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Client Alert

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OIG Recommends Per Diem Hospital Rates for Early Discharges to Hospice; CMS Not Convinced (And Neither Are We)

The Department of Health and Human Services, Office of Inspector General (OIG) published its report on May 28, 2013, titled "Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care." Audit (A-01-12-00507), **http://go.usa.gov/b4Md**. The report describes a sample study conducted by OIG's Office of Audit Services on Medicare beneficiaries' early discharges from acute-care hospitals to hospice. An early discharge was defined by the OIG as being more than one day earlier than the Medicare established average length of stay for the applicable diagnosis related group. The study concluded that, based on an extrapolation from the 100 discharges sampled, Medicare could have saved $602.5 million over a two-year period by implementing a per diem reimbursement for such early hospice discharges. As a result, OIG recommended that the Centers for Medicare & Medicaid Services (CMS) modify its reimbursement methodology for hospitals' early discharges to hospice.

Currently, Medicare pays a full prospective payment to hospitals that discharge a beneficiary to hospice care prior to the end of the applicable average length of stay for the particular diagnosis. However, Medicare already pays hospitals on a per diem basis, rather than by a prospective payment, for early discharges to other post-acute settings, including skilled nursing facilities, home health, long-term care and psychiatric hospitals. OIG estimated that hospitals' early discharges made up approximately 30 percent of all hospital discharges to hospice care. OIG also asserted that the recommended change would not cause a "significant financial disadvantage" for hospitals, or disproportionately impact any hospital.

CMS Fires Back: In its response to the OIG recommendation, CMS diplomatically called for further study. It noted that adoption of such a policy might produce lower than estimated savings by discouraging hospitals from making transfers to hospice, even if hospice is a more appropriate and cost effective care setting, until the patient's length of stay could garner the full hospital prospective payment. CMS also stated that it would need to explore whether it even has authority to expand the post-acute transfer adjustment to apply to hospice transfers.

OIG's Rebuttal: In a further response to CMS' comments, the OIG countered that an overwhelming majority of hospital officials stated in response to an

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OIG questionnaire that a reduction in hospital payments resulting from such a hospice transfer policy would not influence medical practice in a way that increases health risks for beneficiaries or creates an incentive for hospitals to extend hospital stays. OIG further noted that the possibility that hospitals would delay transfers to maximize their reimbursement already exists under the current per diem reimbursement policies for transfers to other hospitals or to other post-acute providers, but provided no data, and presumably collected no data, to show such a result is not occurring.

Our Unsolicited Commentary: Hospitals might also challenge OIG's conclusion that the recommended change would not cause them to suffer a "significant financial disadvantage." Clearly the study did find that hospital reimbursement for early hospice discharges would be significantly reduced under a per diem methodology, although reimbursement on average would still exceed hospital costs. It is also difficult to envision how the recommended change would not act as a disincentive for hospitals to facilitate early hospice discharge, despite what hospital officials may have said in response to an OIG questionnaire; what hospital official would acknowledge a propensity to "game the system" in this litigious climate?