If you are 65 years old or older, if you have a parent or other family member who is 65 years old or older, this is EXTREMELY important information from Keiser's newsletter, from the Wall Street Journal and from other sources. Top-rated US hospitals (Mayo Clinic, Massachusetts General, Beth Israel, St. Luke's and others) speak out: **EVERYONE on Medicare will find it more difficult to find hospital care if you have been in a hospital and then need to go back to the hospital for the same or different issue within 30 days. According to the Obama Administration $715 billion (almost three quarters of a TRILLION dollars) can be "saved" from Medicare and moved to ObamaCare by eliminating "fraud, waste and abuse."**

Despite the administration's and the administration-controlled media's spin, this program is NOT about improving patient care…It IS about denying care to Medicare recipients.

Beginning October 1, 2012, the "fraud, waste and abuse" of readmitting to a hospital, any Medicare patient within 30 days of discharge FOR ANY REASON WHATSOEVER, will cause the hospital who readmits that patient to lose a percentage of Medicare payments due to that hospital. **One of every five Medicare patients is readmitted within 30 days of discharge: A cardiac patient may go home and fall ten days later and break his/her hip; a cardiac patient may go home and, because of the seriousness of his/her condition, experiences another heart attack in 20 days and readmitting him/her allows for additional treatment that results in providing the patient with several more years with his/her family; a woman has a stroke and after going home contracts West Nile virus. Under the Obama Administration's health care law, each of the described instances will result in the hospital being penalized by losing a percentage of the Medicare payments due to that hospital.**

> **"But CMS makes the rules and hospitals will have to abide by them — even more so in the future, as Medicare's penalties will increase to 2 percent in 2014 and 3 percent in 2015."** **These**

percentages sound small, but the dollar amount is calculated to be a MINIMUM of $100,000 for smaller hospitals and millions of dollars for larger hospitals.

And if hospitals will "have to abide by them," will they allow doctors to readmit patients or will they tell the doctors to give them a pill and send them home?

Readmissions also are only one measurement of quality, said Dr. Raymond Durkin, chief of cardiology at St. Luke's. He noted that the network is a top performer in terms of heart failure mortality, so St. Luke's may have had more readmissions, but in the ultimate measurement, life or death, it performs well.

from

HEALTHCARE PAYER NEWS

Hospitals react to readmission penalties

August, 21 2012

By:
Diane Webber

http://www.healthcarepayernews.com/content/hospitals-react-readmission-penalties

"[Medicare] needs to remember that people are not cars," Curt Schroder, head of the Delaware Valley Healthcare Council, told English. "They seem to be treating hospitals like auto repair shops. In other words, 'You should be able to change the tire, send them on their way and not see them for another 5,000 miles.'"

Mayo Clinic's Health System in Fairmont was the highest [in Minnesota] at 0.81 percent. Sanford Medical Center in Worthington and Fairview Ridges Hospital in Burnsville both face penalties of 0.43 percent.

Mayo is concerned about any unnecessary readmission, said **Kevin Burns, regional director of public affairs for Mayo.**

"Every patient deserves the best possible care, the very best comprensive (sic) treatment regardless of our cost to provide that treatment," he said. …

Beth Israel, like several other hospitals with high readmission rates, also has unusually low mortality rates for its patients, which he says may reflect that the hospital does a good job at swiftly getting ailing patients back and preventing deaths

Massachusetts General Hospital in Boston, which U.S. News last month ranked as the best hospital in the country , will lose 0.5 percent of its Medicare payments because of its readmission rates

How many Medicare patients will die because they are refused re-admittance to the hospital? Will you or your Mom or your favorite uncle be that Medicare patient who is refused re-admittance and dies as the result?

