Only Slight Changes Seen for Transfers Under Proposed IPPS Regulations

Proposed changes to the Medicare inpatient prospective payment system (IPPS) by the Centers for Medicare and Medicaid Services (CMS) would significantly affect how hospitals are reimbursed for FY2008. These changes include the continued phase-in of relative weights based on hospital-specific costs and new Medicare severity-adjusted DRGs (MS-DRGs). The regulations would redistribute revenues among medical services and profoundly affect the bottom line for many hospitals.

Since the new MS-DRGs could effect reimbursement for transfers, this study was conducted to measure the extent of any such impact. The complexity of the IPPS makes it difficult to gauge the effects of changes to a particular component of the payment system. Some components are patient-specific, some are hospital-specific, and some are interrelated with other components. It is also difficult to measure the effects for particular types of cases such as transfers. The system includes numerous technical adjustments based on factors such as local area wage differences, a hospital's indigent caseload, and whether a hospital has a teaching program. The system also allows additional payment for cases that are unusually costly, referred to as "outlier" cases.

This analysis is based on the preliminary FY2006 MedPAR file that CMS used in promulgating the proposed regulations for FY2008. More than 3,700 short term acute care hospitals were included representing approximately $110 billion in IPPS payments per year. IPPS payment was then computed on a patient-by-patient basis under existing and/or proposed payment regulations for respective fiscal years. Each component of reimbursement was included in calculating payment: the respective DRG definitions, relative weights, hospital blended rate, capital payments, outlier payments, DSH adjustments, IME adjustments, transfer adjustments, etc.

Under the Medicare IPPS, reimbursement is reduced for certain cases that are transferred to other facilities for continuing care. These cases may include patients requiring treatment in facilities not available at the admitting hospital or those sent to another facility for post acute care.

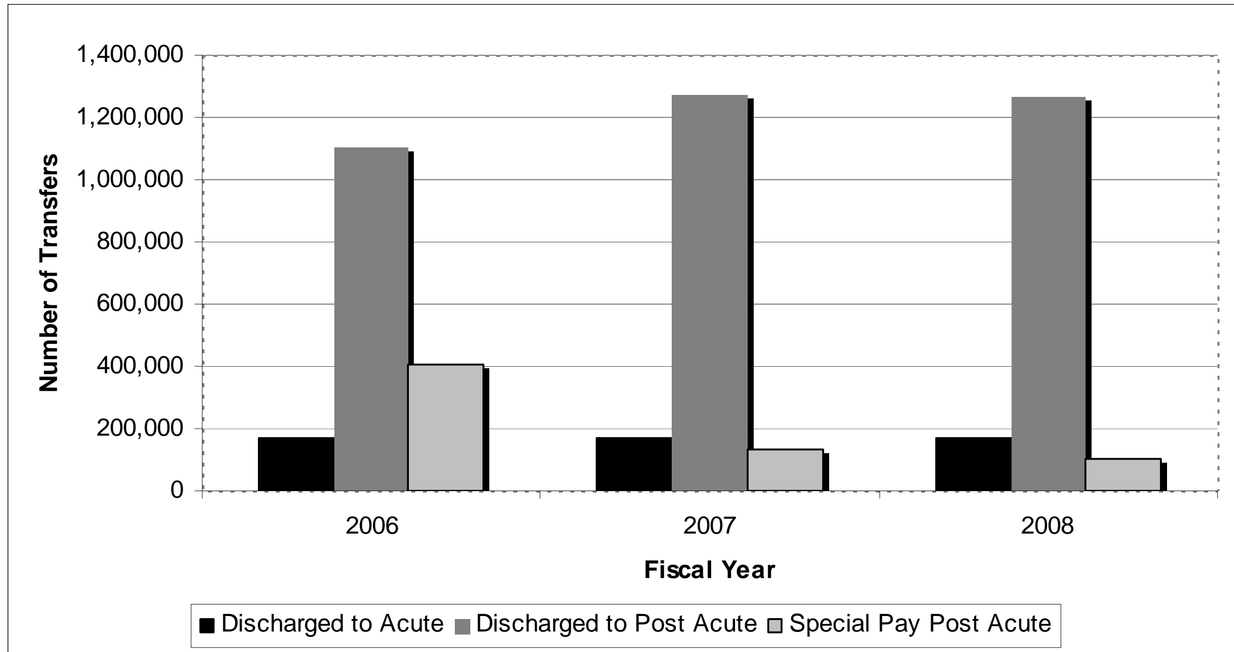
There are three types of effected transfers. For these cases, reimbursement is reduced on a case if the covered days preceding the transfer are less than the published Geometric Mean Length of Stay (GMLOS) of the assigned DRG. Reimbursement is based on a per diem rate that is calculated as a hospital's normal reimbursement for the DRG divided by the GMLOS.

