Readmission Strategies for Homeless Patients

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A recent *Washington Post* article titled “Medicare Penalties for Readmissions Are Likely to Hit Hospitals Serving the Poor” highlights the untenable position that many critical-access hospitals and acute-care hospitals serving large populations of homeless and indigent patients will face when Medicare hospital readmission regulations and oversight are finally implemented. The *Washington Post* article concludes that since these hospitals serve a disproportionate number of patients who are insured by government programs, the penalty provisions being phased in by the Patient Protection and Affordable Care Act (PPACA) for readmissions will have a more dramatic financial impact on those hospitals that serve the poor in both rural and urban settings. This point is further underscored by a recent *New York Times* article on the hundreds of “bed blocker” patients residing in New York City hospitals with no place for discharge. With nowhere to send these patients for less costly care, hospitals wind up absorbing millions of dollars in unreimbursed costs. Additional penalties imposed under the PPACA in connection with readmissions will compound the financial burdens of these hospitals if they cannot find a way to deal with homeless patients that reduces readmission rates.

**PPACA Readmission Penalties Will Compound the Financial Burdens of Hospitals If They Cannot Reduce Readmission Rates of Homeless Patients.**

- Medicare is focused on saving $12 billion from readmissions alone
- the payment system currently leans in favor of readmissions and current hospital profitability
- many homeless patients do have government insurance under state or federal programs
- patients who are homeless tend to be readmitted regularly for a number of reasons:
  - homeless patients spread their loyalty to all hospitals in the community as there is typically no tracking from institution to institution
  - homeless patients typically have chronic diseases that require extensive and comprehensive follow-up care
  - being homeless and exposed to the elements, lack of sleep, street crime, and substance abuse from living on the street exacerbates these chronic illnesses

**Review of Readmission Issues**

To fully understand the readmission issues with respect to the general Medicare population and the special areas of concern relating to hospitalization of the homeless, one must consider the following factors:

- the Centers for Medicare & Medicaid Services (CMS) indicates that 18 percent of Medicare patients are readmitted after discharge for the same complaint
- CMS is convinced that these readmissions are avoidable and unnecessary
• since there is no place for patients to rest, follow-up care is infrequent, if it is obtained at all, for patients who are discharged back to the street.

**Applicable Laws, Regulations and Manuals**

Under the PPACA, CMS may deny the claims of a single hospital or multiple hospitals if a patient is re-admitted in the 30-day period after discharge. Not only may CMS deny payment, but it may also require the hospital to show prospective changes to correct any inappropriate practices likely to result in unacceptable patient claims in the future. Similarly, the Medicare Claims Processing Manual allows quality improvement organizations (QIOs) to deny payments for second admissions no matter how many days have elapsed if the two admissions are considered related. In fact the QIO Manual allows a QIO to deny payment if:

- the QIO determines that there is no medical necessity
- the readmission resulted from a premature discharge, or
- it is shown that the readmission was a result of a circumvention of the prospective payment system (PPS) at the hospital where the readmission took place.

These actions are backed by the QIO regulations at 42 C.F.R. §476.71.

The bottom line is that the QIO or the Medicare program can determine that the readmission was a result of a premature discharge taking into account the patient’s medical condition and instability at the time of discharge and the need for additional medical care at the time of the original discharge, which was not made available to that patient.

**The Homeless Discharge Process**

Hospitals must recognize that a significant number of readmissions are caused by the homeless patients who live within their service areas. This is obviously a transient population that is free to choose their provider. As a result, the readmission dilemma, at least with respect to the homeless, requires a targeted effort not only to assist with their post-discharge care, but ultimately to provide for a transitional and permanent housing solution to remove most homeless families and individuals from the street. Most importantly, discharge planners must be provided with access to the most appropriate available resources from specialty providers such as psychiatric and substance abuse institutions necessary to help homeless persons recover from mental health and addictive conditions, as well as their other existing medical conditions. Further, discharge planners need dynamic information on available programs and available space for recuperative care where such services exist in the community.

**Respite or Recuperative Care**

Respite or recuperative care for patients has been shown to significantly reduce readmission rates and the length of hospital stays as compared to the outcomes for patients who do not have such care available to them. Such programs can take many forms depending upon the foresight of community leaders and their ability to develop available facilities or funding sources. Approximately 40 percent of respite care programs are currently funded by hospitals. Hospitals should support respite care since it allows them to safely discharge patients to a supportive health care environment while moving the homeless patients out of expensive acute care beds. Respite care has been shown to cost approximately 10 percent of the cost of a per diem acute care bed in most parts of the country that have such programs. Funding can be provided on a per-patient basis with an agreed-upon prognosis; bed hold agreements can be established; or hospitals can pay a per diem or daily rate for such care.

Medical treatment in respite and recuperative care facilities is minimal but vital, as the patients are ambulatory and can be taken to a health center or medical office for physician care. Nurses and social workers care for the patients and tend to operate as their primary caregivers. Length of stay at such facilities is usually limited, and the ideal exit strategy for patients is to move them to transitional low-income housing to prevent subsequent, costly readmissions and discharges from occurring.

With discussions and strategies abounding on the issue of total patient care, linkages between hospitals and federally qualified health centers could prove to be alternative solutions using bundled payments and patient-centered medical homes (PCMH). Further, cooperative agreements to enhance discharges to psychiatric and substance abuse facilities can be further enhanced by the sharing of information on patient criteria and availability in the community.

**Conclusion**

Hospitals are certainly aware of the need to reduce readmissions. Because many readmissions involve the homeless population, hospitals should consider tackling discharge and respite care strategies on a community-wide basis.
ENDNOTES

1 “Medicare Penalties for Readmissions are Likely to Hit Hospitals Serving the Poor,” *Washington Post*, December 19, 2011.

2 Public Law No. 111-148 (March 23, 2010).


5 Chapter 3, Section 40.2.5, Medicare Claims Processing Manual.

6 Chapter 4, Section 4240, Quality Improvement Organization Manual.


8 National Health Care for the Homeless Council Survey of Medical Respite Programs (March 2011).