KEISER HEALTH NEWS

http://www.kaiserhealthnews.org/Stories/2012/August/13/medicare-hospitals-readmissions-penalties.aspx

Medicare To Penalize 2,211 Hospitals For Excess Readmissions

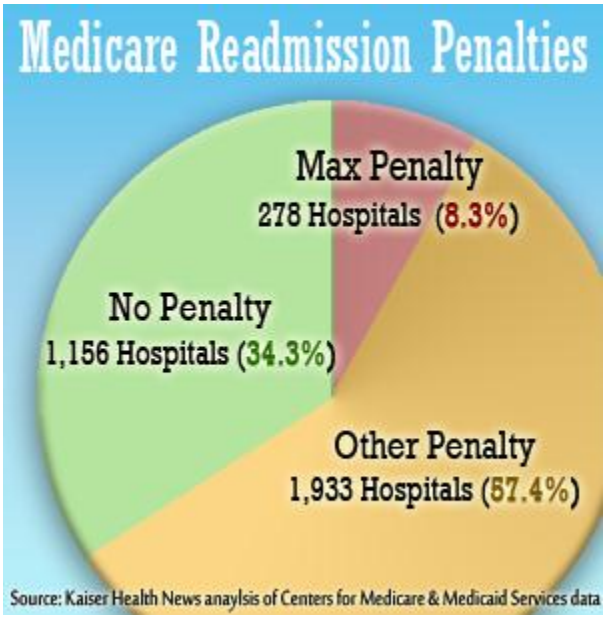
By Jordan Rau
KHN Staff Writer

AUG 13, 2012

More than 2,000 hospitals — including some nationally recognized ones — will be penalized by the government starting in October because many of their patients are readmitted soon after discharge, new records show.

Together, these hospitals will forfeit about $280 million in Medicare funds over the next year as the government begins a wide-ranging push to start paying health care providers based on the quality of care they provide.

With nearly one in five Medicare patients returning to the hospital within a month of discharge, the government considers readmissions a prime symptom of an overly expensive and uncoordinated health system. Hospitals have had little financial incentive to ensure patients get the care they need once they leave, and in fact they benefit financially when patients don't recover and return for more treatment.



Nearly 2 million Medicare beneficiaries are readmitted within 30 days of release each year, costing Medicare $17.5 billion in additional hospital bills. The national average readmission rate has remained

steady at slightly above 19 percent for several years, even as many hospitals have worked harder to lower theirs.

The penalties, authorized by the 2010 health care law, are part of a multipronged effort by Medicare to use its financial muscle to force improvements in hospital quality. In a few months, hospitals also will be penalized or rewarded based on how well they adhere to basic standards of care and how patients rated their experiences. **Overall, Medicare has decided to penalize around two-thirds of the hospitals whose readmission rates it evaluated**, the records show .

The penalties will fall heaviest on hospitals in New Jersey, New York, the District of Columbia, Arkansas, Kentucky, Mississippi, Illinois and Massachusetts, a Kaiser Health News analysis of the records shows. Hospitals that treat the most low-income patients will be hit particularly hard.

A total of 278 hospitals nationally will lose the maximum amount allowed under the health care law: 1 percent of their base Medicare reimbursements**. Several of those are top-ranked institutions**, including Hackensack University Medical Center in New Jersey, North Shore University Hospital in Manhasset, N.Y. and Beth Israel Deaconess Medical Center in Boston, a teaching hospital of Harvard Medical School.

"A lot of places have put in a lot of work and not seen improvement," **said Dr. Kenneth Sands, senior vice president for quality at Beth Israel. "It is not completely understood what goes into an institution having a high readmission rate and what goes into improving" it.**

Sands noted that Beth Israel, like several other hospitals with high readmission rates, also has unusually low mortality rates for its patients, which he says may reflect that the hospital does a good job at swiftly getting ailing patients back and preventing deaths .

Penalties Will Increase Next Year

The maximum penalty will increase after this year, to 2 percent of regular payments starting in October 2013 and then to 3 percent the following year. This year, the $280 million in penalties comprise about 0.3 percent of the total amount hospitals are paid by Medicare.

