopathic Hospital in the early twentieth century, hospital based social workers there were charged with mediating the relationship between the hospital, the patient’s family, and other social service institutions. Perhaps because so many of Dr. Cabot’s patients were under treatment for alcoholism and

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81 Elizabeth Kemper Adams, Women Professional Workers: A Study Made for the Women’s Educational and Industrial Union 96 (1921) (quoting Richard C. Cabot, Social Work: Essays on the Meeting Ground of Doctor and Social Worker 19 (1919)).


84 Although there is some evidence that volunteer social workers were used in this role in both the United States and Britain—Mental After Care Associations having roots back to the immediate post Civil War period in both countries—the professionalization and standardization of the role was a Progressive Era event. See Mathew Thomson, Psychological Subjects: Identity, Culture, and Health in Twentieth-Century Britain 192 (2006).


addiction, the patient’s family was seen as both a potential service solution and as a potential service challenge in successful community re-entry from Boston Psychopathic Hospital. Hospital social work, firmly rooted in the mental hygiene movement of that time, was Boston Psychopathic’s strength, however and Dr. Cabot’s *Social Work: Essays on the Meeting Ground of Doctor and Social Worker* (1919) was a classic of its day.

And so American hospitals entered the middle third of the twentieth century primed for their third great developmental phase: the rise in control by professional hospital administrators because of the increasing complexity of internal organization and relations with outside agencies. General hospitals and psychiatric hospitals, poised on the brink of this development alike, entered this era ambivalently balancing two different models of patient after care and the institution’s role in it. I have argued that general hospitals—as part of their historical transformation into acute care hospitals—increasingly detached patients from their social context, taught learned helplessness while in the role of acute care hospital patient, and deliberately distanced themselves from post-acute care. Psychiatric hospitals, in contrast, re-contextualized the lives of the mentally ill—both as a treatment mechanism and as an after care approach—assigning a dedicated professional workforce to aid the patient and the family in return to the community.

Significantly, both acute care hospitals and psychiatric hospitals developed these models out of a profound desire to improve care, offer more cost effective care, and to improve the overall efficiency of acute care delivery. Their motives, not unlike our motives today, were to improve health care delivery and finance. And both succeeded, to a degree, though their models were rendered obsolete by the rise of third party health insurance, and the entrance of the federal government into health care finance, as well as by a demographic revolution in American living arrangements and lifespan that is still underway.

The rise of the American acute care hospital—a product of the medical and public health advances occasioned by the Civil War, the professionalization of the health care professions, and the rise of an American middle class—in the late nineteenth and early twentieth century makes nomenclature an important aspect of the conversation about hospital after care. I have argued that American hospitals, in their origins, were both peculiarly concerned and unconcerned with after care for their patients. They were concerned for those patients, most often the chronically ill and debilitated, using the hospital as a means to strengthen themselves for a return to an almshouse, a long-term stay in a charitable institution of some sort, or even a return to the poor farm. Why they were concerned was simple: since after care would be as much the responsibility of the public or charitable fisc as the acute care episode had been, these early hospitals had every incentive to see after care delivered in as seamless and efficient a manner as possible. There was no hospital to community “hand off,” the medically needy individual was simply passed from one hand to another.

89 Starr, *supra* note 38, at 178.
Private pay patients, on the other hand, had to be wooed into the brave new world of hospital utilization for medical care. They were ultimately won over by the model of the acute care hospital as a workplace for the production of health.\(^{90}\) While they were still able and eager to receive their post-acute care at home and embraced the model of hospital as repair shop—a place you might periodically return to for repairs and return home when fixed. And so, by the turn of the twentieth century, it was possible to categorize most American hospitals as general acute care hospitals for short stays.\(^{91}\) A modern definition of “general hospital” would have been as apt then as it is today. “A general hospital provides a variety of services, including general and specialized medicine, general and specialized surgery, and obstetrics, to meet the general medical needs of the community it serves.”\(^{92}\) The American general hospital’s ambivalence about the poor and needy, by the late nineteenth century, was already firmly in place. General hospitals, with their newly standardized admissions procedures, newly standardized billing procedures, and tremendous drive to develop the hospital as a scientific—as opposed to social—institution needed middle class private pay customers to continue to grow.\(^{93}\) “Hospitals had gone from treating the poor for sake of charity to treating the rich for sake of revenue and only belatedly giving thought to the people in between.”\(^{94}\)

Hospitals remained incompletely integrated, both as organizations and as a system of organizations—a case of blocked institutional development, a pre-capitalist institution radically changed in its functions and moral identity but only partially transformed in its organizational structure.\(^{95}\)

From 1887 to 1915, the number of general hospitals in the United States ballooned from perhaps 200 to as many as 6,000.\(^{96}\) And by 1928, the number had reached 6,852. This number dropped to 6,189 by 1937, representing the first great contraction in hospital numbers in America.\(^{97}\) The rising American middle class, constrained by Depression economics and by health care inflation, had a finite appetite for acute care hospital services, after all. It was not until the rise of health insurance and the federal government’s entry into health care procurement on a large scale that American hospitals entered a new era of expansion.

The “people in between,” mostly disregarded by the early twentieth century hospital, ended up as the salvation of general acute care hospitals in America. For it was “the people in between” who moved the country toward a system of private health insurance for inpatient care—concomitantly stabilizing the income flow for American general hospitals. Although


\(^{91}\) A short stay is defined as thirty days or less.


\(^{93}\) Arndt & Bigelow, supra note 90, at 36-37.

\(^{94}\) Starr, supra note 38, at 159.

\(^{95}\) Id. at 179.

\(^{96}\) Id. at 73.

\(^{97}\) Shi & Singh, supra note 92, at 295.
American benefit societies had long formed buyer’s cooperatives for outpatient services, it was not until 1929 that the Blue Cross model of prepaid hospital insurance for a set premium was developed in Dallas. Baylor University Hospital’s trustees attempted to insulate the facility from the Depression-induced drop in demand for private pay inpatient general hospital services with the invention of prepaid hospital insurance. By 1939, a California-based group of doctors had developed a somewhat different model for offering a prepaid inpatient hospital plan—the precursor to Blue Cross.

But it was the passage of the Social Security Act of 1935 that moved the federal government into the health care procurement arena for the elderly in an entirely new way. Although the 1935 Act did not reimburse for inpatient general hospital services, it did offer government reimbursement for certain amounts of nursing home care for the elderly, touching off a nursing home building boom that drove the number of nursing homes in the United States from 1,200 in 1935 to 15,000 by 1969. Importantly for hospital after care, these institutions gave the not quite completely well post-acute patients a destination. And, equally importantly for hospitals, the Act established a cost based reimbursement system. Providing a government reimbursed setting for qualified seniors to recuperate from invasive and acute inpatient procedures produced an institutional structure to further detach acute and post-acute care in American medicine.

Acute care hospital services utilization in America is and has always been both demand and supply driven. Supply was ample—even excessive by early twentieth century standards. Demand was influenced by the rise of insurance and the concomitant rise in expectations for access to inpatient acute care services. Private pre-paid health insurance for workers took off in the 1930s, 1940s, and 1950s, substantially fueled by World War II wage freezes, as exemplified by the 1942 birth of the Kaiser Health Plan.

