

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COULD SAVE MILLIONS BY
IMPLEMENTING A HOSPITAL TRANSFER
PAYMENT POLICY FOR EARLY
DISCHARGES TO HOSPICE CARE**

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Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

If Medicare Part A had implemented a hospital transfer payment policy for early discharges from hospitals to hospice care in 2009 and 2010, it could have saved over \$600 million.

WHY WE DID THIS REVIEW

Medicare beneficiaries' discharges from acute-care hospitals (hospital) to hospice care increased significantly from 161,661 discharges in calendar year (CY) 2007 to 269,117 discharges in CY 2010, or approximately 66 percent. Medicare Part A payments to hospitals increased from \$1.5 billion for the services they provided to beneficiaries discharged to hospice care in CY 2007 to \$2.7 billion in CY 2010, or 80 percent. Currently, Medicare has two "transfer payment policies" that adjust payments for discharges from hospitals to other hospitals or postacute-care facilities that are made sooner than a Medicare-established average length of stay (an early discharge). When a beneficiary is discharged early from a hospital to hospice care, however, Medicare does not have a transfer payment policy to adjust the payment to the hospital. During our audit period, more than 30 percent of the discharges from hospitals to hospice care were early and so would have been subject to a transfer payment policy if Medicare had had one.

Our objective was to determine how a hospital transfer payment policy for early discharges to hospice care would financially affect Medicare Part A and hospitals.

BACKGROUND

Medicare pays full prospective payments (full payment), based in part on average lengths of stay, to hospitals that discharge beneficiaries for hospice care. This payment was intended to provide payment in full to hospitals for all inpatient services associated with a particular diagnosis. In contrast and because of its transfer payment policies, Medicare pays hospitals a per diem rate for early discharges when beneficiaries are transferred to another prospective payment system hospital or to postacute-care settings, including skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, long-term care hospitals, and psychiatric hospitals. This is based on the assumption that hospitals should not receive full payments for beneficiaries discharged early and then admitted for additional care in other clinical settings. Consistent with Medicare's existing transfer payment policies, we define an early discharge as being more than 1 day earlier than the Medicare-established geometric mean length of stay for an applicable diagnosis-related group.

WHAT WE FOUND

On the basis of our sample results, we estimated that Medicare could have saved \$602,519,187 for CYs 2009 and 2010 by applying a hospital transfer payment policy for early discharges to hospice care. Medicare payments based on a per diem rate rather than a full payment for the sampled claims would have resulted in \$379,844 in savings. Approximately 30 percent of all hospital discharges to hospice care were early discharges that would have received per diem payments rather than full payments under a hospital transfer payment policy. In addition, this

transfer payment policy would not have caused a significant financial disadvantage for hospitals or disproportionately affected any hospital.

WHAT WE RECOMMEND

We recommend that the Centers for Medicare & Medicaid Services (CMS) change its regulations or pursue a legislative change, if necessary, to establish a hospital transfer payment policy for early discharges to hospice care.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS stated that it would like to study our recommendation further. CMS stated that adopting a transfer policy for hospice may “produce lower than estimated savings by discouraging hospitals from making transfers to more appropriate and cost effective care settings until a patient’s length of stay would not result in a reduction of payment to hospitals.” Furthermore, CMS stated that it needs to explore whether it has the authority “to expand the [postacute-care] transfer adjustment to hospices.”

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding CMS’s comments on the possibility that hospitals would not make transfers to hospice to avoid a reduction in payment, an overwhelming majority of hospital officials stated in response to our questionnaire that a reduction in hospital payments resulting from a hospice transfer policy would not influence medical practice in a way that increases the health risks for beneficiaries or creates an incentive for hospitals to extend hospital stays. In addition, the possibility that hospitals would not make transfers could also exist under the current policies regarding transfers from hospitals to other hospitals or postacute-care facilities. Accordingly, we encourage CMS to pursue the adoption of this policy and determine whether it has the authority to expand the existing transfer payment policies.