According to Medicare records, 1,933 hospitals will receive penalties less than 1 percent; the total number of hospitals receiving penalties is 2,211. **Massachusetts General Hospital in Boston, which U.S. News last month ranked as the best hospital in the country, will lose 0.5 percent of its Medicare payments because of its readmission rates**, the records show. The smallest penalties are one hundredth of a percent, which 50 hospitals will receive.

Dr. Eric Coleman , a national expert on readmissions at the University of Colorado School of Medicine, said the looming penalties have captured the attention of many hospital executives. "I'm not sure penalties alone are going to move the needle, but they have raised awareness and moved many hospitals to action," Coleman said.

The penalties have been intensely debated. Studies have found that African-Americans are more likely to be readmitted than other patients, leading some experts to be concerned that hospitals that treat many blacks will end up being unfairly punished.

Hospitals have been complaining that Medicare is applying the rule more stringently than Congress intended by holding them accountable for returning patients no matter the reason they come back.

Hospitals That Serve Poor Are Hit Harder Than Others

Some safety-net hospitals that treat large numbers of low-income patients tend to have higher readmission rates, which the hospitals attribute to the lack of access to doctors and medication these patients often experience after discharge. The analysis of the penalties shows that **76 percent of the hospitals that have a lot of low-income patients will lose Medicare funds in the fiscal year starting in October.** Only 55 percent of the hospitals treating few poor patients are going to be penalized, the analysis shows.

"It's our mission, it's good, it's what we want to do, but to be penalized because we care for those folks doesn't seem right," said Dr. John Lynch, chief medical officer at Barnes-Jewish Hospital in St. Louis, which is receiving the maximum penalty.

"We have worked on this for over four years," Lynch said, but those efforts have not substantially reduced the hospital's readmissions. He said Barnes-Jewish has tried sending nurses to patients' homes within a week of discharge to check up on them, and also scheduled appointments with a doctor at a clinic, but half the patients never showed. This spring, the hospital established a team of nurses, social workers and a pharmacist to monitor patients for 60 days after discharge.

"Some of the hospitals that are going to pay penalties are not going to be able to afford these types of interventions," said Lynch, who estimated the penalty would cost Barnes-Jewish $1 million.

Atul Grover, chief public policy officer for the Association of American Medical Colleges, called Medicare's new penalties "a total disregard for underserved patients and the hospitals that care for them." Blair Childs, an executive at the Premier healthcare alliance of hospitals, said: "It's really ironic that

you penalize the hospitals that need the funds to manage a particularly difficult population."

Medicare disagreed , writing that "many safety-net providers and teaching hospitals do as well or better on the measures than hospitals without substantial numbers of patients of low socioeconomic status." Safety-net hospitals that are not being penalized include the University of Mississippi Medical Center in Jackson and Denver Health Medical Center in Colorado, the records show .

Bill Kramer, an executive with the Pacific Business Group on Health, a California-based coalition of employers, said the penalties provide "an appropriate financial incentive for hospitals to do the right thing in terms of preventing avoidable readmissions."

The government's penalties are based on the frequency that Medicare heart failure, heart attack and pneumonia patients were readmitted within 30 days between July 2008 and June 2011. Medicare took into account the sickness of the patients when calculating whether the rates were higher than those of the average hospital, but not their racial or socio-economic background.

The penalty will be deducted from reimbursements each time a hospital submits a claim starting Oct. 1. As an example, if a hospital received the maximum penalty of 1 percent and it submitted a claim for $20,000 for a stay, Medicare would reimburse it $19,800.

The Centers for Medicare & Medicaid Services has been trying to help hospitals and community organizations by giving grants to help them coordinate patients' care after they're discharged. Leaders at many hospitals say they are devoting increased attention to readmissions in concert with other changes created by the health law.

Sally Boemer, senior vice president of finance at Mass General, said she expected readmissions will drop as the hospital develops new methods of arranging and paying for care that emphasize prevention. Readmissions "is a big focus of ours right now," she said.