"Subsequently, the growth of private health insurance provided a vehicle enabling people to pay for hospital services, and the flow of insurance funds helped revive the financial stability of hospitals. Insurance also contributed to the increased demand for health services." By the 1940s, general hospitals were deemed to be in under-supply, particularly in rural and remote areas. Congress acted in 1946 by passing the Hospital Survey and Construction Act of 1946—popularly known as the Hill-Burton Act—attempting to achieve the goal of 4.5 hospital beds for every 100

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98 Starr, supra note 38, at 207.
100 Id.
101 Inst. of Med., For-Profit Enterprise in Health Care, supra note 71, at 32.
102 Id.
104 See Meadors, supra note 99, at 15 (noting that Kaiser established its first plan in 1942).
105 Shi & Singh, supra note 92, at 295.
America’s second great hospital building boom was underway. Still, it was not until the 1960s that spending on health and hospital services became predominantly insurance paid. Not coincidentally, the Social Security Act of 1935 was amended in 1965 to add both Medicare and Medicaid. And Medicare contained within it the first federal program to fund inpatient general hospital care for eligible seniors. Although the Medicare statute’s original language contained few limits on the medical expenses to be covered, coverage was soon limited to reasonable and medically necessary care. The combination of a generously worded statute and a cost-based reimbursement system guaranteed that for roughly the first twenty-five years of the Medicare inpatient hospital benefit, hospital stays remained relatively lengthy. Average acute care length of stay did not begin to decrease for individuals sixty-five years of age and older until the early 1980s. In the 1990s, the average length of stay for Medicare patients fell more than 30%.

Although some of the mid to late century decline in acute care length of stay was certainly attributable to improved medical techniques, a large proportion was driven by Medicare’s payment system reform in the form of the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA). TEFRA, teamed with the introduction of the Inpatient Prospective Payment System (IPPS) diagnosis Related Groups revolutionized inpatient hospital services for seniors and, even more importantly, revolutionized after care services.

Medicare’s prospective payment system with diagnosis related groups represented a change in the paradigm of Medicare. Abandoning a reimbursement based model, the new model paid hospitals a predetermined set rate based on diagnosis. The adoption of this alternative reimbursement system codified a dramatic change in the balance of power between hospitals and physicians, driving acute care hospitals to value shorter, more efficient acute care stays while also valuing increasing numbers of admissions. Medicare’s abandonment of path dependence in its shift from reimbursement based payment to a prospective payment system triggered a parallel transformation in the acute care hospital world. Medicare certified acute care hospitals were launched as free-standing health care businesses. “Medicare was no longer part of a universe of social insurance programs but rather gained a new identity as a health financing program—one in need of stronger

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spending controls.”114 Medicare’s abandonment of the commitment to do nothing with its payment policy that would threaten physician professional sovereignty represented the triumph of fiscal exigency over market ideology.115 Medicare’s abandonment of reimbursement based payment language heightened the contrast nicely.

C. MEDICARE ACUTE CARE HOSPITAL DISCHARGE PLANNING AS OF 2010

The history of Medicare attempts to promote successful hospital discharge planning has been primarily one of exhortation. Failed Medicare discharge planning and its accompanying costs have languished for attention because of ambivalence over proposed cures. Uncertainty over whether Medicare hospital recidivism could best be controlled by market based or by regulatory solutions produced, until relatively recently, stunning inaction. Medicare’s aspirational language to improve hospital discharges and to reduce preventable readmissions was never paired with incentives and structures in Medicare’s payment system designed to advance these goals.

General acute care hospitals that want to participate in the Medicare program must be certified. Medicare certified hospitals, consistent with 42 C.F.R. § 482.43, and 42 U.S.C. § 1395x(ee) are formally required to: determine if a Medicare beneficiary needs discharge planning assistance, identify services needed and assess availability of those services; assess whether a return to pre-admittance living arrangements will suffice, develop and implement discharge plan if requested by a doctor, use professional staff to deliver discharge planning services, ensure that necessary care and services are delivered upon discharge, prepare the Medicare patient and family for discharge through education and counseling, and transfer or refer the Medicare beneficiary (along with necessary medical information) to appropriate facilities, agencies, or outpatient services for follow-up care.116

Medicare certified hospitals satisfy the unfunded discharge planning mandate by combining three aspects of acute care hospital throughput into one role, that of the case manager. A modern acute care hospital case management department typically includes individuals who combine the functions of utilization management, care coordination, and discharge planning. And a modern acute care hospital case management department is typically highly computerized, as is the hospital discharge planning function.117 Because Medicare’s discharge planning mandate is unfunded, it serves as hand-maiden to the financially driven utilization management role. As a result, Medicare certified hospital discharge planning is utilization review driven. This means discharge planning in a Medicare certified hospital is highly unlikely to begin until a Medicare beneficiary has been flagged as requiring discharge under utilization review. This causal link will inevitably

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114 Oberlander, supra note 4, at 126.
115 Id. at 123.
117 The use of proprietary software to manage acute care hospital discharge planning is a story that deserves to be told. This is both because the software combines the functions of utilization management and discharge planning and because its very use shapes the nature of discharge planning. See A. Jacqueline Mitus, The Birth of InterQual: Evidence-Based Decision Support Criteria that Helped Change Healthcare, 13 PROF. CASE MGMT. 228, 228-30 (2006).
produce tight time frames that render successful hospital discharge planning very difficult. It is ironic that one of the most frequent causes of a hospital discharge delay is waiting time for a bed in a post-acute care facility when the delay in beginning the search often rests with the combined utilization review/hospital discharge function.\textsuperscript{118}

As a practical matter, these conditions of Medicare participation requirements are also difficult to enforce. CMS's interpretation of this list of affirmative hospital responsibilities has devolved into the assertion that the ubiquitous “Important Message from Medicare” language delivered to each Medicare inpatient at or near hospital discharge serves as notice to the Medicare patient that inpatient care is no longer medically necessary, that discharge is imminent, and that an appeal of the discharge plan is available on a time-limited basis.\textsuperscript{119} If a Medicare beneficiary disagrees with the appropriateness of the discharge plan, either because of a belief that continued acute care is appropriate or that the discharge plan proffered is inappropriate, the hospital may respond with a notice of non-coverage.\textsuperscript{120} This notice requires an individualized assessment of the patient’s need for a further inpatient hospital stay as a matter of medical necessity,\textsuperscript{121} and it requires the agreement of the physician who is responsible for the beneficiary’s inpatient care,\textsuperscript{122} or a Quality Improvement Organization (“QIO”)\textsuperscript{123} determination in lieu of the physician’s agreement. If the inpatient continues to disagree with the decision that further inpatient care is unnecessary, the QIO for that hospital is asked to review the decisions.

The cost of appeal can be high. The same notice that advises that inpatient acute care services are no longer medically necessary also indicates that customary charges\textsuperscript{124} will be made for continued hospital care beyond the second day following the date of the notice. A hospital’s notice of non-

\textsuperscript{118} At least one attempt has been made to develop a predictive score to identify a patient’s risk of discharge to a post-acute care facility in order to jump start hospital discharge planning in the U.K. See Martine Louis Simonet et al., A Predictive Score to Identify Hospitalized Patients’ Risk of Discharge to a Post-Acute Care Facility, 8 BMC HEALTH SERVS. RES., no. 154, July 22, 2008, http://www.biomedcentral.com/1472-6963/8/154.

\textsuperscript{119} CMS, Hospital Discharge Appeal Notices, http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp (last updated Oct. 12, 2010) (click “Important Message from Medicare” and “Detailed Notice of Discharge” links for templates). The Notice of Discharge and Medicare Appeal Rights is sometimes referred to as the NODMAR document. A revised NODMAR document will be in use as of April, 2011. Id.

\textsuperscript{120} 42 C.F.R. § 412.42(c)(3) (2006).

\textsuperscript{121} CMS advises its Medicare Advantage partners to explain the term “medically necessary” to Medicare beneficiaries as follows:

Medically Necessary means services or supplies that: are proper and needed for the diagnosis or treatment of a medical condition, are provided for the diagnosis, direct care, and treatment of a medical condition, meet the standards of good medical practice in the local area, and are not mainly for the convenience of a member or doctor.

\textsuperscript{122} CMS, Medicare Advantage Compliance Training 151 (2009), http://www.iceforhealth.org/podcast/20080407_Resources.pdf.

