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Issue Brief:

Controls on the Premature Discharge By Hospitals to Post-Acute Providers

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Table of Contents

SUMMARY	1
INTRODUCTION	2
REIMBURSEMENT POLICIES	2
HOSPITAL ISSUES	4
POST-ACUTE CARE PROVIDERS	4
PHYSICIANS	5
CONCLUSIONS	5
REFERENCES	7
APPENDIX	9

Appendix

TABLE 1: MEDICARE SHORT STAY HOSPITAL UTILIZATION: 1995 - 2006	9
TABLE 2: MEDICARE SHORT STAY HOSPITAL DRGs RANKED BY DISCHARGES: FY 2006.....	10

Summary

The prevalence of the practice of transferring patients to sub-acute levels of care has created concerns with hospital discharge planners. Their apprehension arises from the possibility that if they do not quickly transfer patients from an acute care setting to a post-acute level of care, their hospital may be at an economic disadvantage to those hospitals that have shorter lengths of stay due to differing transfer practices.

However, the fiscal incentive for hospitals to transfer a patient to a lower level of care is mitigated by at least four factors including: Medicare's post-acute care transfer policy, a hospital's evaluation of potential savings versus risk (e.g., reduced reimbursement, audit, regulatory control, litigation, etc.), the willingness of the post-acute care provider (or family caregivers) to accept responsibility for patient care, and the physician's agreement to the transfer.¹

These factors should cause hospital staff to rethink the manner in which patient stays are controlled and to be mindful that the shortest length of stay is not always the best.

¹ Fitzgerald, J., Boscardin, W., Hahn, B., & Ettner, S. (2007, February).

Introduction

Fundamental changes have occurred over the past twenty years in the health care environment, especially in regard to the use of post-acute care (PAC) providers after an acute inpatient hospital stay. As shown in Table 1,² the average length of stay for an acute hospital stay has decreased from 9.0 days in 1990 to 5.6 days in 2006. An unknown part of this decrease is due to increased hospital efficiency, for example the use of hospitalists.³ The average length of stay in hospitals can also be affected by state health policies⁴. Concern has also been expressed about the influence of reimbursement policies of large payors such as Medicare, Medicaid, and large insurance companies, and the degree to which hospitals are reducing the average length of stay through transfers to post-acute care settings.

The reduction in the average length of stay for acute care hospitals has been accompanied by an increase in the number of transfers from hospitals to post-acute care settings. Medicare currently covers post-acute care services in the following provider settings: skilled nursing facilities (SNFs), home health aides (HHA), long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs). The most recent data available shows the transfer rate increased from 20.5 percent of patients in 1991, to 30.2 percent of patients in 1998.⁵ Post-acute providers are able to treat a wider range of patients, some with more severe conditions, enabling acute care hospitals to discharge patients earlier.⁶

This paper looks at four factors that mitigate the incentives to transfer patients from an acute care setting to a post-acute care provider, ensuring proper levels of care and an equitable distribution of payments.

Reimbursement Policies

Since the inception of Medicare's prospective payment system, concerns have been expressed regarding financial incentives that may result in the premature discharge of patients from an acute care setting. An early study showed that while there were instances of early discharges, the number was relatively small and was more likely the result of a hospital trying to mitigate losses rather than maximize profits.⁷ Medicare initially attempted to control these premature discharges through peer review organizations and changes in reimbursement policies. For example, readmissions to the same facility within a set time period received no additional reimbursement.

² US Department of Health and Human Services. 2007 CMS Statistics: Table 38. Available at: http://www.cms.hhs.gov/DataCompendium/17_2007_Data_Compendium.asp#TopOfPage.

³ For example see Kaboli, Barnett, & Rosenthal (2004), which found that the use of hospitalists reduced length of stay by one day.

⁴ Troyer and Chang found that in Tennessee, hospital lengths of stay dropped from 6 to 5 days, during the TennCare managed care program.

⁵ Gilman, B., Cromwell, J., Adamache, W., & Donoghue, S. (2000, July).

⁶ Medicare Payment Advisory Commission (1998, June). The authors have unsuccessfully searched for updated data.

⁷ US Dept. of Health and Human Services. Office of Inspector General. (1988, February).