TABLE OF CONTENTS

| | <u>Page</u> |
|---|-------------|
| INTRODUCTION | 1 |
| Why We Did This Review | 1 |
| Objective | 1 |
| Background | 1 |
| Medicare Program | 1 |
| Acute-Care Hospital Prospective Payment System..... | 1 |
| Hospice Care | 1 |
| Hospitals Often Discharge Beneficiaries to Inpatient Hospice Care | 2 |
| Transfer Payment Policies..... | 2 |
| Common Diagnosis-Related Groups..... | 3 |
| How We Conducted This Review | 3 |
| FINDINGS | 4 |
| Per Diem Payments for Early Discharge to Hospice Care Could Have Saved on Average More Than \$4,000 per Claim | 4 |
| A Transfer Payment Policy for Early Discharges to Hospice Would Not Have a Significant Financial Effect on Hospitals | 4 |
| Estimates of Savings Realized If a Change to Discharge Policies Had Been Implemented | 5 |
| CONCLUSION | 5 |
| RECOMMENDATION | 6 |
| CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS | 6 |
| OFFICE OF INSPECTOR GENERAL RESPONSE | 6 |
| APPENDIXES: | |
| A: Destinations, Numbers, and Percentages of Early Discharges to Hospice Care: Calendar Years 2009 and 2010 | 7 |
| B: Top 10 Diagnostic-Related Drugs for Hospital Early Discharges to Hospice | 8 |
| C: Audit Scope and Methodology | 9 |

D: Sample Design and Methodology..... 11

E: Sample Results and Estimates..... 12

F: Centers for Medicare & Medicaid Services Comments..... 13

INTRODUCTION

WHY WE DID THIS REVIEW

Medicare beneficiaries' discharges from acute-care hospitals (hospital) to hospice care increased significantly from 161,661 discharges in calendar year (CY) 2007 to 269,117 discharges in CY 2010, or approximately 66 percent. Medicare Part A payments to hospitals increased from \$1.5 billion for the services they provided to beneficiaries discharged to hospice care in CY 2007 to \$2.7 billion in CY 2010, or 80 percent. Currently, Medicare has two "transfer payment policies" that adjust payments for discharges from hospitals to other hospitals or postacute-care facilities that are made sooner than a Medicare-established average length of stay (an early discharge). When a beneficiary is discharged early from a hospital to hospice care, however, Medicare does not have a transfer payment policy to adjust the payment to the hospital. During our audit period, more than 30 percent of the discharges from hospitals to hospice care were early and so would have been subject to a transfer payment policy if Medicare had had one.

OBJECTIVE

Our objective was to determine how a hospital transfer payment policy for early discharges to hospice care would financially affect Medicare Part A and hospitals.

BACKGROUND

Medicare Program

Medicare provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. Medicare Part A helps cover certain inpatient services in hospitals, hospice care, skilled nursing facilities, and some home health care services. The Centers for Medicare & Medicaid Services (CMS) administers Medicare.

Acute-Care Hospital Prospective Payment System

The Social Security Act, section 1886(d), established the prospective payment system (PPS) for hospital services. Under the PPS, Medicare pays hospital costs for beneficiaries at predetermined rates. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned (e.g., 871, Septicemia). The prospective payment was intended to provide payment in full to hospitals for all inpatient services associated with a particular diagnosis. (We will refer to this as the "full payment.") Therefore, the earlier a beneficiary is discharged from the hospital, the greater the chance that the beneficiary's length of stay will be below that average figure used in calculating the full payment and the hospital will benefit financially.

Hospice Care

Hospice care provides terminally ill beneficiaries with palliative care rather than traditional medical care and curative treatment. The goal of palliative care is to improve a beneficiary's

quality of life through pain management and symptom relief. Hospice care, including nursing care and therapies, may be provided to beneficiaries in inpatient hospitals, inpatient hospice facilities, nursing facilities, or their own homes. Medicare pays hospice providers a prospective per diem payment (per diem payment) for each day that a beneficiary is in hospice care based on the level of care required. Medicare Part A reimbursement for hospice care increased from approximately \$10.3 billion in CY 2007 to \$13 billion in CY 2010. According to the Hospice Association of America, the significant increase in the use of hospice care is due most likely to increased beneficiary, family, and physician awareness of the benefits of hospice care, together with the rapid increase in hospice care facilities (*Hospice Facts & Statistics*, November 2010).