\textsuperscript{123} Quality Improvement Organizations, most often third party vendors, represent the first line of appeal for Medicare beneficiaries appealing hospital discharge decisions and denials of Medicare funded services. 42 C.F.R. § 412.42(c)(2)-(4) (2006).

\textsuperscript{124} 42 C.F.R. § 413.13(a) (2009) (defining customary charges as “the regular rates that providers charge both beneficiaries and other paying patients”).
coverage from which a beneficiary has filed a timely request for reconsideration of an initial denial determination must have a completed reconsideration by a QIO within three working days after the QIO receives the request for reconsideration. The beneficiary is still an inpatient in a hospital for the stay in question when the QIO receives the request for reconsideration, leaving at least several days of financial exposure for the beneficiary who appeals from within the acute care facility.

Those who risk the financial exposure of failed inpatient discharge appeal are often rewarded with a reversal of the QIO’s decision. In 1997, some 72% of these appeals resulted in the inpatient prevailing. The majority of Medicare appeals for denial of coverage continue to be successful.

Although Qui Tam or whistle blower litigation under the Federal False Claims Act may be brought both to challenge untimely Medicare hospital discharges and improperly coded hospital discharges, there is little evidence that resolution of these billing disputes has reinvigorated the substance of Medicare hospital discharges.

General hospital licensing requirements also contain language requiring the provision of discharge planning for all patients. The Joint Commission’s consumer activation website recommends that patients ask questions about the availability and adequacy of discharge planning when selecting a hospital. Interestingly, the Joint Commission acknowledges that consumer choice in selection of acute care hospitals is not frequently exercised.

The National Committee for Quality Assurance (NCQA) promotes quality and delivery standards in health plans. Although hospital readmissions are not included in the NCQA’s Healthcare Effectiveness Data and Information Sets (HEDIS) tool for quality measurement of managed care health plans, a voluntary care management and health improvement standard targeted to reducing general population hospital readmissions has been piloted.

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125 Different, longer time limits may apply if the beneficiary is no longer in acute care. 42 C.F.R. § 405.1205 (c)(2) (2007).
130 The Joint Comm' n, Helping You Choose the Hospital for You 2 (2010), http://www.jointcommission.org/assets/1/18/HYC_Hospital.pdf.
131 Id. at 1.
III. DELIVERY AND PAYMENT SYSTEMS REFORM PROPOSALS
FOR MEDICARE HOSPITAL DISCHARGE

The problem with our current system of Medicare hospital discharge is that there is nothing systematic or forward-looking about it. It is not designed to promote successful community re-entry or reduce hospital recidivism. It is a product of the history of acute care hospitalization after care arrangements in America. The rise of utilization review as a byproduct of managed care has extended this trajectory by reducing the average length of stay for acute care hospitalizations for all acute care patients including Medicare enrollees. This highlights the lack of any systematic approach to Medicare acute hospitalization after care planning and any recognition that successful community re-entry for the Medicare population might require tailoring of services to a disproportionately older population. The conflation of the discharge planning and utilization review functions in modern American hospitals—one an unfunded mandate and the other a valuable business practice—has produced the triumph of a backward looking hospital discharge process. Acute care hospitalization discharge planning is housed in an institution that will have little to nothing to do with the implementation of the plan, crafted by employees who will play little to no role in the implementation of the plan, and financed by an institution that will achieve no financial gain for designing and implementing a plan that prevents acute care hospitalization recidivism. In fact, the current Medicare reimbursement model provides every incentive for speedy discharge and tolerates rapid recycling of recidivists as a by-product of this rapid discharge priority.

Even more complex than the debate over how Medicare discharge planning evolved to its current status is the debate over whether or how to elevate it from its debased status. In this section of the paper, I consider various solutions proposed to the problem of Medicare hospitalization recidivism and categorize Medicare hospitalization recidivism reform proposals as either delivery, finance, or payment system oriented in their approach.

A. Delivery Reform to Heal Medicare Hospitalization Recidivism

Here, I sub-divide a survey of some of the most promising delivery system proposals offered as solutions to hospitalization recidivism in general and/or Medicare hospitalization recidivism, in particular, by the type of service delivery model proposed: physician-centric, hospital-centric, pharmacist-centric, or consumer-centric.234

Dr. Eric Coleman of the University of Washington, perhaps the most prominent contemporary hospital discharge reformer, is the leading proponent of what might be called a patient activation model of improved hospital discharge planning. Specifically, Dr. Coleman’s Care Transitions

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model is based on the idea that what is wrong with acute care hospital
discharge planning is that both patients and their families are ill-equipped to
navigate a system that requires accessing multiple health care and health care
related service providers. His solution is patient activation. The Care
Transitions Program contemplates that a coach may be useful to teach
patients and their families how to navigate the brutally complex system for
follow-up care. One variant of the Care Transitions Program uses advanced-
practice nurses in training to assist patients and their families in self-care
skills. The Coleman approach, in its study groups, has reduced
rehospitalization rates for the same condition as well as reduced total costs.135

Dr. Coleman’s work has garnered much attention for the provider and
payer communities, all of whom are understandably interested in a model that
does not ask a great deal more of them but, rather, asks that consumers
become better self-advocates and self-caregivers. There is much to commend
about a patient and family caregiver centered approach.136 It assumes, of
course, that each patient involved is cognitively137 and physically equipped to
become a better self-advocate or self-caregiver or has sufficient family or
family-like connections to help with the care. Consumers, in short, need
reinvention more than the hospital discharge system does if the hospital
recidivism problem is to be addressed. And, to its credit, it addresses the “too
little training” problem inherent in the current system, for health care
consumers who are trainable. It sets a high bar, however, for those with
cognitive or physical impairments that prevent self-care, indicating that it
may function best as partial solution to hospital recidivism—targeted to those
with the least complex of the complex conditions.

Most troublingly, this model offers no sustainable funding mechanism for
the self-care coach.138 And, it offers no larger response to the problem and
irony of likely increased demand for scarce home health care services from
newly self-activated consumers. Medicare funded home health care is
currently premised on a form of rationing that relies on the complexity and
obscurity of the system preventing some individuals from asking for assistance
for which they are surely eligible and others who are eligible yet
underconsuming home health services because of an inability
to manage and orchestrate multiple providers.139 In short, if all eligible seniors learn to
navigate the home health system well, demand will grow exponentially.140

135 Thomas Bodenheimer, Coordinating Care—A Perilous Journey Through the Health
136 See generally Sunil Kripalani et al., Promoting Effective Transitions of Care at Hospital
http://onlinelibrary.wiley.com/doi/10.1002/jhm.228/pdf (Patients are vulnerable after
discharge, so hospitalists should assist patients “through appropriate discharge planning and
effective communication with patients, their family members, and outpatient physicians.”).
137 See Brenda L. Plassman et al., Prevalence of Cognitive Impairment Without Dementia
in the United States, 148 Annals Internal Med. 427, 433 (2008),
http://annals.org/content/148/6/427.full.pdf+html.
138 It is possible, however, that volunteer coaches may be of some assistance. These
services are, however, exclusively hospital and clinic based.
139 See Joseph Bernstein, Topics in Medical Economics: Health Care Rationing, 88 J. Bone
140 This phenomenon, sometimes called “the woodwork effect,” can produce the perverse
conclusion that if a government service is too popular, no government will be able to offer it.
Professor Mary Naylor of the University of Pennsylvania School of Nursing has developed an Advanced Practice Nurse Specialist Transitional Care model that substitutes for routine hospital-based discharge planning and home care. Under this model, chronically ill seniors are screened out of the standard hospital discharge planning program and placed into a more intensively managed system of discharge and home care. Specifically, the model of advance practice nurse specialist transitional care includes a comprehensive discharge planning combined with home follow-up. Several different iterations of the model have been and continue to be studied, with the most costly and labor intensive (involving a follow-up home visit or, in the case of heart failure patients, a series of follow-up visits) proving the most effective at preventing Medicare hospitalization recidivism.\textsuperscript{141} The improvement in post-discharge outcomes for chronically ill seniors has been impressive as well, so impressive that Professor Naylor’s model is being implemented as pilot projects at both Kaiser and Aetna.\textsuperscript{142} Although it is also labor intensive, this approach does address the “too little instruction” problem often identified as the failure point of contemporary hospital discharge planning by, in essence, extending the discharge process into the post-acute period for complex cases.