Gundersen Lutheran Health System in La Crosse, Wis., and Intermountain Medical Center in Murray, Utah, were among 1,156 hospitals where Medicare determined the readmission rates were acceptable. Those hospitals will not lose any money. On average, the readmissions penalties were lightest on hospitals in Utah, South Dakota, Vermont, Wyoming and New Mexico, the analysis shows. Idaho was the only state where Medicare did not penalize any hospital.

Even some hospitals that won't be penalized are struggling to get a handle on readmissions. Michael Baumann, chief quality officer at the University of Mississippi Medical Center, said in-house doctors had made headway against heart failure readmissions by calling patients at home shortly after discharge. "It's a fairly simple approach, but it's very labor intensive," he said.

The problems afflicting many of the center's patients—including obesity and poverty that makes it hard to afford medications—make it more challenging. "It's a tough group to prevent readmissions with," he said.

Data for individual hospitals are available as a PDF file and as a CSV spreadsheet.

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More On Readmission Penalties

- Hospitals Treating The Poor Hardest Hit By Readmissions Penalties
- Readmissions Penalties By Hospital (PDF file)
- Readmissions Penalties By State
- Readmissions Penalties By Hospital By Region
- Sources And Methodology
- Download Data For All Hospitals (CSV file)

Medicare penalizes hospitals over readmissions

Area hospital officials say the reform is overly harsh.

August 20, 2012|By Tim Darragh, Of The Morning Call

http://www.mcall.com/news/local/mc-medicare-penalizes-hospitals-20120819,0,13968.story

Amid the ongoing political hullabaloo over the Obama administration's health care law, a mini-revolution in the larger effort to slow down the rising cost of health care took place last week — and many of the country's most prestigious hospitals were not too happy about it.

The U.S. Centers for Medicare and Medicaid Services announced the first set of penalties on hospitals for having too many patients readmitted 30 days or less after their initial hospital stay. The penalties, which are estimated to cost Pennsylvania hospitals nearly $13 million in the coming year, represent a step toward paying health care providers for quality care, not for the number of times they provide it.

The fee-for-service system has "perverse incentives" that encourage health care providers to order as many tests and services as they can, said Gus Geraci, vice president for Physician Quality at the Pennsylvania Medical Society. "CMS, in their infinite wisdom, is saying, 'We've got to do something. What we've done hasn't worked,' " he said.

So CMS looked at hospital readmissions for patients treated for pneumonia, heart attacks and heart failure and announced that, after adjusting for differences in populations served, it would keep up to 1 percent of a hospital's fee-for-service Medicare payments if readmissions were below national standards.

Locally, hospitals were at the extremes of the penalty process. Coordinated Health's two hospitals received no penalty, as did Sacred Heart Hospital in Allentown and Westfield Hospital in South Whitehall Township. But Easton Hospital will be docked the maximum 1 percent and St. Luke's University Hospital in Fountain Hill will lose 0.92 percent.

The penalties will be assessed beginning Oct. 1.

"It's another step in moving from paying for sheer volume and complexity of services to paying more for services that produce good outcomes," said Stuart Guterman, vice president and executive director of the Commission on a High Performance Health System at The Commonwealth Fund, a private foundation focused on health reform.

Medicare, the federal health insurance program for people 65 and older, is often the largest single payer to health care providers, so the decisions CMS makes for it have enormous market impact. CMS estimates that hospitals nationwide will forfeit $280 million in excess readmission penalties, and private insurers take their cues from Medicare as well.

Readmissions are in many cases preventable and can be caused by hospital-acquired infections, misdiagnosis or poor patient education. According to CMS, nearly 2 million Medicare beneficiaries are readmitted within 30 days, costing the health care system an additional $17.5 billion.

Medicare based its penalties on three years of comparative readmission rankings for patients who had been admitted with pneumonia, heart attack and heart failure, conditions that have been associated with high numbers of readmissions. In all, 2,211 hospitals will lose funding.