While policies were in place to control premature discharges where necessary services had been withheld, Medicare became increasingly concerned about the practice of transferring patients to post-acute care settings, especially within the same hospital. Studies in 1995 and 1996 identified a trend of declining average lengths of stay as hospitals transferred Medicare patients into post-acute care settings.⁸ As more patients received services after inpatient hospitalization, Medicare questioned the relationship among the different care settings and proper reimbursement. For example, Medicare found it was fully reimbursing an acute care hospital for a given case and in addition was paying a rehabilitation unit or skilled nursing facility for continuation of similar care under separate reimbursement rules.

Medicare responded in the 1990s by revisiting and changing reimbursement programs for inpatient hospitals and follow-up care at post-acute care facilities. Inpatient reimbursement reforms were heavily addressed in the Balanced Budget Act of 1997.⁹ Medicare implemented short stay transfer payments that affected hospitals transferring patients to post- acute care sooner than a recommended number of days in the hospital.¹⁰

Medicare began to penalize hospitals if stays were too short before a transfer to post-acute care. Beginning in FY 1999, patients were classified into one of ten specified “diagnosis related groups” (DRGs). If they were transferred from acute hospitals to post-acute care settings these patients were considered discharges but were reimbursed as transfers. If the length of stay exceeded the geometric mean length of stay for persons in that DRG minus one day, the case was deemed a long-stay post-acute care transfer and the full DRG payment was made to the hospital. Short stay post-acute care transfers were cases where the patient was transferred at least one day prior to the geometric mean length of stay for the DRG.

Short stay transfers are of great interest because of the heightened potential that post-acute care services can be substituted for acute care. As implemented, the distribution of payments between acute hospitals and post-acute care providers corresponds with their resource use.¹¹ Medicare has since expanded the post-acute care transfer DRGs to 273, as of FY 2008. Table 2 (See Appendix: Page 10) displays the top 25 DRGs by volume and their coverage in regard to the post-acute care transfer policy. Medicare’s expanded use of post-acute care transfer DRGs may also prompt other payors, such as state Medicaid agencies, to adopt similar reimbursement policies.

⁸ Federal Register. (1996, August 30).

⁹ McCall, N., Korb, J., Petersons, A., & Moore, S. (Winter 2002). The changes in the July 1997 Balanced Budget Act of 1997 (BBA) also affected home health agencies. From the late 1980s through 1996, Medicare's payments for home health increased dramatically as home health services grew more than 30 percent per year. Efforts to rein in Medicare home health costs began with federal compliance initiatives focused on the home health industry in the mid-1990s. The new payment system replaced cost-based reimbursement methodology for home health services and resulted in substantial decreases in the amount of Medicare home health use. The Outcome and Assessment Information Set (OASIS) for home health agencies was also established in 2000, and OASIS was tied into the new prospective payment.

¹⁰ For a description of transfer DRGs see: http://www.smainformatics.com/publications/FAQ_TDRG.pdf.

¹¹ Federal Register. (2005, August 12).

Hospital Issues

Hospitals contemplating short stay post-acute care transfers must also contend with increased scrutiny for compliance with the post-acute care transfer policy. A 2005 review of hospitals' compliance with the post-acute care transfer policy identified reimbursement errors in 95 percent of all post-acute care transfer DRG claims, with potential reimbursement recoveries by Centers for Medicare & Medicaid Services (CMS) amounting to 22 percent of initial payments.¹² CMS has since implemented edits in the claims process to detect transfers improperly coded as discharges. The end result is that while hospitals that engage in short stay transfers do realize cost savings, there may also be a loss in revenue that exceeds initial expectations. Hospitals will need to increase efforts in tracking DRG discharges to ensure they are in compliance with Medicare regulations that further reduce potential savings.