Hospitals Often Discharge Beneficiaries to Inpatient Hospice Care

Hospitals discharge beneficiaries to various settings for hospice care, such as inpatient hospitals, inpatient hospice facilities, nursing homes, and beneficiaries' homes; however, most of hospice beneficiaries remain at inpatient facilities. For CYs 2009 and 2010, the majority, or approximately 57 percent, of hospice care after early discharge from hospitals was provided in inpatient facilities and billed by the hospice providers at a general inpatient per diem rate. (See Appendix A for additional information about early discharges to hospice care.) In some cases, beneficiaries stay at the discharging hospitals to receive hospice care, and the hospitals then receive reimbursement for the hospice services they provide from the hospice providers.

Transfer Payment Policies

Medicare pays full payments to hospitals that discharge beneficiaries to their homes or to hospice care. In contrast, for all DRGs, Medicare pays transferring hospitals using a per diem rate when beneficiaries undergoing acute care are transferred to another hospital for continued treatment.¹ Using the same per diem rate calculation methodology, but only for certain DRGs,² Medicare pays transferring hospitals the per diem rate when beneficiaries are discharged to postacute-care settings, including skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, long-term care hospitals, and psychiatric hospitals.³ For both acute-care and postacute-care transfers, the sum of the per diem is not to exceed the full DRG payment that would have been made had the beneficiary not been transferred.⁴ This has the effect of reducing the payment made for a discharge to another facility that occurs sooner than a Medicare-established average length of stay for the applicable DRG. The policy is based on the premise that hospitals should not receive full payments for Medicare beneficiaries discharged early and then admitted for

¹ The acute-care hospital-to-hospital transfer payment policy was established for discharges effective in fiscal year (FY) 1984 (Fed. Reg. Vol. 48, No. 171, page 39759, Sept. 1, 1983). The current acute-care transfer policy is codified at 42 CFR § 412.4(a).

² The hospital-to-postacute-care transfer payment policy, established for discharges occurring in FY 1999, was applicable to 10 DRGs (section 1886(d)(5)(J)(iii) of the Social Security Act). The number of DRGs included in this policy increased over several years and to 275 for discharges occurring in FY 2012 (Fed. Reg. Vol. 76, No. 160, page 51711, Aug. 18, 2011).

³ 42 CFR § 412.4(c).

⁴ 42 CFR § 412.4(f).

additional care in other clinical settings.⁵ The per diem transfer payment is calculated by dividing the full payment by the geometric mean length of stay (GMLOS)⁶ for an applicable DRG. The total payment to the hospital is the per diem rate multiplied by a number equal to the length of stay plus 1 day, not to exceed the full payment.⁷ Consistent with Medicare's current transfer payment policies, we define an early discharge as being more than 1 day earlier than the GMLOS for an applicable DRG.

Common Diagnosis-Related Groups

The hospital transfer payment policy for a discharge to a postacute-care setting applies to certain DRGs. In CYs 2009 and 2010, the most common DRG for early discharges to hospice care was DRG 871 (Septicemia), which accounted for more than 10 percent of all the billed DRGs. Nine other DRGs, related mainly to respiratory, nervous, heart, or hemorrhage conditions, accounted for 30 percent of the DRGs for early discharges to hospice care. (See Appendix B for a list of common DRGs.) These 10 DRGs accounted for more than 40 percent of all the billed DRGs for early discharges to hospice care for CYs 2009 and 2010.

HOW WE CONDUCTED THIS REVIEW

We identified hospital claims in which the discharge dates of the hospital claims matched the start dates of hospice claims in CYs 2009 and 2010. We then identified hospital claims that had lengths of stay at least 1 day fewer than the GMLOS for the billed DRGs. From a population of 158,623 nationwide hospital claims, we randomly selected a sample of 100 claims and (1) reviewed medical records to confirm that beneficiaries were discharged to hospice care, (2) calculated the per diem payment, and (3) calculated the hospitals' costs on the basis of their total charges and cost-to-charge ratio.⁸

Our fieldwork consisted of contacting hospitals nationwide and visiting two hospitals in Rhode Island and Massachusetts. We conducted our fieldwork from June through August 2012.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix C contains the details of our scope and methodology, Appendix D contains our sample design and methodology, and Appendix E contains our sample results and estimates.

⁵ Fed. Reg. Vol. 48, No. 171, page 39759, September 1, 1983.

⁶ The GMLOS is the national mean length of stay for a DRG as determined and published by CMS.

⁷ Fed. Reg. Vol. 63, No. 147, page 40982, July 31, 1998, provides an example of a transfer payment.

⁸ The cost-to-charge ratio is the factor applied to a hospital's covered charges to determine estimated costs for medically necessary services.

