

Financial Impact of Medicare Transfer DRG Payment Policy



SMA / CMC Health Policy Institute

The national, regional and provider specific analysis of the Financial Impact of CMS Payment Regulations for Transfer DRGs, FFYs1999 to FFY 2006 presented in this report was developed by the SMA / CMC Health Policy Institute as a component of an ongoing, internally funded research program.

The SMA / CMC Health Policy Institute is a joint venture sponsored by [Strategic Medical Alliances, Inc](#) and Casemix Consulting LLC to develop detailed, provider specific, analyses of proposed and implemented federal and state healthcare payment policies. [Henry Dove PhD](#) founder of CMC has served as principal investigator for this project. James Janousek, served as Data Analyst Manager, for SMA Informatics.

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Published 2006 by SMA / CMC

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Central Issue for Understanding Impact of Medicare T DRGs Policy

What is a Transfer DRG?

For FFY 06 Medicare has instituted modified DRG payment policies designating 182 DRGs which will result in reduce DRG payments based on length of stay and discharge settings criteria.

The underlying assumption for CMS being that acute care hospitals should not receive full DRG payments for Medicare patients discharged 'early' --and then admitted for additional medical care in other clinical settings.

Import to Acute Care Hospitals

For FFY 06 Medicare payment reductions for short-stay discharges are forecast to average 0.9% of total Medicare reimbursement for the 155 newly designated DRGs nationwide.

Furthermore, the combined set of 182 DRGs subject to this modified payment policy, may result in payment reductions of as much as 3-10% of the standard Medicare DRG payment for certain DRGs at acute care hospitals with higher than normal numbers of "early or short-stay" discharges.



Origins of CMS Policy plus Regulations for Transfer DRGs

Policy Background

- The primary purpose of this report is to explain the impact of the Postacute Care Transfer payment policy for FFY 06 under the inpatient prospective payment system (iPPS) on hospital treatment decisions and Medicare expenditures. The CMS transfer payment policy became effective in FFY99 for an initial group of 10 DRGs. – (see Appendix I)
- The US Congress required HCFA (now CMS) through the Balanced Budget Act of 1997 to begin applying the T DRG payment methodology historically used to reimburse sending PPS hospitals for acute-to-acute care transfers to ten pilot DRGs for acute-to-Postacute care transfers.
- The **'standard' transfer DRG** payment methodology entails calculating a hospital-specific per diem for each DRG and paying hospitals twice the per diem on the first day plus the per diem for each additional day of inpatient care not to exceed the full DRG amount.
- For **'special transfer' DRGs** the payment methodology failed to cover average costs, CMS reimburses hospitals the per diem plus half the full DRG amount on the first day and half the per diem for each additional day up to the full DRG amount.
- Given the way in which the per diem payment amount is calculated, DRG payment amounts are reached at lengths of stay one day less than the national geometric mean length of stay for each DRG.
- CMS expanded the list of DRGs subject to the Transfer rules to 30 for FFY04 –(see Appendix II)



CMS Regulations for Transfer DRGs for FFY 06

Regulations for FFY 06

- Final CMS regulations dated August 12, 2005 set forth the following criteria for transfer DRGs—(see Federal Register, page 47419.)
 - The DRG has at least 2,050 Postacute transfer cases nationwide.
 - At least 5.5% of the cases in the DRG are discharged to Postacute care prior to the GM LOS
 - The DRG has a geometric mean LOS of at least 3.0 days
- CMS defines a “transfer” as a discharge of a Medicare eligible hospital inpatient to any of the following:
 - hospital or distinct part hospital united excluded from the PPS system
 - skilled nursing facility
 - to a home under a written plan of care for home health services beginning within 3 days of discharge.....
- Calculation of the geometric mean length of stay - GMLOS is
$$\text{GMLOS} = \exp\{[\sum (\ln \text{LOS})]/n\}$$
- A total of 182 DRGs for FFY 06 are classified as Postacute Transfer DRGs- (see Appendix III)
- Transfer DRG policy does not apply to acute care hospitals designated as SCH, CAH, MDH, RRC, and EACHS.