In fact, it is this most expensive iteration of the Naylor model—that highlights the real challenge in efforts to reduce hospital recidivism. Put simply, these efforts, if successful, may harm the hospital financially. Park Nicollet Health Services, based in St. Louis Park, Minnesota, has made a four year effort to reduce hospital recidivism for heart patients by employing more nurses and implementing sophisticated software to track heart failure patients via telephone after discharge. Nurses contact patients if the monitoring detects changes in the health. Unfortunately, reducing the facility’s heart failure recidivists from nearly one in six patients to one in twenty-five patients was not cost effective. Park Nicollet’s Medicare bonus for running the program covered only one third of the cost of running it.\textsuperscript{143}

Catholic Healthcare Partners in Cincinnati also attempted a heart patient follow-up program but found it could not afford the additional expense of keeping heart failure patients out of the hospital.\textsuperscript{144} There, heart patients in the program monitor their weight and symptoms daily, forwarding the information to a monitoring center by telephone keypad. Software alerts a nurse to follow-up with selected patients. Ideally, intervention occurs before hospitalization is required, and is oriented toward managing symptoms. Catholic Health care’s six nurses dedicated to this review of high-risk heart failure patients were very good at what they did. Hospital recidivism dropped sharply, but the end of the Medicare special grant brought the end of the

\textsuperscript{141} Mary D. Naylor et al., Comprehensive Discharge Planning and Home Follow-up of Hospitalized Elders: A Randomized Clinical Trial, 7 JAMA 613, 618 (1999), http://jama.ama-assn.org/content/281/7/613.full.pdf+html.
\textsuperscript{142} See Mary D. Naylor, Director, NewCourtland Ctr. for Transitions & Health, Presentation at the National Health Policy Forum: The Transitional Care Model for Older Adults 11 (Apr. 3, 2009), http://www.nhpf.org/library/handouts/Naylor.slides_04-03-09.pdf.
\textsuperscript{143} Reed Ableson, Hospitals Pay for Cutting Costly Readmissions, N.Y. Times, May 9, 2009, at B1.
\textsuperscript{144} Id.
program. From the hospital’s perspective, the payer reaps all the benefit\(^{145}\) of improved practice but refuses to take ownership for the expense, raising interesting questions about whether the discharge planning responsibility might be better lodged with those with a financial interest in the outcome.

Other hospital-based hospital discharge models have also had a measure of success. A program called “Reengineered Hospital Discharge” has been studied at Boston Medical Center,\(^{146}\) an academic safety net hospital. The Reengineered Hospital Discharge intervention was implemented by six part-time nurse discharge advocates. These employees were dedicated to the program. Although this program did not target Medicare hospitalizations but rather a general medical population and specifically excluded discharges to an institutional setting, its results are useful for considering Medicare hospital discharges. The patient mix of a facility like Boston Medical Center is quite diverse and predictably top heavy with patients with multiple chronic conditions correlated with lower incomes, consistent with the facility's safety net hospital status.\(^ {147}\) It is these kinds of patients who are the challenge to contemporary Medicare hospital discharge practice as well.

At Boston Medical Center, the nurses took a more activist role: helping to arrange follow-up appointments, confirming medication reconciliation, and training patients in self-care skills with individualized printed instructions to be shared with their primary care provider. Further, a clinical pharmacist made the two to four day follow-up call to reinforce the discharge plan and review medications.\(^ {148}\)

The goals of the program were two-fold: to reduce hospital recidivism and to reduce non-emergent emergency room use. But the program also had secondary goals: self-reported preparedness for discharge, rate of primary care follow-up visits, and knowledge of discharge diagnosis. And Boston Medical Center was bold enough to call its goal “minimizing discharge failures.” Toward that end, the facility developed and implemented a discharge intervention that included elements of patient education, comprehensive discharge planning, and post-discharge telephone reinforcement.\(^ {149}\)

The results are remarkable, particularly as compared with the usual care group data. The usual care group was discharged with 35% of participants with a primary care appointment while the intervention group was discharged with 94% with a primary care appointment.\(^ {150}\) Even more strikingly, though only 62% of the program participants were reached by the program

\(^{145}\) Id.

\(^{146}\) Id. Boston Medical Center Hospital was created in 1996 by the merger of Boston City Hospital and Boston University Medical Center Hospital. It has the largest twenty-four-hour Level I trauma center in New England and an emergency department with more than 132,000 visits in 2010. Facts, BOSTON MED. CTR., http://www.bmc.org/Documents/BMC-Facts-2010.pdf (last updated Nov. 15, 2010).

\(^{147}\) Id. Boston Medical Center is the largest safety net hospital in New England. Id.

\(^{148}\) Brian W. Jack et al., A REENGINEERED HOSPITAL DISCHARGE PROGRAM TO DECREASE REHOSPITALIZATION: A RANDOMIZED TRIAL, 150 ANNALS INTERNAL MED. 178, 178 (2009).

\(^{149}\) Id. at 178-80.

\(^{150}\) Id. at 182 (Increased access to primary care may be a key driver of hospital readmission reduction.). For a similar study conducted at Veterans Affairs Medical Centers, see Morris Weinerger et al., DOES INCREASED ACCESS TO PRIMARY CARE REDUCE HOSPITAL READMISSIONS?, 334 NEW ENG. J. MED. 1441 (1996).
pharmacist in the three to four post-discharge day time frame, a full 65% of the patients who completed the medication review had at least one medication problem, and 53% needed corrective action by the pharmacist such as contacting the participant’s primary care physician. Overall, the Reengineered Hospital Discharge intervention decreased hospital utilization (combined emergency department and recidivism) within thirty days of discharge by a remarkable 30%. Interestingly, the cost analysis (combining actual hospital utilization cost and estimated outpatient cost) was a savings for plan participants of $412 per person, or roughly a one-third savings compared with the usual care group. The Reengineering Hospital Discharge intervention is interesting for its aggressive solution to the “too few instructions” complaint against conventional contemporary hospital discharge.

Its cost calculations are interesting, as well, but the savings calculations are profoundly inconsistent with Medicare's current reimbursement structure for hospital services. The acute care hospital—in this case Boston Medical Center—does not bear the financial cost of the outpatient care for any potential inpatient care associated complication. Accordingly, any putative savings do not redound to the acute care facility, essentially removing any financial incentive to save the money spent on overall health care by delivering after care in the least expensive venue.

The stark reality of poorly aligned financial incentives for reducing hospital recidivism has produced a series of proposals and projects designed to rework hospital after care, and hospital discharge, from a finance or payment systems perspective. These projects shift some or all of the risk for failed hospital discharges to the acute care facilities doing the discharging, in the belief that delivery reform will follow financial reform and not the other way around.