FINDINGS

For CYs 2009 and 2010, on the basis of our sample results, we estimated that Medicare could have saved \$602,519,187⁹ by applying a hospital transfer payment policy for early discharges to hospice care for all DRGs. Medicare prospective payments based on a per diem rate rather than a full payment for our sampled claims would have resulted in \$379,844 in savings. Approximately 30 percent of all hospital discharges to hospice care were early discharges that would have received per diem payments rather than full payments under a hospital transfer payment policy. In addition, this transfer payment policy would not have caused a significant financial disadvantage for hospitals or disproportionately affected any hospital.

PER DIEM PAYMENTS FOR EARLY DISCHARGE TO HOSPICE CARE COULD HAVE SAVED ON AVERAGE MORE THAN \$4,000 PER CLAIM

Medicare prospective payments that were based on a per diem rate¹⁰ (rather than a full payment) and that covered all DRGs for our sampled claims would have resulted in \$379,844 in savings in CYs 2009 and 2010, or an average of \$4,084 per claim.¹¹ Example 1 shows how this worked for one of our sample claims.

Example 1. A Per Diem Payment for an Early Discharge to Hospice Care

A hospital admitted a beneficiary on July 13, 2010, and discharged him to hospice care on July 14. The hospital billed DRG 974, HIV with major related condition, with a GMLOS of 7.1 days. Medicare reimbursed the hospital a full payment of \$19,739. Using a per diem rate, Medicare would have reimbursed the hospital \$5,363, resulting in \$14,376 in savings.

Approximately 30 percent of all hospital discharges to hospice care were early discharges that would have received per diem payments rather than full payments under a hospital transfer payment policy.

A TRANSFER PAYMENT POLICY FOR EARLY DISCHARGES TO HOSPICE WOULD NOT HAVE A SIGNIFICANT FINANCIAL EFFECT ON HOSPITALS

A hospital transfer payment policy for early discharges to hospice care would not cause a significant financial effect on hospitals. Specifically, for 73 percent of our sampled claims, per diem payments would have exceeded hospital costs. Although this payment policy would not

⁹ We estimate that Medicare could have saved \$602,519,187 if all DRGs were included in a hospital-to-hospice transfer payment policy. This would be similar to the acute-care hospital-to-hospital transfer payment policy. However, if only certain DRGs were included in a hospital-to-hospice transfer payment policy (similar to the hospital-to-postacute-care transfer payment policy), Medicare could have saved a lesser amount.

¹⁰ We used the same per diem rate as the rate under current hospital transfer payment policies. Generally, hospitals receive twice the per diem rate for the first day and the per diem rate for each additional day up to the full DRG payment.

¹¹ Seven claims were not subject to a hospital transfer payment policy because they were managed care claims.

fully cover 27 percent of the hospitals' costs, we found that, on average, the per diem payments would have still exceeded hospitals' costs by \$1,100 for all our sampled claims. In addition, this transfer payment policy would not have disproportionately affected any hospital because no one hospital in our sample accounted for more than four-tenths of 1 percent of all the early discharges to hospice care in CYs 2009 and 2010.

Example 2. A Per Diem Payment That Covered Hospital Costs

Using the same situation as in Example 1, the hospital would have received \$5,363 if Medicare had used a per diem rate. For the same stay, we determined that the hospital's costs would have been \$2,181 by applying the hospital's cost-to-charge ratio of 25.3 percent to its billed charges of \$8,621. As a result, the reduced payment to the hospital would have exceeded the hospital's costs by \$3,182.

ESTIMATES OF SAVINGS REALIZED IF A CHANGE TO DISCHARGE POLICIES HAD BEEN IMPLEMENTED

On the basis of our sample results, we estimated Medicare Part A would have saved \$602,519,187 during CYs 2009 and 2010 by implementing a hospital transfer payment policy for early discharges to hospice care (Appendix E).

CONCLUSION

Trustees of the Part A Hospital Insurance trust fund have determined that it is not adequate to meet the demands of the next 10 years and will be exhausted by 2024.¹² These projections indicate an urgent need to address the exhaustion of the trust fund. The trustees state in their report that the sooner significant reforms are enacted, the more flexible and gradual they could be.

