Money Influences the Length of Hospital Stays

By AUSTIN FRAKT

After one of her operations, my sister-in-law left the hospital so quickly that she couldn't eat for days; after other stays, she wasn't discharged until she felt physically and mentally prepared. Five days after his triple heart bypass surgery, my stepfather felt well enough to go home, but the hospital didn't discharge him for several more days.

You undoubtedly have similar stories. Patients are often left wondering whether they have been discharged from the hospital too soon or too late. They also wonder what criteria doctors use to assess whether a patient is ready to leave.

"It's complicated and depends on more than clinical factors," said Dr. Ashish Jha, a Harvard physician who sees patients at a Boston Veterans Affairs hospital. "Sometimes doctors overestimate how much support is available at home and discharge a patient too soon; sometimes we underestimate and discharge too late."

New economic incentives, not always evident in individual cases, have also played a role. Recent changes to how hospitals are paid appear to be affecting which patients are admitted and how often they are readmitted.

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Hospital stays used to be much longer. In 1980, the average in the United States was 7.3 days. Today it's closer to 4.5. The difference isn't because hospitalized patients are becoming younger and healthier; by and large, today's patients are older and sicker.

In the early 1980s, Medicare stopped paying hospitals whatever they claimed their costs were and phased in a payment system paying them a predetermined rate tied to each patient's diagnosis. This "prospective payment system," as it is called, shifted the financial risk of patients' hospitalization from Medicare to the hospital, encouraging the institutions to economize.

One way to economize is to get patients out of the hospital sooner. The prospective payment system pays a hospital the same amount whether a Medicare patient stays five days or four. But that extra day adds costs that hit the hospital's bottom line.

So it's in a hospital's financial interest to encourage doctors to discharge patients sooner. It's now easier for doctors to discharge patients sooner to a skilled nursing facility — where they'll be monitored and professionally cared for — because so many more of them have been built in recent years.

Almost since the prospective payment system started, experts have raised concerns that it would lead to higher rates of readmissions. After all, patients discharged more quickly may tend to be sicker, more prone to complications or require a level of care that's harder to provide outside the hospital. It seems logical, therefore, that more of them would need to return to the hospital. Evidence backs this logic. In the United States and other nations, when lengths of stay decline, readmissions rise.

Financial incentives in admission and discharge decisions.

Until recently, hospitals did not suffer financially when a patient was readmitted, so long as it was more than 24 hours after discharge. Indeed, readmission represented only additional revenue. If reducing lengths of stay increased readmissions while decreasing costs of each stay, hospitals benefited financially on both ends of the equation.

But Medicare and private insurance companies picking up the tab lose money when a patient is readmitted.

The federal government has created several new programs that penalize hospitals for readmissions. Under Medicare's Hospital Readmissions Reduction Program, hospitals now lose up to 3 percent of their total Medicare payments for high rates of patients readmitted within 30 days of discharge.

Since 2010, when almost one in five Medicare hospital patients returned within 30 days, hospital readmissions have fallen considerably.

Though this fact was highlighted by the Obama administration, some people are seeing evidence that hospitals are gaming the metric. For instance, patients who are placed under "observation status" are not counted in the readmissions metric even though they may receive the same care as patients formally admitted to the hospital.

Patients treated in the emergency room and not admitted to the hospital do not affect the readmissions metric either. As readmissions have fallen, observation status stays and returns to the emergency department after a discharge have risen.