B. Payment System Reform to Heal Medicare Hospitalization Recidivism

1. The Role of Medicare Pilot Projects

The Medicare reimbursement system has been the subject of calls for reform—for various ends—for some time. Most recently, "the most broken

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152 See Jack et al., supra note 148, at 184.

part of Medicare has been of keen interest to those interested in improving the quality of health care outcomes as well as managing health care inflation. Only recently, however, has payment system reform targeted at reducing hospital readmissions been of specific interest to fee for service Medicare reformers. Most recently, CMS has announced a nationwide pilot program aimed at reducing preventable readmissions for Medicare beneficiaries both to eliminate increased risk of harm to Medicare beneficiaries and to control costs to Medicare. Piloted in fourteen communities nationwide, the Care Transitions Project is designed so that each local QIO will study which practices coordinate care most effectively and most efficiently between the acute care and community care setting. The project is interested in hospital to home, hospital to skilled nursing care, and hospital to home health care transitions. The fourteen locations chosen for project participation are a diverse mixture of urban and rural locations, with significant geographic diversity across the United States. And the project seems particularly primed to study whether there are locality-specific programs that reduce preventable readmissions that might be generalized to other locales. The fourteen QIOs participating in the study are implementing three types of interventions to prevent Medicare readmissions: systemic improvements that include redesigning hospital discharge protocols, disease specific interventions seeking to manage readmissions for certain specific conditions, and interventions that address community-specific reasons for hospital readmission, such as a lack of community based palliative care. Many possible approaches will be encouraged simultaneously, as a result, in an attempt to distill best practices from what succeeds. It is unclear how a project that does not address reimbursement related incentives and disincentives will meet this goal.

On the private side of the ledger, the Institute for Healthcare Improvement and the Commonwealth Fund have also announced an initiative to promote the reduction of avoidable rehospitalizations. The State Action on Avoidable Rehospitalizations Initiative (STAAR) has targeted four areas of improvement to achieve this goal: enhanced assessment of post-discharge

154 See Robert Pear, *Long-Term Fix is Elusive in Medicare Payments*, N.Y. TIMES, July 13, 2008, at A18 (quoting Gail R. Wilensky, Administrator for CMS under George H.W. Bush, describing Medicare’s physician payment system as “hands down the most broken part of Medicare”).


156 The following QIOs serve as Care Transitions leaders throughout the country: Quality Partners of Rhode Island; IPRO Inc. (in New York); Quality Insights of Pennsylvania; Healthcare Quality Strategies Inc. (in New Jersey); Georgia Medical Care Foundation Inc.; FMIQAI (in Florida); AQAF (in Alabama); Health Care Excel (in Indiana); MPRO (in Michigan); CIMRO of Nebraska; Louisiana Health Care Review; Colorado Foundation for Medical Care; TMF Health Quality Institute (in Texas); and Qualis Health (in Washington). Press Release, CMS, Medicare Announces Sites for Pilot Program to Improve Quality as Patients Move Across Care Settings (Apr. 13, 2009), http://www.cms.gov/apps/media/press_releases.asp (search keyword: medicare announces sites).

needs, enhanced teaching at discharge, enhanced communication at discharge, and timely post-acute follow-up. The STAAR initiative is specifically oriented toward producing a variety of locale-specific programs to decrease avoidable hospital readmissions and specifically spurns a one size fits all approach.\textsuperscript{158}

Although the two programs are similar, the apparent tilt of the STAAR program toward locality-specific solutions raises interesting thoughts about a contrarian approach to the trend of much health care financial reform that questions finance and delivery differences correlated with geography. The STAAR program appears to acknowledge the health care truism that, in the provision of health care, “geography is destiny,”\textsuperscript{159} by seeking to understand the underlying local drivers of rehospitalization without promoting geographic disparities.

Although finance reforms to reduce Medicare hospital recidivism are, as a result, only in their incipient phase, it is possible to see the broad outlines of what may be attempted and what may work, based on work that has been done to date and analogous projects outside of the Medicare hospital recidivism realm. And even as front-line process improvement is promoted, both the CMS and IH plans appear to acknowledge, for the first time, that delivery and payment incentives will need to be in alignment for any real change to occur.

CMS has plainly indicated that each pilot project will need to establish a system of penalties and rewards designed to induce acute care provider buy-in to a program of shared responsibility for successful Medicare post-acute care after care. It makes sense to look at other public insurance payment reform proposals that are built around penalty and reward structures for favorable or desired outcomes. As a first step in constructing payment system incentives aligned with utilization incentives, CMS is investigating data collection and research on Medicare costs per episode of care, hoping to initiate a conversation with doctors about their comparative Medicare costs.\textsuperscript{160} MedPAC has urged CMS to develop and, confidentially, share data on Medicare rehospitalization rates with acute care facilities.\textsuperscript{161} MedPAC has also suggested that such data eventually become part of the publicly reported data on hospital quality.\textsuperscript{162}

The influence MedPAC imagines the public disclosure of such data would have on patient hospital choice is unclear for several reasons. Insured patients, particularly managed care patients, do not typically shop hospitals


\textsuperscript{159} William C. Nugent, Editorial, In Health Care, Geography is Destiny, 120 J. Thoracic & Cardiovascular Surgery 976 (2000).


\textsuperscript{162} Id. at 84.
on a comparative basis. The data is overwhelming that to the extent insured health care consumers shop health care providers, they shop physicians (or doctors' groups, in the case of managed care) and typically accept elective hospital admissions at the hospital to which their physician (or doctors' group) refers them.163 Hospital scorecards, dashboards, and ratings systems are some of the least utilized, and perhaps least well understood, health care data made available to patients.164 Perhaps the real audience for such consumer oriented data will be CMS itself—the payor for both acute care services for the original hospitalization as well as for any subsequent related rehospitalizations.

The IH project is also hopeful that as a side effect of reducing avoidable hospital readmissions. Specifically, implementing some of the practices that target better management of chronic illness may help to reduce original unnecessary hospital admissions.165

This highlights how the most promising front line components of re-engineered hospital discharge practice highlight problems endemic to the American health care system in general. Specifically, the high percentage of Medicare hospital recidivists who have not seen a physician since discharge—often estimated at a full 50% of those discharged to the community—highlights the difficulty of obtaining a timely appointment with a primary care physician or, indeed of obtaining a primary care physician if one is lacking.166 It is no accident that the newly insured in Massachusetts have quickly formed a several month long queue for new primary care patient appointments.167 The shortage of primary care physicians is itself partly a payment systems failure that rewards specialists with much higher incomes—and concomitantly much higher professional status—than that accorded primary care physicians.168


166 See Mark Murray et al., Improving Timely Access to Primary Care: Case Studies of the Advanced Access Model, 289 JAMA 1042, 1045 (2003); Mark Murray & Donald M. Berwick, Reply to Letter to the Editor, Advanced-Access Scheduling in Primary Care, 290 JAMA 332, 333 (2003).


2. Promoting Medicare Beneficiary and Caregiver Education

The failure of post-acute primary care follow-up is also a failure of Medicare beneficiary and caregiver education: failing to impress upon Medicare recipients and their caregivers the importance of follow-up primary care, rather than feeding a self-fulfilling assumption that a return to the emergency department is always a fall back if community re-entry fails. One of the most pervasive health care utilization myths is that the uninsured crowd our emergency departments when in fact it is overwhelmingly the insured who make up the emergency department crowd. Of course, few elders actively enjoy emergency department visits. There is evidence that some Medicare beneficiaries and their families understand the risks of emergency departments: the problems of boarding patients, the risk of hospital acquired illness, and the disorienting experience of short or long-term hospital stays. Nonetheless, many have become habituated to receiving what are essentially disease management services in hospital emergency departments, quite possibly the most expensive and least effective venue for such services. But it is a venue that, for the Medicare beneficiary, offers first dollar coverage and guarantees access to a physician—for those willing to wait long enough—powerful incentives to seek disease management in the emergency department.