One such reform CMS could implement is a hospital transfer payment policy for early discharges to hospice care, similar to the transfer payment policies it has for early discharges to hospitals and to postacute-care facilities. These policies' premise that hospitals should not receive full payments for Medicare beneficiaries discharged early and then admitted for additional care in other clinical settings also applies to beneficiaries discharged early to hospice care. The implementation of a transfer payment policy for early discharges from hospitals to hospice care would result in immediate and significant Medicare savings. Moreover, this reform would not cause hospitals a significant financial disadvantage or disproportionately affect any hospital.

Lastly, hospitals and other inpatient facilities provided the majority of the hospice care after early discharge, and 10 DRGs accounted for more than 40 percent of all the billed DRGs for early discharges to hospice care for CYs 2009 and 2010. Therefore, CMS could establish a transfer payment policy for early discharges to hospice care that covers all billed DRGs or for only the most prevalently billed DRGs and still save.

¹² 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, April 23, 2012.

RECOMMENDATION

We recommend that CMS change its regulations or pursue a legislative change, if necessary, to establish a hospital transfer payment policy for early discharges to hospice care.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS stated that it would like to study our recommendation further. CMS stated that adopting a transfer policy for hospice may “produce lower than estimated savings by discouraging hospitals from making transfers to more appropriate and cost effective care settings until a patient’s length of stay would not result in a reduction of payment to hospitals.” Furthermore, CMS stated that it needs to explore whether it has the authority “to expand the [postacute-care] transfer adjustment to hospices.” CMS’s comments are included in their entirety as Appendix F.

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding CMS’s comments on the possibility that hospitals would not make transfers to hospice to avoid a reduction in payment, an overwhelming majority of hospital officials stated in response to our questionnaire that a reduction in hospital payments resulting from a hospice transfer policy would not influence medical practice in a way that increases the health risks for beneficiaries or creates an incentive for hospitals to extend hospital stays. In addition, the possibility that hospitals would not make transfers could also exist under the current policies regarding transfers from hospitals to other hospitals or postacute-care facilities. Accordingly, we encourage CMS to pursue the adoption of this policy and determine whether it has the authority to expand the existing transfer payment policies.

**APPENDIX A: DESTINATIONS, NUMBERS, AND PERCENTAGES
OF EARLY DISCHARGES TO HOSPICE CARE:
CALENDAR YEARS 2009 AND 2010**

| Destination Code | Early Discharge Destination | No. of Discharges | Percentage of All Discharges |
|-------------------------|------------------------------------|--------------------------|-------------------------------------|
| Q5006 | Inpatient Hospice Facility | 47,865 | 30.2% |
| Q5001 | Patient's Home/Residence | 46,544 | 29.3% |
| Q5005 | Inpatient Hospital | 41,916 | 26.4% |
| Q5002 | Nursing Long-Term Care Facility | 9,490 | 6.0% |
| Q5004 | Skilled Nursing Facility | 6,965 | 4.4% |
| | All Other Facilities | 5,843 | 3.7% |
| | TOTAL | 158,623 | 100% |

**APPENDIX B: TOP 10 DIAGNOSIS-RELATED GROUPS
FOR HOSPITAL EARLY DISCHARGES TO HOSPICE**

Top 10 DRGs Billed for the 77,231 Hospital Early Discharges to Hospice Care in CY 2009

| DRG | DRG Description | GMLOS | No. of Discharges to Hospice | Percentage of All Discharges to Hospice |
|------------|---|--------------|-------------------------------------|--|
| 871 | Septicemia | 5.5 | 8,050 | 10.4% |
| 177 | Respiratory Infection & Inflammations | 7.2 | 4,021 | 5.2% |
| 064 | Intracranial Hemorrhage or Cerebral Infarction With MCC | 5.5 | 3,468 | 4.5% |
| 065 | Intracranial Hemorrhage or Cerebral Infarction With CC | 4.3 | 2,479 | 3.2% |
| 280 | Acute Myocardial Infarction | 5.8 | 2,424 | 3.1% |
| 291 | Heart Failure & Shocks | 5.0 | 2,291 | 3.0% |
| 682 | Renal Failure | 5.2 | 2,201 | 2.8% |
| 189 | Pulmonary Edema & Respiratory Failure | 4.8 | 1,891 | 2.4% |
| 193 | Simple Pneumonia & Pleurisy | 5.4 | 1,877 | 2.4% |
| 180 | Respiratory Neoplasms | 6.0 | 1,767 | 2.3% |
| | TOTAL | | 30,469 | 39.5%* |