Hospital discharge planners must also consider outside regulatory control and the current litigious environment in their short stay post-acute care transfer decisions. An increase in negative outcomes for short stay transfers can lead not only to litigation but also interference by regulatory bodies. For example, states implemented mandatory two-day minimum stays for neonatal deliveries when hospitals were deemed too aggressive in their discharge policies.¹³

Hospitals that do not practice short stay transfers should not be concerned that short stay transfers from other facilities will affect their reimbursement. These short stay transfers do not reduce the payments for non-post-acute care cases¹⁴. Instead, post-acute care discharges are weighted by the ratio of their acute lengths of stay versus the DRG geometric mean of non-transfer cases to ensure that non-transfer discharges receive a fair DRG payment.¹⁵

Post-Acute Care Providers

For a patient to be transferred from an acute setting to a post-acute setting requires not only the hospital to transfer the patient but also the post-acute setting to accept the patient. While technological advances have enabled post-acute care providers to treat a wider range and severity of conditions, the post-acute care provider must agree that the patient no longer requires acute care. The post-acute care provider is also taking on financial risk in accepting these patients due to the implementation of prospective payment systems (PPS) for all major post-acute care provider groups.¹⁶ Thus, post-acute care providers, like hospitals, must evaluate the cost of providing the necessary level of care against expected reimbursement. With the implementation of PPS for post-acute

¹² Department of Health and Human Services. (2005, April).

¹³ Eaton, A.P. (2001, February).

¹⁴The transfers do not reduce the payments despite the possibility that the annual recalibration of DRG relative weights might reflect changes in the site of care caused by an increasing number of post-acute care transfers.

¹⁵Cromwell, J., Donoghue, S., & Gilman, B. (2002, Winter).

¹⁶ Cotterill, P., & Gage, B. (2002, Winter).

care providers, the growth of post-acute care services stabilized and reached a plateau in the late 1990s.¹⁷

Physicians

The other gatekeeper that can prevent a patient from being transferred from a hospital to a post-acute care setting is the patient's physician. While hospitals have financial incentives to discharge or transfer patients before their length of stay exceeds the DRGs statistical mean, the physician is obligated to ensure an adequate level of care. A hospital's financial considerations are not a valid defense for sub-standard care.¹⁸ Physicians also have personal and economic relationships with their patients that can be severed if the patients believe the physician is not acting on their behalf. In this manner, patients (and family caregivers) are also able to challenge the transfer of care.

Since the inception of inpatient PPS, physicians have occasionally been in conflict with hospitals regarding the proper length of stay. Physicians have come to practice defensive medicine due to malpractice issues. As a result, a physician may require a minimum length of stay in the acute care setting before a transfer to a post-acute care setting is acceptable.¹⁹

Conclusions

The financial incentives for a hospital to quickly transfer a patient from an inpatient acute care setting to a post-acute care setting are balanced by four factors:

- Medicare's reimbursement policies, including the short stay DRG transfer policy, ensure reimbursement is distributed equitably between hospitals and post-acute care providers;
- Prospective payment reimbursement systems for post-acute care services prevent cost shifting and excessive post-acute care services;
- Litigation concerns (including possible regulatory control) for hospitals, physicians, and post-acute care providers ensure appropriate levels of care to the patient; and,
- Physicians and their patients are reluctant to consent to hospital accounting preferences.

Transfers from an inpatient setting to a post-acute care setting are an acceptable practice that can potentially reduce expenditures for both the payor and provider community.²⁰ However, the decision to prematurely transfer patients to a post-acute care setting is subject to Medicare controls and has some risk to hospital providers.

¹⁷ Ibid.

¹⁸ Wilcox, D., & Francisco, C. (1990, May).

¹⁹ Johnson, R. (1986, February).

²⁰ Fitzgerald, J., Boscardin, W., Hahn, B., & Ettner, S.: (2007, February).

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Appendix

Table 1: Medicare Short Stay Hospital Utilization: 1995 - 2006

	1985	1990	1999	2000	2004	2005	2006
Discharges:							
Total in millions	10.5	10.5	11.7	11.8	13.0	13.0	12.5
Rate per 1,000 Enrollees ¹	347	313	310	303	316	308	291
Days of Care:							
Total in millions	92	94	71	71	75	75	71
Rate per 1,000 Enrollees ¹	3,016	2,805	1,897	1,825	1,834	1,771	1,655
Average Length of Stay:							
All short stay	8.7	9.0	6.1	6.0	5.8	5.7	5.6
Excluded Units ²	18.8	19.5	12.6	12.3	11.5	11.6	11.7
Total Charges per Day	\$597	\$1,060	\$2,496	\$2,720	\$4,458	\$4,882	\$5,344

Source: CMS data from 2007 Data Compendium, Utilization Statistics.

¹ The population base excludes enrollees residing in foreign countries.