If better chronic disease management is a large part of reducing avoidable Medicare rehospitalizations as well as avoidable Medicare original hospitalizations, it seems worthwhile to ask whether the role of outpatient disease management, to forestall avoidable emergency department visits, might better be played by the commercial disease management companies employed by private industry. Few topics on best practices in managing chronic illness in the Medicare beneficiary population engender more dispute. On the one hand, there is ample empirical evidence that “high touch” methods of chronically ill patient monitoring and coaching work well to prevent avoidable emergency department visits and unnecessary rehospitalizations. “High touch” approaches are expensive, particularly if doctors or nurses are involved, however, an emergency department—a classically expensive health care delivery venue—is a high touch environment. The alternative of

171 See Eric A. Coleman et al., Reducing Emergency Visits in Older Adults With Chronic Illness: A Randomized, Controlled Trial of Group Visits, 4 Effective Clinical Practice 49, 54-56 (2001).
telephonic contact and monitoring is not unambiguously a good substitute. Why telephonic chronic care management may not substitute for face to face coaching may tell us something about both human nature and the provision of quality health care that is of use far beyond the chronic disease management context. There is evidence that Medicare beneficiaries who are chronically ill appreciate the contact they receive around disease management. It is observable, however, that the truthfulness of their reported conduct around medication regime compliance, activity levels, and dietary regimes is markedly reduced by lack of face to face contact with the coach. In chronic disease management—as in all things—it is, apparently, much easier to dissemble when not looking someone else in the eye. There are, in short, limits to the willingness of humans to credibly self-report discretionary behavior to faceless interviewers.

IV. ALIGNING THE INCENTIVES—PAYMENT SYSTEM AND DELIVERY SYSTEM REFORM

A. Obtaining Buy-In from Providers

The business of medicine will neither know nor care about the business of health outcomes unless and until the financial incentives are aligned with the delivery systems that require them to care. This is why the most promising Medicare hospitalization recidivism containment proposals are payment system designed. Since payment system design and implementation drove us to the impasse of the separation of health care delivery from health care revenues, it is only payment system design and implementation reform that can realign incentives to be outcome and not revenue based. Medicare Part A and Medicare Part B create conflicting payment incentives for the treatment of illnesses that span both inpatient and outpatient services. It is only when this conflict is resolved, through partial or total integration of treatment of an episode of illness across settings, that even the best and most subtly designed integrated delivery system reform proposals will have a chance to succeed.

One model of Medicare hospital recidivism reduction payment system reform is designed to penalize hospitals with unacceptably high readmission rates for several common chronic diseases. It is modeled on the recently launched “never event” Medicare protocol that denies fee for service Medicare.

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173 See id. at 3.
174 See Cheryl L. Shigaki et al., Nurse Partners in Chronic Illness Care: Patients’ Perceptions and Their Implications for Nursing Leadership, 34 Nursing Admin. Q. 130 (2010) (In a primary care setting, patients with chronic conditions appreciate their nurses’ role in care management.).
175 Brown, supra note 172, at 3.
reimbursement for remediation of selected “never” events or certain hospital acquired conditions such as hospital acquired pressure ulcers.

Like the “never event” rules, the Medicare hospital recidivism reduction model will have to struggle to define non-performance. Even CMS’s new Preventable Hospital Acquired Conditions (HACs) rules have evolved to differentiate between reasonably foreseeable HACs and genuine “never events”. Just as in the case of the Medicare “never events” rules, acute care providers may be able to challenge the idea that some events should never occur in medically complex populations with co-morbidities and, further, raise important questions about who pays for unreimbursed care—even non-performing care—when Medicare won’t. The Senate Finance Committee proposal targets hospitals with readmission rates higher than the national’s average or higher than seventy-five percent of other hospitals. The Senate Finance Committee proposes a 20% hold-back on DRG payments for certain procedures, an amount that will be paid after thirty days without a preventable readmission. The House Tri-Committee’s gloss on preventable readmissions financial penalties is based on each hospital’s percentage of potentially preventable Medicare readmissions, as identified by the National Quality Forum. This proposal spreads the readmission responsibility a bit wider by proposing payment reductions to other post-acute providers for patients readmitted within thirty days of initial discharge.

A not-for-profit hospital may still, in the case of denied Medicare reimbursement for non-performing care, be able to charge the unreimbursed non-performing Medicare to charity care, raising grave concerns about whether tax exempt status should be built on arguably sub-standard care.

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177 As part of the ongoing implementation of section 5001(c) of the Deficit Reduction Act of 2005, CMS has addressed the prevalence of certain hospital-acquired conditions through a reimbursement disincentive structure built into the Inpatient Prospective Payment System final rules for fiscal years 2008 and 2009. The HACs covered under the fiscal year 2009 provision include the following: object left in patient during surgery, air embolism, blood incompatibility, catheter-associated urinary tract infection, pressure ulcers, vascular-catheter-associated infection, surgical site infection (specifically mediastinitis after coronary artery bypass graft surgery), hospital-acquired injury due to external causes (fractures, dislocations, intracranial injury, crushing injury, burns, and other unspecified effects), surgical site infections following certain orthopedic procedures and bariatric surgery for obesity, manifestations of poor blood sugar control, such as diabetic ketoacidosis and hypoglycemic coma, and deep vein thrombosis or pulmonary embolism associated with total knee and hip replacement procedures. The list of HACs found above includes seven never events which will not be reimbursed. Never events comprising falls, burns, and electric shock are grouped as one HAC. Preventable Hospital-Acquired Conditions (HACs), 73 Fed. Reg. 48,471, 48,471-74 (Aug. 19, 2008).

178 As of January 2009, CMS further clarified the limits of Medicare reimbursement for services related to never events. See CMS, pub. no. 100-02, Medicare Benefit Policy Manual, ch. 1 §§ 10, 180 (2010), http://www.cms.gov/Manuals/IOM/ (click publication #100-02); id. ch. 16 § 120.


180 Not-for-profit hospitals are exempt from federal taxation under section 501(c)(3) of the Internal Revenue Code. The IRS’s Hospital Compliance Project, begun in 2006 to study not-for-profit hospitals and community benefit, has collected some of the most comprehensive data on not-for-profit hospitals’ activities, governance, expenditures, and executive compensation practices. This project elaborates on the data on not-for-profit hospitals
addition, some of the unreimbursed Medicare non-performing care might be charged to bad debt. The cost of bad debt is often shifted, through the charge master, to the shoulders of the uninsured or fee for service population in a hospital, often times the highest rate payer in the entire acute care consumer world.\(^{181}\)

Cost shifting concerns aside, it may take CMS considerable time and effort to determine a definition for acceptable levels of Medicare hospital recidivism, though Medicare acuity indices and patient mix formulas already exist to assist in other Medicare reimbursement calculations. CMS proposed several alternative models for how to change Medicare hospital payment to incorporate increased payment for quality performance.\(^{182}\)

In 2007, CMS proposed to build on Medicare’s “Value-Based Purchasing Program,” a program that pays hospitals a better Medicare rate if they collect and report data on various performance measures designed to assess quality. The proposal would expand this program to include enhanced payment for each Medicare discharge that produced a quality outcome.\(^{183}\) Significantly, facility-specific improvement would produce financial reward, as would meeting national thresholds of care. Hospital industry groups were opposed to the proposal.\(^{184}\)

B. Obtaining Buy-In from Medicare Beneficiaries

Interestingly, just as patient dissatisfaction appears to be anecdotally correlated, in popular culture, with the chaotic hospital discharge process, it appears to be correlated, in formal patient survey data, with patient dissatisfaction with inpatient care.\(^{185}\) Indeed, data collection by the United States Department of Health and Human Services under the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey program has shown, in the words of one professional association for hospitalists:

ordinary filed with the IRS on Form 990, Schedule H, each year. IRS, IRS Exempt Organizations Hospital Compliance Project Final Report 147-151 (2009), http://www.irs.gov/charities/charitable/article/0, id=203109,00.html.