Top 10 DRGs Billed for the 81,392 Hospital Early Discharges to Hospice Care in CY 2010

| DRG | DRG Description | GMLOS | No. of Discharges to Hospice | Percentage of All Discharges to Hospice |
|------------|---|--------------|-------------------------------------|--|
| 871 | Septicemia | 5.4 | 9,709 | 11.9% |
| 064 | Intracranial Hemorrhage or Cerebral Infarction With MCC | 5.3 | 3,925 | 4.8% |
| 177 | Respiratory Infection & Inflammations | 7.1 | 3,836 | 4.7% |
| 291 | Heart Failure & Shocks | 5.0 | 2,575 | 3.2% |
| 065 | Intracranial Hemorrhage or Cerebral Infarction With CC | 4.1 | 2,467 | 3.0% |
| 280 | Acute Myocardial Infarction | 5.4 | 2,396 | 2.9% |
| 682 | Renal Failure | 5.1 | 2,357 | 2.9% |
| 193 | Simple Pneumonia & Pleurisy | 5.3 | 2,253 | 2.8% |
| 189 | Pulmonary Edema & Respiratory Failure | 4.7 | 2,104 | 2.6% |
| 180 | Respiratory Neoplasms | 5.9 | 1,815 | 2.2% |
| | TOTAL | | 33,437 | 41.1%* |

MCC = major complication or comorbidity, CC = complication or comorbidity

* Amounts do not total because of rounding.

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

We identified hospital claims in which the discharge dates of the hospital claims matched the start dates of hospice claims in CYs 2009 and 2010. We then identified hospital claims that had lengths of stay at least 1 day fewer than the GMLOS for the billed DRG. The population consisted of 158,623 nationwide hospital claims with Medicare payments totaling more than \$1.65 billion.

We limited our review at hospitals to the controls related to discharging beneficiaries to hospice care.

Our fieldwork consisted of contacting hospitals nationwide and visiting one hospital in Rhode Island and one in Massachusetts. We conducted our fieldwork from June through August 2012.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted hospital claim data for claims in which the discharge dates of the hospital claims matched the start dates of hospice claims from the CMS National Claims History file for CYs 2009 and 2010;
- analyzed the beneficiaries' hospital lengths of stay and discharge status billed on the claims to determine whether their lengths of stay were at least 1 day fewer than the applicable DRG's GMLOS;
- identified 158,623 hospital claims that had discharge dates in CYs 2009 and 2010 and that had beneficiary lengths of stay shorter than the applicable DRGs' GMLOS;
- selected a simple random sample of 100 hospital claims from the 158,623 claims (Appendix D);
- reviewed data from CMS's Common Working File for the 100 hospital claims and the corresponding hospice claims to (1) validate claim information extracted from the National Claims History file, (2) determine whether any of the selected claims had been canceled or adjusted, and (3) identify the services billed;
- reviewed medical records, such as physician notes and discharge summaries, to confirm the discharges to hospice care;
- sent questionnaire to 93 hospitals to determine what financial impact a hospital transfer payment policy for early discharges to hospice care would have on hospitals;

- reviewed questionnaire responses and, if necessary, followed up with hospital officials for clarification or to request additional information;
- calculated the hospitals' costs for the billed claims on the basis of their total charges and cost-to-charge ratios;
- repriced the hospitals' claims on the basis of a per diem rate to determine the reduced payment amounts;
- calculated the potential Medicare savings by subtracting each reduced payment from the full payment;
- estimated the total value of potential Medicare savings on the basis of our sample results (Appendix E); and
- discussed the results of our review with CMS officials.

We assessed the reliability of the hospital and hospice claims by tracing a random sample of data to source documents. We determined that the data were sufficiently reliable for the purpose of this audit.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX D: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of nationwide Medicare acute-care hospital claims for CYs 2005 through 2011 with discharge dates that matched the start dates of hospice claims for the same beneficiaries.

SAMPLING FRAME

We identified acute-care hospital claims with discharge dates that matched the start dates of hospice claims for the same beneficiaries.

We then identified those acute-care hospital claims on which a cost savings could have been realized if a transfer payment policy had been established in CYs 2009 and 2010. The resulting sampling frame consisted of 158,623 acute-care hospital claims with a total paid amount of \$1,651,953,817.

