FREQUENTLY ASKED QUESTIONS ABOUT TRANSFER DRGS

1. What are Transfer DRGs and why are they relevant to acute care hospitals?

"Transfer DRGs" are a short-cut term for the post acute transfer (PACT) policy of Medicare.

Hospitals are paid for acute inpatient care of Medicare patients on the basis of diagnosis related groups (DRGs). For some DRGs, special rules have been created for patients who are discharged immediately following their hospitalization to a rehab hospital, skilled nursing facility, a long-term care hospital or home health care. These DRGs are what we call "Transfer DRGs."

2. ***Why did CMS create rules for Medicare patients who are transferred for post-acute care?***

"Transfer DRGs" are an outgrowth of the Balanced Budget Act of 1997. The Center for Medicare and Medicaid Services (CMS) devised them following several research projects. Studies revealed that in some DRGs, many patients were being transferred shortly after their admission to an acute hospital to other postacute care facilities. CMS assumes it was overpaying for these patients since they were paying the acute hospital at the full DRG rate, and then, in the postacute phase, paying a home health agency or rehab hospital the full amount under their payment rules.

3. ***How many DRGs are there? How many Transfer DRGs are there?***

- For FY06, which began on October 1, 2005, there are 559 DRGs*.
- Initially, there were 10 Transfer DRGs, beginning in FY99.
- By FY04, there were 29 Transfer DRGs.
- In FY06, the number of Transfer DRGs expanded from 29 to 182 DRGs.
- Thus, of the approximate 12M Medicare discharges per year, about 52% are in a Transfer DRG.

4. ***On what basis did CMS select which DRGs needed special payment rules?***

CMS has access to huge inpatient datasets that it acquires from Medicare fiscal intermediaries. CMS and research contractors identified several DRGs in which a high percent of patients were transferred from an acute hospital to another site for postacute care.

- For example, most patients with a stroke need rehabilitation after inpatient care. Physicians, patients, and CMS agreed that it is clinically appropriate and economically sensible for this care to be rendered in a rehab facility, home health care agency, SNF, or long-term care hospital.

- Another factor used to identify Transfer DRGs was the percentage of transferring patients who were "early discharges." An "early transfer" patient is one who is discharged more than 1 day sooner than the geometric mean length of stay of patients in that DRG. CMS noticed that in some DRGs, patients were being transferred after staying only for a short period in the acute hospital setting, and the hospitals were getting full DRG payment.

Of course, hospitals are given financial incentives to minimize Medicare patients' length of stay under prospective payment. However, such early transfers actually increased Medicare costs because Medicare was paying for care in both the acute and postacute settings.

5. How is a hospital penalized financially for a patient in a Transfer DRG?

A Hospital is penalized financially if a Medicare patient is an "early transfer" in a Transfer DRG.

- The reduction in payment follows a complicated formula that depends on the patient's actual length of stay (LOS) and the geometric mean LOS for that DRG.
- It is impossible for a hospital to increase its Medicare revenues; the best it can do is minimize its reduction in payments.

6. ***What is a "Transfer Adjusted Case"?***
Instead of counting the number of Medicare discharges for an acute hospital (in which each discharge is given a weight of 1.000), a patient in a Transfer DRG that receives Postacute care is given an "adjusted" weight of (1+LOS)/GMLOS for the Transfer DRG they are allocated to, which cannot exceed 1.000.

Thus, a hospital's "Transfer Adjusted Cases" will be less than its number of discharges.

7. ***How much is a hospital "penalized" or lose in revenue for an early transfer in a Transfer DRG? How we calculate a "transfer-adjusted case weight"?***
This is not a simple calculation! 169 of the 182 Transfer DRGs use what is called the **"STANDARD RULE":**

- For short-stay cases which involve a transfer, first calculate the transfer adjusted case value = (LOS +1)/GMLOS
- Transfer-adjusted case weight = DRGWT* (LOS +1)/GMLOS
- For example, suppose a case has a LOS of 2, was transferred to a skilled nursing facility, and is in a Transfer DRG with a GMLOS of 5.0 days, a relative weight of 7.25, and which uses the "standard payment rule."
- (2+1)/5 = 0.6. We say that the case has a "transfer adjusted case value" of .6. That case would count as 0.6 and the payment would be 7.25 * .6 = 4.35. The hospital's reduction in payment for this case would be 40%.

"SPECIAL RULE"
Thirteen of the 182 Transfer DRGs are covered by the "special payment rule." Suppose a case has a LOS of 3, was transferred to a skilled nursing facility, and is in a Transfer DRG with a GMLOS of 12.0 days, a relative weight of 10.2, and which uses the "special payment rule."