\(^{182}\) CMS has decided to dedicate fiscal year 2010 to an evaluation of the HAC program’s impact. CMS, Medicare Adds Quality Measures for Reporting by Acute Care Hospitals for Inpatient stays in FY 2010 (July 31, 2009), http://www.cms.gov/apps/media/fact_sheets.asp (search keyword: quality measures).


\(^{184}\) Id.

There is some evidence that a systematic effort to assist patients in their post-discharge transition yields a marked improvement in patient satisfaction. A post-discharge outbound call program, for example, is easy to implement. The benefits of a call program may extend to other quality metrics, such as lower readmission rates and better patient compliance, but the impact on improved patient perceptions of their hospital stay is more than enough to justify the investment.\textsuperscript{186}

Acute care patients value assistance with successful community re-entry, apparently enough to advise government surveyors of this fact. And a number of hospitalists apparently appreciate that such valued assistance may improve acute care outcomes.\textsuperscript{187} But the expense and effort of engaging systematically with post-discharge transitions can only be justified as an investment in improved HCAHPS patient survey data, newly public data since March of 2009. A culture and regulatory system of accountability is what is driving these hospitalists to overcome the countervailing concern about expense and scarcity of resources. Even then, the emphasis is not oriented to improving patient outcomes as much as it is to offering the minimum required amount of discharge planning assistance to improve patient satisfaction survey results.

Another way to characterize non payment for non-performance might be to propose that certain common Medicare acute care procedures come with warranties. Medicare fee for service contemplates, with the exception of “never event” rules and regulations, that the risk of medical failure will fall on the payor. Requiring a warranty or guarantee of a certain range of acceptable outcomes for a given procedure is one way to shift the risk of medical non-performance back onto the provider.

Geisinger Health System in Pennsylvania offers a prominent example of an acute care provider willing to warranty acute care outcomes—in Geisinger’s case, for heart surgery.\textsuperscript{188} Geisinger does this by offering a global episode price for elective coronary artery bypass grafting (CABG) that includes a ninety-day warranty.\textsuperscript{189} Geisinger was persuaded that the current average cost of elective bypass surgery was inflated by avoidable complications it felt it could contain with a rigorous forty point best practices checklist and that the savings from containment would more than cover the cost of offering the warranty.

For some time the warranty concept has played a role in the self-pay portion of health care, such as corrective eye surgery, general cosmetic surgery, and dental care.\textsuperscript{190} Only recently, however, has the model of global

\textsuperscript{186} Id. at 3.
\textsuperscript{187} Cross-health system data on the effectiveness of hospitalists in reducing acute care hospital recidivism is scant. The Phoenix Group, a trade association of hospitalists in the United States, offers one of the few voices on health care policy from the perspective of a hospitalist. Phoenix Group estimates a full 30% of hospitalists in the United States are affiliated with their organization. Id. at 1.
\textsuperscript{189} Id.
episode of care with warranties been extended to third party payor insurance. A new payment model called PROMETHEUS payment has been designed by a research group interested in determining whether a global episode of care with warranty model, based on evidence-informed case rates, may be generalized beyond heart surgery to cancer care, chronic care, interventional cardiology and orthopedic care. This novel payment method attains savings by paying for care as a defined clinical episode rather than individual services or encounters.191 This study group has concluded that, as a theoretical matter, sufficient billing and clinical data exists, or could be collected, to price warranties very accurately.192 Warranties also offer other advantages over unwarranted care. Because consumers and payers cannot easily observe quality of care when they contract with providers or seek treatment, warranties would serve as a proxy quality indicator. This concept fits broadly within the trend toward performance-based pay and the idea that health care providers should compete based on delivering good outcomes. Warranties are also natural extensions of episode-based payment models.193

Health procedure warranties may also provide Medicare health care providers with a vocabulary and a format to discuss relative risk with their Medicare patients. The willingness to warranty a particular procedure, and to what degree, naturally leads to a conversation about the likelihood of a successful outcome—about probabilities. The unwillingness to warranty a particular procedure naturally leads to a conversation about the probability of a poor outcome and the consideration of other less invasive—and less expensive—treatment. This may be particularly useful in patient counseling around end of life care, when, at present, Medicare providers—particularly specialists—may be reluctant to be the first to raise the issue of medical futility with Medicare beneficiaries and their families.194

C. THE PROMISE OF EPISODE-BASED PAYMENT

Medicare’s Diagnosis Related Groups payment system represents Medicare’s twenty-five-year partial experiment with episode-based payment.195 A more fulsome experiment with episode-based care is found in the idea of bundling payments to hospitals for both the hospitalization and for a certain period of time following hospitalization. Reimbursement based on episode of care rather than for each procedure or visit might also bundle payments to groups of providers that would be collectively responsible for a patient’s health and recovery. This is, in fact, a model currently under consideration for the Massachusetts Commonwealth Care system.196

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192 de Brantes et al., supra note 190, at w682.
193 Id. at w686.
196 Christine E. Eibner et al., RAND Corp., Controlling Health Care Spending in Massachusetts: An Analysis of Options 12-13 (2009),
Bundling can take a number of forms. Payment could be based on: a single episode of acute care, a discrete diagnosis, a portion of an episode of illness such as acute care plus thirty days of rehabilitation, or even as treatment for all care needed for a specific individual over a period of time. Payment system reform interests for broadening bundled payments circles around bundling involving high-cost episodes of care.\(^{197}\)

Bundling services across separate providers has been rare in Medicare fee for service reimbursement. Under conventional fee for service Medicare, a Medicare beneficiary’s hip replacement surgery will reimburse the hospital and the surgeon involved separately. Even the limited bundling of payments contemplated in CMS’s Acute Care Episode (ACE) demonstration project is a significant departure from decades of Medicare practice. ACE may represent the leading edge of the instruction of a global payment for an episode of care as an alternative approach to fee for service payment for service delivery. But it is off to a modest start. First, ACE’s demonstration program will be limited to specified cardiovascular and orthopedic procedures. Second, episode based bundled payment system reform for Medicare might be part of a comprehensive reform of Medicare acute care delivery and finance but, in isolation, raises concerns that it might actually do nothing to reduce, and possibly even exacerbate the problems of the status quo. Specifically, an episode-based bundled program does nothing to address the problem of Medicare beneficiary health care over-consumption, whether demand or supply driven.\(^{198}\) And there is grave concern that the demarcation of an episode of care would make it possible to continue to pass responsibility for the chronically ill from provider to provider without any improvement in quality from coordination and consistency. This, of course, bears no small resemblance to the status quo.\(^{199}\) There is also concern that reimbursement policy changes could disproportionately penalize facilities that serve the poor.\(^{200}\)

Bundling acute and post-acute care was proposed by the Senate Finance Committee’s version of the 2010 health care reform legislation.\(^{201}\) The Senate Finance Committee’s more detailed proposal contemplates a single bundled payment to hospitals to cover inpatient care and thirty days of post-acute services, whether delivered in the home, a skilled nursing facility, or some other long-term care facility. The bundled payment formula was to be based on the current DRG hospital payment and thirty day DRG-related post-acute expenses. Hospitals would receive no additional payment for patients


\(^{198}\) Whelan & Feder, supra note 195, at 18.

\(^{199}\) Id.


rehospitalized during the thirty day period and hospitals would lose payment for those patients who, for whatever reasons, required no post-acute care.\textsuperscript{202}

The PPACA’s final form incorporates only a pilot program on payment bundling. By January 1, 2013, HHS must develop and implement a National Pilot Program on Payment Bundling for integrated care focusing on coordination, quality, and efficiency improvements. HHS may extend the pilot program beyond January 1, 2016, if progress is being made on improving quality and reducing costs.\textsuperscript{203} Section 3023’s bundled payment pilot extends only to certain diagnoses and only for an episode of care that extends as far as thirty days post-acute care hospital discharge.\textsuperscript{204}

The payment bundling pilot is accompanied by Section 3025’s Hospital Readmission Reduction Program. Beginning on October 1, 2012, excess readmissions will produce reduced Medicare reimbursements.\textsuperscript{205} CMS’s first challenge will be to track national and hospital specific data on the readmission rates of Medicare participating hospitals for certain high cost conditions that have been identified as subject to potentially avoidable hospital readmissions.

