American Hospital Association

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United States Senate
Washington, DC 20510

Dear Senator:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) wishes to outline its opposition to a potential policy that would cut payments to hospitals treating hospice patients.

In 2013, the Department of Health and Human Services' Office of Inspector General (OIG) published a report titled "Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care." In that report, the OIG recommends "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," and estimated that Medicare could save significantly "by applying a hospital transfer payment policy for early discharges to hospice care."

Hospitals discharge patients to hospice because the hospice setting is the most appropriate for delivering the care they need to meet their health needs and care goals. We believe the OIG's recommendation, and the assumed resulting savings, fails to account for fundamental payment realities in the Inpatient Prospective Payment System (IPPS), as well as the real-world care that physicians and nurses provide to cancer and other hospice patients. Expanding the post-acute care transfer policy to also apply to discharges to hospice is not based on sound policy.

The IPPS is based on a system of averages – hospitals receive a fixed payment for inpatient services based on the cost of the average patient. Some patients will be more costly than average to treat while other patients will be less costly than average to treat. The OIG's recommendation to reduce the IPPS payment is yet another attempt to adopt a policy that ensures hospitals get paid less for a lower–than-average cost patient while receiving the same payment for more costly patients. This policy is inconsistent with the basic principle of IPPS.

Currently, hospitals are paid less for a lower-cost patient under the post-acute transfer policy. While we have long held concerns about this policy, it was instituted to avoid providing an incentive for a hospital to transfer patients to another hospital, a skilled nursing facility or home health agency early in the patient's stay in order to minimize costs while still receiving the full MS–DRG payment.

This is theoretically possible because post-acute care providers also provide curative care – they have some capabilities that are redundant with the services that acute care hospitals provide. If a hospital discharges such patients early, in theory, it could be "transferring" some of its costs to these post-acute care providers while still receiving the full payment.

However, such rationale does not apply to hospice transfers. By definition, hospices do not provide curative care – there is no redundancy with acute care hospital services. In discharging patients to hospice, hospitals are not transferring any of their costs to them.

Further, in order to qualify for hospice care, a patient must be certified by a physician as having a life expectancy of less than six months. The patient must forgo coverage of all services related to their terminal illness. This is a serious decision that a patient makes together with his or her family and physician. Hospitals do not "push" patients into hospice in order to be able to discharge a day earlier, they transfer patients to hospice because it is the best setting in which to provide the care they need and have elected – to suggest that hospitals make this decision based on anything other than the patient's wishes and their physician's judgement is preposterous.

In its 2013 report, the OIG recommended expanding the post-acute transfer policy to hospice. In making this recommendation, the agency did not include any actual concerns about providers or policy rationales. The OIG simply cites the fact that it wanted to examine the financial ramifications of expansion. It was a solution in search of a problem.

Also of concern is the fact that the OIG's results are based on a sample size of 100 out of 158,623 claims, or 0.006 percent of claims. This is far too small a sample size on which to base serious payment policy.

Equally disturbing is that the OIG's fieldwork "consisted of contacting hospitals nationwide and visiting two hospitals." Even CMS was wary of the recommendation, stating 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."

The OIG dismissed CMS's concern by saying "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." It follows, therefore, that the converse of this point is also true – hospitals would not be discharging patients early to hospice merely to receive the full IPPS payment. Hospitals are discharging patients to hospice because that is the care they need.

Hospitals and their clinician partners take their end-of-life care responsibilities very seriously. The decision to transfer a patient to hospice is a medical and quality of life decision undertaken by the patient, his or her family and their clinical team. This policy would penalize hospitals for respecting patient wishes and working to get them the appropriate care they want and need, when they need it.

We appreciate your attention to the needs of Medicare patients and the hospitals who serve them, and thank you for your consideration of our analysis. If you or your staff have questions, please contact Erik Rasmussen, vice president of legislative affairs, at (202) 626-2981 or erasmussen@aha.org.

Sincerely,

Thomas P. Nickels
Executive Vice President