- First, we calculate the transfer adjusted case value, i.e., (LOS + 1)/GMLOS
- (3+1)/12 = 0.3333, which is the transfer adjusted case value.
- The "special pay" formula is .5*(1+transfer adjusted case value) = .5*(1+.3333) = .6667.
- And the transfer-adjusted case weight would be .6667*10.2 = 6.7998, which is a 33% reduction.

These are two extreme cases, but the impact of the Transfer DRG policy is to take revenue from every hospital.

CMS estimated that the 5-year savings of this policy are approximately $4B.

8. ***Which hospitals will suffer the most financially in FY06 from the Transfer DRG payment policy?***
We can see from the above scenarios and formulae that a hospital that has a high proportion of patients in Transfer DRGs and a high proportion of early transfers will be hurt the most from the new policy.

The Transfer DRGs will impact every hospital's bottom line. Investment analysts will ask: What will be the effect on publicly traded hospital companies' earnings in 2006? CMS has estimated an overall reduction in payments of 0.9%. However, the distributional effects will vary from hospital to hospital.

9. ***How much will my hospital lose in Medicare revenue?***
We have carefully reviewed the changes published in the Federal Register, and performed our analysis for all hospitals treating Medicare patients, based on Medicare's ~12M discharges in FY2004.

10. How can I estimate my hospital's Medicare losses in FY06 under Transfer DRGs?
It involves a long set of calculations. Here's what we did: for every hospital in the US treating Medicare patients and for every DRG, we created the following table:

- Short-stays, no transfer
- Short-stays, transfer
- Long stay, no transfer
- Long stay, transfer
- Total cases.

Even though 52% of all patients are in a Transfer DRG, most cases are not affected by the Transfer DRGs, because a payment reduction occurs only if ***all*** of the following conditions are met:

a. patient is in a Transfer DRG
b. patient was a "short-stay" or early discharge (LOS+1<GMLOS)
c. patient was transferred to either a SNF, home health care, rehab hospital, or LTC hospital

If conditions a-c are met, then we adjusted payment according to either the "regular payment rule" or "special payment rule."

We assumed that the number and mix of admissions and the transfer patterns in FY2006 will be the same as in FY2004. We also consider how a hospital responded in the past to the earlier ("old") set of Transfer DRGs.

11. How can I use SMA/Casemix Consulting analyses to minimize my hospital's Medicare losses in FY06 under Transfer DRGs?

We recommend a 3 step process.

- First, we estimate the total percent reduction in Medicare payments from the Transfer DRGs. If a hospital's FY2004 Medicare revenue was $10,000,000 and we estimate only a 0.5% reduction, that's only $50,000. It's probably not worth worrying about---but it's still a forecast that is comforting to know!

- But suppose a hospital's FY2004 Medicare revenue was $15,000,000 and we project a 2% reduction, i.e. $300,000. We would suggest a more detailed report, in which we pinpoint certain DRGs or Major Diagnostic Categories that are the source of the losses. It might require only a single meeting with a small number of physicians to educate them about Transfer DRGs and what they can do to solve most of the problems.

- A hospital that has an extremely high proportion of early transfers might consider examining its treatment protocols or even its coding procedures. It may be curious to learn to what it is doing that is leading to these remarkable results.

Finally, suppose a multi-hospital system with total Medicare revenue of $800,000,000 from 20 different facilities and estimated Medicare reductions of 1.25%, or $10,000,000. We can identify

system-wide problems and can recommend a consulting firm that can educate and monitor changes quickly.

12. Suppose I find that my hospital is projected to suffer almost no loss in revenue. Should we celebrate?

Not necessarily.

The Transfer DRGs could be a useful tool in another way. A hospital with very few early transfers might need to re-examine its length of stay controls and its transfer policies. A hospital that is keeping a large fraction of its Medicare patients longer than the Medicare geometric mean LOS may be losing money under prospective payment. It may need tighter utilization controls or consider partnering with other SNFs, home health agencies or rehab hospitals.

13. ***What are CMS's plans to further expand the number of Transfer DRGs?***

CMS has not ruled out the possibility of making the Transfer DRG rules applicable to all DRGs.

Many politicians have noted that the real fiscal challenge of the federal government is not Social Security, but it is Medicare. Both CMS and MedPAC have done analyses that involve more than 182 Transfer DRGs.

Efforts by various hospital lobbying groups were unsuccessful in 2005. Who knows what will happen in FY07? Managed care organizations may try to use a similar payment method to Transfer DRGs as it negotiates with hospitals. Only time will tell.