Lehigh Valley Health Network, the region's largest employer, will be docked 0.23 percent of its adjusted Medicare payments for its Salisbury Township and Allentown hospitals, and 0.51 percent for its Muhlenberg campus. That will cost it roughly $480,000, hospital spokesman Brian Downs said. Representatives at Easton Hospital and St. Luke's, which had the highest penalties in the region, did not provide cost figures.

Tony Ardire, LVH senior vice president of quality and patient safety, and other hospital representatives said readmissions are in many cases poor indicators of quality, arguing that CMS doesn't distinguish between readmissions caused by the hospital's care and those caused by noncompliant patients — those who don't understand or remember their discharge instructions and unrelated events.

"What happens if you have a person with heart failure who then goes home and falls and breaks a hip and gets readmitted within that 30 days?" asked Lynn Leighton, vice president of Health Services for the Hospital and Healthsystem Association of Pennsylvania.

Leighton also said CMS didn't account sufficiently for hospitals that care for planned readmissions, such as those for patients who require multiple surgeries, and older, sicker populations.

Pennsylvania hospitals will lose around $12.9 million, she said.

Readmissions within seven days, only for causes related to the initial hospital visit, would be a better measure of hospital performance, Ardire said. If CMS continues to use a measurement that includes readmissions unrelated to the previous hospital visit, he said, hospitals will be able to make only minor improvements to the readmission rate.

Readmissions also are only one measurement of quality, said Dr. Raymond Durkin, chief of cardiology at St. Luke's. He noted that the network is a top performer in terms of heart failure mortality, so St. Luke's may have had more readmissions, but in the ultimate measurement, life or death, it performs well.

But CMS makes the rules and hospitals will have to abide by them — even more so in the future, as Medicare's penalties will increase to 2 percent in 2014 and 3 percent in 2015.

Hospitals are working hard to get the numbers down. LVH, for instance, has been working with a national health carenonprofit, the Institute for Healthcare Improvement, for three years to improve outcomes.

At Sacred Heart, St. Luke's and LVH, nurses have been trained in a "teach back" program to educate patients about their condition and what they should do upon discharge.

Blue Mountain Health System, which operates Gnaden Huetten Memorial Hospital in Lehighton and Palmerton Hospital, has a home health care team that monitors heart failure patients shortly after discharge and re-educates them on the signs and symptoms of the disease.

Across the region, hospital officials say they'll make follow-up doctor appointments or order prescription medicines before the patient is discharged. LVH will send out a home care nurse for at-risk patients, and all Easton Hospital patients who are at the highest risk for readmission are assigned a nurse navigator who calls patients after discharge to check on their progress.
LVH, St. Luke's and Sacred Heart also are involved in a collaboration called the Care Transitions Project. The CMS-sponsored project is designed to coordinate care in a community, involving hospitals, nursing homes, physicians, home health care agencies, pharmacies and area agencies on aging.

Naomi Hauser of Quality Insights of Pennsylvania, who directs the program in a number of communities across Pennsylvania, said CMS has a three-year goal of reducing readmissions by 20 percent. Readmissions are a quality issue, but people should not view them as a reflection of poor care.

"It's not been on the radar screen," Hauser said. "But it is now."

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Hospital penalties

Area hospitals and their readmission penalties:

- **Coordinated Health Orthopedic Hospital, Bethlehem:** 0 percent
- **Surgical Specialty Center at Coordinated Health, South Whitehall:** 0 percent
- **Easton Hospital:** 1 percent
- **Gnaden Huetten Memorial Hospital:** 0.16 percent
- **Grand View Hospital, Sellersville:** 0.14 percent
- **Lehigh Valley Hospital-Cedar Crest/17th and Chew:** 0.23 percent
- **Lehigh Valley Hospital-Muhlenberg, Bethlehem:** 0.51 percent
- **Palmerton Hospital:** 0.35 percent
- **Sacred Heart Hospital, Allentown:** 0 percent
- **St. Luke's University Hospital, Fountain Hill:** 0.92 percent
- **St. Luke's University Miner's Memorial Hospital:** 0.16 percent
- **St. Luke's University Quakertown Hospital:** 0.02 percent
- **Westfield Hospital, South Whitehall:** 0 percent