National Impact

Estimate of National Impact of Transfer DRGs FFY 06

Percent of Discharges

- CMS estimates a total of 12,300,000 Medicare discharges during FFY 06.
- For the relevant IPPS acute care hospitals the 182 Transfer DRGs account for 6,828,000 discharges or 62 % of the total number of Medicare discharges.
- The SMA / CMC forecast of FFY 06 total “short-stay transfers” (based on utilization patterns described by the Med Par FFY 2004 data file) for all acute care hospitals, predicts that 685,515 or 10.1% of the total Medicare discharges will be classified as ‘short stay.’ and therefore subject to reduced payment policy.

Estimated National Financial Impact

- CMS Impact Analysis suggests that the total financial impact of the 155 new DRGs in the FFY 06 Transfer DRG set will be approximately \$1.1B or 0.9% of total annual Medicare IPPS expenditures for acute care hospital services.
- The combined financial impact of the entire set of 182 T DRGs, composed of all currently used DRGs designated in 1999, 2004 and 2006, is estimated to be more than \$2B in FFY 06.



SMA / CMS Study Methodology Overview

Objective

- To estimate the financial impact of the list of DRGs reimbursed according to CMS's postacute transfer rules.

Work Plan

- Our initial study strategy was to follow the logic used by CMS professional staff who had estimated the financial impact of the new CMS postacute transfer policy for each hospital.
- We utilized a version of the MedPAR 2004 data file; however, the MedPAR file can change slightly overtime. The records in the file that CMS used when they performed their analysis probably differed slightly from the MedPAR 2004 data which we used. Neither CMS nor we made any assumptions about "behavioral offset."
- CMS forecast the financial impact of the new transfer payment rules only at the facility level.
- We also forecast the impact on FY06 for each acute inpatient facility. In addition, we used a more detailed analysis which enabled us to account for the reduction in Medicare payments by DRG, for each facility.
- We obtained the list of the 155 DRGs which would come under the postacute transfer methodology effective October 1, 2005. {We refer to these as the "new Transfer DRGs" or "new TDRGs."} We noted which followed the "standard" Postacute payment rule and which used the "special" payment rule.
- We used the V21 Federal DRGs, following CMS's analysis strategy. We assumed that the Medicare patient load, casemix and discharge patterns a facility experienced in FY04 would remain the same in FY06. For each record in the MedPAR 2004 data file, we studied only those patients who met the following criteria:
 - Was in a "new" or "old" Transfer DRG;
 - Received postacute care (based on their "destination discharge" code) using the same codes used by CMS
 - Were discharged at least one day prior to the geometric mean LOS for that DRG.



SMA / CMS Study Methodology Overview

- We confirmed our study logic by comparing the impact calculated for each hospital against that estimated by CMS. This analysis was performed at the hospital level and the minor differences which we noticed were attributable to differences in the Med PAR files.
- After verifying that our logic was correct (given that our internal results matched those of CMS), we then used the DRG assignment using the V23 Grouper, and the corresponding relative weights and geometric mean length of stay.
- We calculated the reduction in DRG relative weights for each case and the “transfer-adjusted case value.” To convert the reduction in relative weight to a monetary value, we used the hospital-specific payment value based on the operating and capital “pricer.”

Study Outputs

By noting which of the DRGs were “old” TDRGs {which were paid using CMS’s Postacute transfer payment rules prior to FY06} and which were “new” TDRGs, we were able to isolate the impact of Postacute transfer payments for the “new” 155 TDRGs and the “old” 27 TDRGs.

Our more detailed data analysis strategy enabled us to summarize the impact for a given acute inpatient facility by DRG, product line, and MDC. We extended our analysis by aggregating our results to the state and regional levels, based on an algorithm that maps each Medicare Provider Number into the appropriate state and region.



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