Provider reimbursement bundling’s potential to realign the interests of quality and cost control faces formidable opponents. Much depends on the skill with which payment bundles are designed. Bundled payments for procedures with defined outcomes may be easier to design than those for chronic conditions. And bundling payments alone will not resolve the payment system enhanced problem of overutilization. Bundled payments for episodes of care will have to be launched on a price system, most likely the current price system, rife with “existing mispriced values” rewarding treatment intensity over outcome.\textsuperscript{206}

At Medicare’s launch, President Johnson bartered an agreement for American Medical Association (AMA) support of the program for his agreement to make the rules for paying both doctors and hospitals extremely generous, consistent with the status quo, and subject to little control over oversight.\textsuperscript{207} Whether bundled payment reform is implemented in this century’s attempt at health care reform will depend in part on CMS’s ability to withstand the same pressures.

It is encouraging that PPACA’s relatively modest launch of bundled payment pilots may have already prompted experimentation with bundled payment reform in the commercial insurance world. Modeled on the ACE Program, discussed above, private insurers in California have begun to

\textsuperscript{202} Id. at 14-15.
\textsuperscript{204} Id.
\textsuperscript{205} Id. § 3025, 42 U.S.C. § 1395ww.
experiment with bundled payment programs with commercial insurers, including Aetna, Blue Shield of California, CIGNA, and HealthNet.\textsuperscript{208}

It should be noted that the shape of post-acute care and the post-acute care industry could be radically reformed by this payment system reform.\textsuperscript{209} This point is not lost on the skilled nursing facility industry.\textsuperscript{210} Not unlike the transformation of the home health industry from a collection of free-standing entities to a roster of hospital owned or affiliated providers,\textsuperscript{211} acute care hospitals might see the best way to improve care coordination as to control the post-acute care as well as the acute care parts of the equation. And, not unlike the home health industry, such a reformation of the industry would have its proponents and opponents.

One form of episode based payment might be fostered by the 2010 PPACA's provisions to foster the growth and development of Accountable Care Organizations.\textsuperscript{212} Massachusetts' state specific health care reform is premised on the use of accountable care organizations to make global payment system work. Whether global payment can be done right in an environment such as Massachusetts with predominately not-for-profit insurers may offer limited guidance on whether the same reforms may succeed in markets dominated by for-profit care.\textsuperscript{213}

It should also be noted that acute care hospitals are, in some venues, already substantial providers of post-acute services.\textsuperscript{214} The rise of on-campus rehabilitation beds—often in the same buildings as acute care beds—is one of the under-discussed developments at the confluence of acute care bed oversupply, Medicare’s twenty-one day post-acute care benefit, and the increasing frequency of joint replacement surgery of all sorts for Medicare beneficiaries.\textsuperscript{215} Acute care hospitals would now have to perfect this model to extend it to a thirty-day timeframe. There is little doubt that, given the abysmally low Medicaid skilled nursing facility reimbursement rate, that acute care hospitals would want to move into serving a population that needs more than thirty days of post-acute care. This raises the concern,

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\textsuperscript{209} See Robert E. Mechanic & Stuart H. Altman, \textit{Payment Reform Options: Episode Payment Is a Good Place to Start}, 28 \textit{Health Aff.} w262 (2009), http://content.healthaffairs.org/cgi/content/abstract/28/2/w262.

\textsuperscript{210} Prospect Medical Holdings, Inc., for example, disclosed in its July 8, 2009 8-K SEC disclosure that adoption of proposed bundled payments for Medicare beneficiaries would negatively affect its bottom line. Prospect Med. Holdings, Inc., Annual Report (Form 8-K), at 13 (July 8, 2009), available at www.secinfo.com/d11MXs.s19Ea.9.htm.

\textsuperscript{211} See U.S. Gov't Accountability Office, GAO/HEHS 96-16, \textit{Report to the Chairman, Special Committee on Aging, U.S. Senate, Medicare: Home Health Utilization Expands While Program Controls Deteriorate} 9-10 (1996).


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foreshadowed in much of the current long-term care system, of a tiered system of post-acute care where the frailer and sicker would be shunted to the less desirable off site facilities for their post-acute rehabilitation.

Bundling per episode of care across care settings would, in the long-term, likely advance the vertical integration of acute and post-acute care providers. Before this vertical integration is formalized, it would create a challenge for acute care providers to exercise the necessary control over post-acute environments required to limit avoidable acute care readmissions. It is likely that the earliest payment system reform-driven gains in reducing preventable Medicare rehospitalizations would come from modifying practices most directly in the control of acute care hospitals—such as surgical site infection rates. It is also likely that gains in preventable Medicare rehospitalizations will be made in chronic care only if delivery reform is integrated with payment system reform.

The American Association of Retired Persons has proposed that Congress establish a Medicare program to reimburse transitional care.216 The Senate Finance Committee also has a proposal to reimburse case management activities to be performed by nurse-case managers for Medicare beneficiaries with one of six major chronic conditions: congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, asthma, diabetes, and depression.217 What is most remarkable about this proposal is that it includes a mental health diagnosis among the targeted chronic illnesses and that it is accompanied by a proposed supplemental fee to be paid directly to primary care practices for chronically ill patients that constrain hospital readmissions. The House Tri-Committee’s proposal on transitional care is also primary care physician participation focused.

V. CONCLUSION

The wide variability of the focus of these care-transition proposals highlights an enormous ongoing uncertainty about why Medicare rehospitalization rates are really so high, and what it might take to successfully lower them.

From one perspective, it may be seen as a problem to be laid at the hospital’s door, where it has historically been left, leading to hospital-based solutions that emphasize the need to staff hospital-based discharge services—whatever the identity of the provider—more generously.

From another perspective, the problem may be seen as the fault of the lack of cooperation of the hospital and the community-based after care, with a focus that may lead to creating financial incentives to link the two, such as bundled services or episode of care reforms.

From yet another perspective, the problem may be seen as symptomatic of a larger failure of chronic disease management, producing fixes that are

oriented toward better reimbursement for chronic care disease management in the community.

The purpose of this paper is to argue that none of these perspectives is any more adequate than any of the blind philosophers had an accurate model of the elephant.

The multi-faceted source of the problem of Medicare hospital recidivism may be well-suited to a multi-faceted solution. Perhaps a penalty-oriented approach would reduce certain kinds of Medicare hospital recidivism. Hospital acquired infections as a contributor to Medicare hospital recidivism may be amenable to this approach, exemplifying something within the control of the acute care facility, or where the acute care facility is clearly the least-cost risk avoider or reducer. A premium-oriented approach may be particularly apt as a solution to the problem of under allocation of finances to post-acute care Medicare beneficiary chronic disease management. Rewarding primary care physicians for sustaining chronically ill Medicare beneficiaries outside of acute care hospitals could help to re-balance the allocation of post-acute resources towards non-hospital based services.

But a touching faith in the belief that all that ails Medicare’s hospital recidivism problem is a failure in understanding will surely not be sufficient. To call for better delivery of post-acute geriatric care and geriatric chronic care in a community-based setting, and hope that people of goodwill will then make this happen, is likely to be in vain. Medicare hospital recidivism is, ultimately, a place where the problems of delivery and finance intersect. And it is unlikely that either an exclusively delivery oriented or an exclusively finance oriented proposal will make a dent in the problem. It seems likely that only an approach that combines financial incentives, financial penalties, and regulatory requirements will be able to successfully reduce Medicare hospital recidivism.