Source: Centers for Medicare and Medicaid Services

THE WALL STREET JOURNAL

http://online.wsj.com/article/SB10000872396390443404004577578980699719356.html?mod=WSJ_Opinion_LEADTop

OPINION

- Updated August 14, 2012, 7:19 p.m. ET

John C. Goodman: Why the Doctor Can't See You

The demand for health care under ObamaCare will increase dramatically. The supply of physicians won't. Get ready for a two-tier system of medical care.

By JOHN C. GOODMAN

Are you having trouble finding a doctor who will see you? If not, give it another year and a half. A doctor shortage is on its way.

Most provisions of the Obama health law kick in on Jan. 1, 2014. Within the decade after that, an additional 30 million people are expected to acquire health plans—and if the economic studies are correct, they will try to double their use of the health-care system.

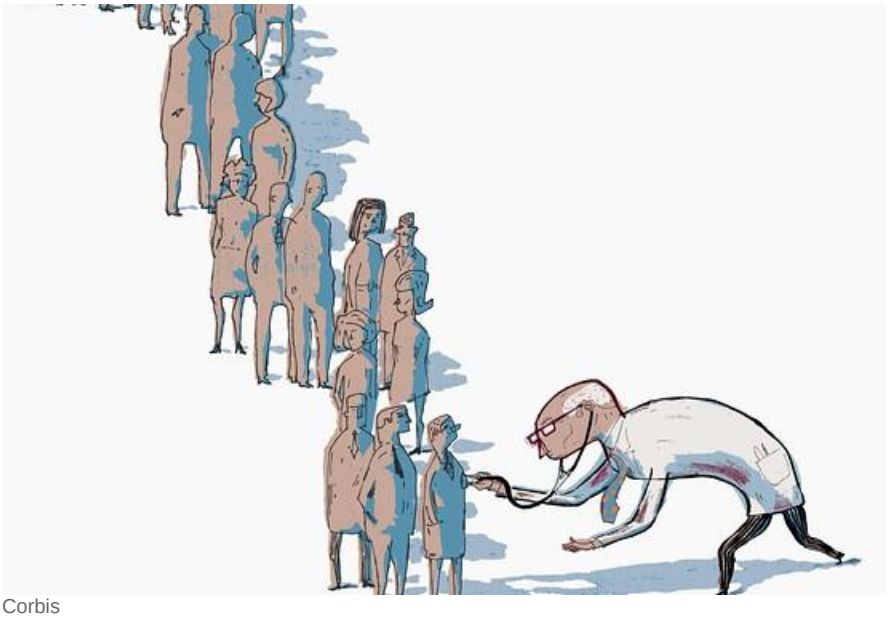
Meanwhile, the administration never seems to tire of reminding seniors that they are entitled to a free annual checkup. Its new campaign is focused on women. Thanks to health reform, they are being told, they will have access to free breast and pelvic exams and even free contraceptives.

Once ObamaCare fully takes effect, all of us will be entitled to a long list of

preventive services—with no deductible or copayment.

Here is the problem: **The health-care system can't possibly deliver on the huge increase in demand for primary-care services. The original ObamaCare bill actually had a line item for increased doctor training. But this provision was zeroed out before passage, probably to keep down the cost of health reform. The result will be gridlock.**

Take preventive care. ObamaCare says that health insurance must cover the tests and procedures recommended by the U.S. Preventive Services Task Force. What would that involve? In the American Journal of Public Health (2003), scholars at Duke University calculated that arranging for and counseling patients about all those screenings would require 1,773 hours of the average primary-care physician's time each year, or 7.4 hours per working day.



