March 10, 2015

Glenn M. Hackbarth, J.D., Chairman, and Members
Medicare Payment Advisory Commission
425 Eye Street, NW
Suite 701
Washington, DC 20001

Dear Chairman Hackbarth and Members of the Commission:

We have monitored with interest the Medicare Payment Advisory Commission’s (MedPAC’s) discussions on policy changes to ease concerns over increased use of hospital “observation” status in response to Recovery Audit Contractor (RAC) reviews of short-term hospital stays, as well as policy changes that could offset any increased costs resulting from the Commission’s recommendations. As a potential “offset” to the Commission’s short-term hospital stay recommendations, MedPAC has referenced expansion of Medicare’s post-hospital transfer policy to include discharges to hospice. Based on discussions at MedPAC’s meeting on Thursday, March 5, we are appreciative that the Commission has decided to explore this issue in greater depth before issuing any recommendation relative to it.

Under Medicare’s post-acute transfer policy, hospital payments are reduced in cases where patients are on service under specific Diagnosis-related Groups (DRGs) for a shorter period of time than normal and after which patients receive continuing treatment in a post-acute setting. The policy was established, in part, to protect Medicare from paying for the same services twice. The transfer policy is not applied in all instances under which post-acute care is utilized following a relatively short hospital stay, which indicates that Congress and CMS recognize that...
a “transfer” policy is not appropriate in all instances under which a patient receives care following a hospital stay. Given the nature of hospice, we have serious concerns about extension of the post-acute transfer policy to hospice care. We trust that after careful consideration of the merits and potential negative consequences of extending the transfer policy to hospice, MedPAC will determine that making such a recommendation is inadvisable at this time.

When a Medicare beneficiary elects hospice care, that election represents a decision to forego curative care and opt for palliative services to manage pain and symptoms resulting from the terminal and related conditions for the remainder of the patient’s life. Rather than a continuation of the same type of services that were received in the hospital (or elsewhere), hospice care is a shift in the focus of treatment. The circumstances are substantially different from those in play with existing post-acute transfer policies, under which services might be considered to be a continuation of treatment that was started as part of a patient’s hospitalization. In a significant portion of cases where hospital patients are discharged to hospice, the patient leaves the hospital and returns to his or her residence and the hospice team begins palliative care. In cases where hospitalized patients are discharged to hospice but remain in the hospital or another facility that is not the patient’s residence, it is likely that the patient is receiving either general inpatient care to stabilize the patient following the change in treatment or inpatient respite care that is required so that a home caregiver’s needs may be addressed. Regardless, the care that the patient receives represents a shift in treatment as opposed to an extension of the curative or rehabilitative care that was provided in the hospital.

In recent years, the Commission and others have raised concerns not only about extremely long lengths of stay on hospice care, but also about patients that elect hospice and die within a very short time frame. We are in agreement with the Commission’s concern that these very short-stay patients and their families likely do not reap the full benefit that hospice care has to offer. We believe that inclusion of hospice in the existing post-acute transfer policy will create a strong financial incentive for hospitals to retain patients on care, thereby delaying the start of hospice services and increasing the incidence of very short hospice stays. As one hospice provider stated, “This translates directly into sacrifices of quality of life and appropriate care on the hospital side, and makes the job of hospices on the other side all the more difficult when dealing with 72-hour lengths of stay.”

Of even greater importance, individuals with considerable experience in the hospice field have observed that patients that are discharged “early” from hospital care to hospice all too often would have benefited from a referral to hospice care weeks or even months prior to their hospital stay. Instead, it is only after several hospitalizations and/or emergency department interactions (which might have been avoided) that it is determined that hospice may be the most appropriate, humane, and desired treatment option. While potentially beyond the scope of the Commission’s current discussion of short-term hospitalization policies, we encourage the Commission, at the earliest opportunity, to look more broadly at issues related to discharge
planning and referral for care as patients approach the end of life. We believe that more deliberate efforts at communication, assessment, and coordination would yield not only considerable Medicare program savings but also ensure that terminal patients receive care that responds to their preferences and allows them the maximum opportunity to participate in their final days of life.

As always, we thank you for the opportunity to comment on the Commission’s work. We look forward to continued discussions on issues of importance to the hospice community and the Commission. Please let us know if we can be of additional assistance at any time.

Sincerely,

Theresa M. Forster
Vice President for Hospice Policy & Programs