

NPHI POLICY BRIEF:

EXPANSION OF MEDICARE INPATIENT HOSPITAL PACT POLICY TO INCLUDE HOSPICE

Until October 1, 2018, hospice was excluded from the Medicare Post-Acute Care Transfer (PACT) policy. Under this policy, Medicare reduces its payment to an inpatient hospital when an admitted patient is transferred to a post-acute care setting after a much shorter than average length of stay in that hospital. Starting October 1, 2018, hospice is included in the PACT policy for certain Diagnosis-Related Groups (DRGs). This policy change was enacted into law by Congress earlier this year through the Bipartisan Budget Act of 2018 and implemented by CMS through the FY 2019 Inpatient Prospective Payment System (IPPS) final rule.¹

How hospital-to-hospice discharge policy worked until October 1, 2018

Under the previous policy, Medicare made a full DRG payment to a hospital when it discharged a Medicare beneficiary to hospice care, regardless of the timing of that discharge during the patient's hospital stay. In contrast, Medicare patients with specific DRGs who are discharged to a skilled nursing facility (SNF), an inpatient rehabilitation facility (IRF), a long-term care hospital (LTCH), or to home health care, are considered "post-acute care transfers" (PACT) if the discharge occurs after a much shorter than average length of stay in the hospital. In these cases, Medicare pays the hospital a fraction of the full DRG payment, in the form of a per diem for the stay. This is the policy that now applies to discharges from an inpatient hospital to a hospice provider effective October 1, 2018.

Rationale for the PACT policy

The rationale for the PACT policy is to discourage hospitals from discharging patients to another site of care after a very short hospital stay, which would minimize the hospital's costs while still receiving a full DRG payment. For discharges to PAC settings where a patient will receive curative care, the PACT policy arguably makes sense—a hospital that discharges patients "early" to post-acute care for ongoing treatment indeed may be "transferring" some of its costs to the receiving PAC provider.

The Balanced Budget Act of 1997 authorized CMS to implement the PACT policy beginning in fiscal year 1999 to cover discharges to post-acute care providers in 10 DRGs. In October 2003, CMS expanded the policy to 29 DRGs and it has continued to expand the number of DRGs to which the policy applies over the ensuing years. As of FY 2018, there are 280 DRGs subject to the PACT policy.²

Implications for NPHI members

NPHI argued to CMS that the PACT rationale does not make sense for discharges to hospice since, by definition, a hospice patient has elected to forego curative care for their terminal condition and therefore logically there could not be any overlap with the acute care services provided by the discharging hospital. We also urged CMS to limit the number of DRGs covered by the policy, for example to exclude DRGs typically assigned to patients with advanced illness, but CMS chose not to make any exceptions to the DRG list. As implemented in the final rule, CMS estimates that the expansion of the

¹ <https://www.gpo.gov/fdsys/pkg/FR-2018-08-17/pdf/2018-16766.pdf>, pages 41150 and 41393-41394.

² The list of Inpatient DRGs to which the PACT policy applies is available for download here: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2019-CMS-1694-FR-Table-5.zip>.

PACT policy to include discharges to hospice will reduce Medicare spending on inpatient hospital services by \$240 million in FY 2019. Whether or not the change in the PACT policy changes hospitals' discharge patterns to hospices remains to be seen.

Looking Forward

MedPAC is required to evaluate this change preliminarily by March of 2020 and to present a final report by October of 2021. MedPAC is required to look at the following factors:

- 1) the numbers of discharges of patients from an inpatient hospital setting to a hospice program;
- 2) the lengths of stays of patients in an inpatient hospital setting who are discharged to a hospice program;
- 3) spending under the Medicare program under title XVIII of the Social Security Act; and
- 4) other areas determined appropriate by the Commission.

In preparing their report and considering the factors above, MedPAC must also evaluate whether the timely access to hospice care by patients admitted to a hospital has been affected through changes to hospital policies or behaviors made as a result of this policy change.

NPHI members should be tracking their hospital referrals to see if there are changes in length of stay and the timeliness of the referrals. Additionally, it would be useful to note if there are particular diagnoses that are impacted (though the admitting diagnosis to hospice and hospital DRG may not line up perfectly, it would be a starting point for consideration). This information will help us to inform MedPAC, CMS, and the Congress about the impacts of this policy change.