Corbis

And all of this time is time spent searching for problems and talking about the search. If the screenings turn up a real problem, there will have to be more testing and more counseling. Bottom line: To meet the promise of free preventive care nationwide, every family doctor in America would have to work full-time delivering it, leaving no time for all the other things they need to do.

When demand exceeds supply in a normal market, the price rises until it reaches a market-clearing level. But in this country, as in other developed nations, Americans do not primarily pay for care with their own money. They pay with time.

How long does it take you on the phone to make an appointment to see a doctor? How many days do you have to wait before she can see you? How long does it take to get to the doctor's office? Once there, how long do you have to wait before being seen? These are all non-price barriers to care, and there is substantial evidence that they are more important in deterring care than the fee the doctor charges, even for low-income patients.

For example, **the average wait to see a new family doctor in this country is just under three weeks, according to a 2009 survey by medical consultancy Merritt Hawkins. But in Boston, Mass.—which enacted a law under Gov. Mitt Romney that established near-universal coverage—the wait is about two months.**

When people cannot find a primary-care physician who will see them in a reasonable length of time, all too often they go to hospital emergency rooms. Yet a

2007 study of California in the Annals of Emergency Medicine showed that up to 20% of the patients who entered an emergency room left without ever seeing a doctor, because they got tired of waiting. Be prepared for that situation to get worse.

When demand exceeds supply, doctors have a great deal of flexibility about who they see and when they see them. Not surprisingly, they tend to see those patients first who pay the highest fees. **A New York Times survey of dermatologists in 2008 for example, found an extensive two-tiered system. For patients in need of services covered by Medicare, the typical wait to see a doctor was two or three weeks, and the appointments were made by answering machine.**

However, for Botox and other treatments not covered by Medicare (and for which patients pay the market price out of pocket), appointments to see those same doctors were often available on the same day, and they were made by live receptionists.

As physicians increasingly have to allocate their time, patients in plans that pay below-market prices will likely wait longest.

Those patients will be the elderly and the disabled on Medicare, low-income families on Medicaid, and (if the Massachusetts model is followed) people with subsidized insurance acquired in ObamaCare's newly created health insurance exchanges.

Their wait will only become longer as more and more Americans turn to concierge medicine for their care. Although the model differs from region to region and doctor to doctor, concierge medicine basically means that patients pay doctors to be their agents, rather than the agents of third-party-payers such as insurance companies or government bureaucracies.

For a fee of roughly $1,500 to $2,000, for example, a Medicare patient can form a new relationship with a doctor. This usually includes same day or next-day appointments. It also usually means that patients can talk with their physicians by telephone and email. The physician helps the patient obtain tests, make appointments with specialists and in other ways negotiate an increasingly bureaucratic health-care system.

Here is the problem. A typical primary-care physician has about 2,500 patients (according to a 2009 study by the Centers for Disease Control and Prevention), but when he opens a concierge practice, he'll typically take about 500 patients with him (according to MDVIP, the largest organization of concierge doctors): That's about all he can handle, given the extra time and attention those patients are going to

expect. But the 2,000 patients left behind now must find another physician. So in general, as concierge care grows, the strain on the rest of the system will become greater.

I predict that in the next several years concierge medicine will grow rapidly, and every senior who can afford one will have a concierge doctor. A lot of non-seniors will as well. We will quickly evolve into a two-tiered health-care system, with those who can afford it getting more care and better care.

In the meantime, **the most vulnerable populations will have less access to care than they had before ObamaCare became law.**

Mr. Goodman is president of the National Center for Policy Analysis and the author of "Priceless: Curing the Healthcare Crisis" (Independent Institute, 2012).

A version of this article appeared August 15, 2012, on page A13 in the U.S. edition of The Wall Street Journal, with the headline: Why the Doctor Can't See You.