² Includes alcohol/drug, psychiatric, and rehabilitation units through 1990, and psychiatric and rehabilitation units from 1997 through 2006.

NOTES: Data may reflect under reporting due to a variety of reasons including: operational difficulties experienced by intermediaries; no-pay, at-risk managed care utilization; and, no-pay Medicare secondary payer bills. Average length of stay is shown in days. The data for 1990 through 2006 are based on 100 percent MEDPAR. Data may differ from other sources or from the same source with different update cycle.

Table 2: Medicare Short Stay Hospital DRGs Ranked by Discharges: FY 2006

		Discharges ¹				
DRG	Description	Number	Percent	Average LOS	Average Payment ²	Post-Acute Care DRG
127	Heart Failure & Shock	635,662	5.1	5.0	6,289	Yes ⁴
089	Simple Pneumonia & Pleurisy Age >17 W CC	476,068	3.8	5.3	6,147	Yes ⁴
544	Major Joint Replacement Or Reattachment Of lower Extremity	445,454	3.6	4.3	11,953	Yes
088	Chronic Obstructive Pulmonary Disease	381,113	3.1	4.7	5,345	
430	Psychoses	344,303	2.8	10.6	7,098	Yes ⁵
182	Esophagitis, Gastroent & Misc Digest Disorders Age >17 W CC	333,115	2.7	4.4	5,225	
416	No Longer Valid	313,249	2.5	7.4	10,753	
014	Intracranial Hemorrhage Or Cerebral Infarction	267,519	2.1	5.3	7,624	Yes ⁴
462	Rehabilitation	260,350	2.1	12.2	14,962	Yes ⁵
174	G.I. Hemorrhage W CC	249,990	2.0	4.6	6,237	
316	Renal Failure	234,401	1.9	6.0	7,916	Yes ⁵
320	Kidney & Urinary Tract Infections Age >17 W CC	229,961	1.8	4.9	5,211	Yes ⁴
143	Chest Pain	224,031	1.8	2.1	3,552	
296	Nutritional & Misc Metabolic Disorders Age >17 W CC	211,814	1.7	4.4	5,068	Yes ⁴
138	Cardiac Arrhythmia & Conduction Disorders W CC	208,908	1.7	3.8	5,094	
558	Percutaneous Cardiovascular Proc W Drug-eluting Stent W/O Maj CV DX	185,591	1.5	1.7	13,790	
079	Respiratory Infections & Inflammations Age >17 W CC	151,934	1.2	7.8	9,479	Yes ⁵
121	Circulatory Disorders W AMI & Major Comp, Discharged Alive	133,409	1.1	5.9	9,279	Yes ⁴
557	Percutaneous Cardiovascular Proc W Drug-eluting Stent W Major CV DX	129,739	1.0	3.9	18,159	
148	No Longer Valid	129,160	1.0	11.8	22,230	
210	Hip & Femur Procedures Except Major Joint Age >17 W CC	127,756	1.0	6.5	11,352	Yes ³
475	No Longer Valid	127,204	1.0	10.1	22,917	
141	Syncope & Collapse W CC	126,813	1.0	3.4	4,714	
277	Cellulitis Age >17 W CC	123,573	1.0	5.3	5,392	Yes ⁴
395	Red Blood Cell Disorders Age >17	116,821	0.9	4.2	5,160	Yes ⁴
Total of the 25 Diagnosis Related Groups		12,492,501	100.0	5.6	9,704	

		Discharges ¹				
DRG	Description	Number	Percent	Average LOS	Average Payment ²	Post-Acute Care DRG
Footnotes						
¹ Based on the stay records for 100% of Medicare aged and disabled beneficiaries as recorded in the MEDPAR file.						
² Average payments are calculated using actual dollar amount, not rounded data as shown.						
³ Added to Post-Acute Care DRG list in FY 1999 (10 Post-Acute Care DRGs)						
⁴ Added to Post-Acute Care DRG list in FY 2004 (29 Post-Acute Care DRGs)						
⁵ Added to Post-Acute Care DRG list in FY 2006 (182 Post-Acute Care DRGs)						
Source:						
MEDPAR based on 100% of Medicare beneficiaries, FY 2006						
Post-Acute Care DRG list from Federal Register, Volume 70 No. 155 (August 12, 2005), pages 47411-47420						