SAMPLE UNIT

The sample unit was an acute-care hospital claim.

SAMPLE DESIGN

Our sample design was a simple random sample.

SAMPLE SIZE

We selected a sample of 100 acute-care hospital claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software.

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the sampling frame. After generating 100 random numbers, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the dollar value of potential cost savings for payments made to acute-care hospitals.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Sample Results

| Frame Size | Value of Frame | Sample Size | Value of Sample | Claims That Would Qualify for Transfer Payment | Value of Cost Savings |
|-------------------|-----------------------|--------------------|------------------------|---|------------------------------|
| 158,623 | \$1,651,953,817 | 100 | \$1,073,323 | 93 | \$379,844 |

Estimated Cost Savings

(Limits Calculated for a 90-Percent Confidence Interval)

| | |
|----------------|---------------|
| Point estimate | \$602,519,187 |
| Lower limit | \$511,204,398 |
| Upper limit | \$693,833,975 |



APPENDIX F: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

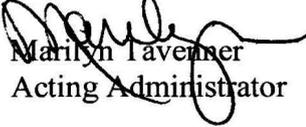
Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: APR - 1 2013

TO: Daniel R. Levinson
Inspector General

FROM: 
Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care (A-01-12-00507)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on this OIG Draft Report. CMS appreciates the OIG's continuing effort to examine areas for potential program savings. The Medicare Hospital inpatient prospective payment system determines appropriate payment amounts based on several factors. The Medicare severity diagnosis-related group (MS-DRG) system was designed to assign relative values of hospital care associated with treating beneficiaries with the same diagnosis. As part of this process, CMS calculates the average lengths of stay associated with each MS-DRG. Currently, CMS implements two types of adjustments for cases where the beneficiary is transferred to another care setting before the geometric mean length of stay (GMLOS). The acute-care (hospital-to-hospital) transfer adjustment reduces standard payments if a beneficiary is transferred to another acute care hospital before the GMLOS length of stay of a MS-DRG is reached. The post-acute care (PAC) transfer adjustment applies to certain MS-DRGs if the beneficiary is discharged and transferred to certain defined PAC settings. Hospice care facilities are not among the types of providers currently subject to the PAC transfer policy.

The OIG report presents findings from a review of hospital claims from calendar years (CYs) 2009 and 2010. After matching hospital discharge dates with hospice start dates, OIG identified claims where the patient was discharged from the hospital at least 1 day before the GMLOS of a MS-DRG. From 158,623 nationwide hospital claims from CYs 2009 and 2010, they selected a random sample of 100 cases to confirm the discharge status, estimate potential savings, and compare how any payment reductions would compare to the hospitals' actual costs of providing care.

The OIG reports estimated that CMS would save about \$600 million during CYs 2009 and 2010 if it implemented a hospice care transfer adjustment similar to our acute-care transfer policy. OIG estimated that approximately 30 percent of all hospital discharges to hospice care were discharges made before the GMLOS of a MS-DRG, and found that a reduced per-diem payment methodology would still exceed actual hospital costs in 73 percent of cases. The OIG also found that 10 MS-DRGs accounted for more than 40 percent of early discharges to hospice. They

suggest that CMS could propose an adjustment that targets only the most prevalent MS-DRGs, and still see significant savings.

OIG Recommendation

The OIG recommends that CMS change its regulations or pursue a legislative change, if necessary, to establish a hospital transfer payment policy for early discharges to hospice care.

CMS Response

The CMS would like to study OIG’s recommendation further. We acknowledge that there is a tangible financial incentive for hospitals to initially admit hospice-bound beneficiaries as hospital inpatients. OIG estimates that the program could have saved over \$600 million during CYs 2009 and 2010 by implementing a hospice transfer adjustment for all DRGs. However, it is possible that adopting a transfer policy to the hospice setting would produce lower than estimated savings by discouraging hospitals from making transfers to more appropriate and cost effective care settings until a patient’s length of stay would not result in a reduction of payment to hospitals. We would require further analysis to determine what savings could be achieved by expanding the PAC transfer adjustment to include hospice care, and the appropriateness of making such an adjustment if CMS were to adopt this policy. We also need to explore whether we have the authority under the current statute to expand the PAC transfer adjustment to hospices as OIG suggests.

The CMS thanks OIG for the work done on this issue and looks forward to working with OIG in the future.