- Transfers to another acute care hospital
- Designated DRGs transferred to a post acute care setting
- Designated special pay DRGs transferred to a post acute care setting

For transfers to another acute care hospital and for designated DRGs transferred to a post acute setting, the hospital receives double the per diem rate for the first day of stay plus the per diem rate for each subsequent day prior to the transfer. For special pay DRGs transferred to a post acute setting, the hospital receives the per diem rate for the first day plus one-half the per diem rate for each subsequent day prior to the transfer.

The difference between the normal DRG payment and the per-diem payment is referred to as the *transfer adjustment*. The study revealed that from FY2007 to FY2008 there was little change in the number of discharges or the average transfer adjustment for each of three types of transfers.

Exhibit 1 - National trends in number of transfers by type



Projections were further detailed to show the frequency of transfers by medical service and the percentage change in transfer adjustments from FY2007 to FY2008.

Exhibit 2 - Projected adjustments for transfers (all types)

	FY2007				FY2008				
	Total	Adjusted Transfers			Total	Adjusted Transfers			
	Discharges	#	%	$ (million)	Discharges	#	%	$ (million)	% Chg
Medical Service									
Pulmonology	1,645,247	199,781	12.1%	-$1,145.9	1,645,251	226,977	13.8%	-$1,112.7	-2.9%
Orthopedics	1,409,446	385,217	27.3%	-$1,238.6	1,398,273	396,646	28.4%	-$1,047.7	-15.4%
Surgery	775,277	106,599	13.7%	-$568.0	789,498	103,785	13.1%	-$609.2	7.3%
Cardiovascular Surg	839,876	50,678	6.0%	-$484.6	839,876	58,066	6.9%	-$513.1	5.9%
Medicine	3,030,912	272,118	9.0%	-$366.1	3,027,171	258,679	8.5%	-$377.6	3.1%
Cardiology	1,540,837	220,921	14.3%	-$292.4	1,540,836	213,814	13.9%	-$293.5	0.4%
Urology	761,022	117,405	15.4%	-$126.2	746,599	107,309	14.4%	-$136.3	8.0%
Neurology	705,854	132,547	18.8%	-$138.6	705,852	109,926	15.6%	-$135.8	-2.0%
Neurosurgery	66,444	12,265	18.5%	-$76.8	66,509	9,026	13.6%	-$73.8	-3.9%
Oncology	248,741	21,779	8.8%	-$49.0	248,540	14,708	5.9%	-$36.8	-24.9%
Vascular Surgery	268,447	17,367	6.5%	-$72.1	268,381	5,521	2.1%	-$24.5	-66.0%
Psychiatry	177,695	20,494	11.5%	-$24.2	177,694	14,747	8.3%	-$12.8	-47.1%
Surg for Malignancy	48,902	1,048	2.1%	-$5.0	81,337	206	0.3%	-$1.4	-72.0%
Gynecology	113,512	230	0.2%	-$0.5	96,395	203	0.2%	-$0.4	-7.8%
Burns	4,499	81	1.8%	-$0.4	4,499	77	1.7%	-$0.4	9.8%
TOTAL	11,653,416	1,558,695	13.4%	-$4,588.5	11,653,416	1,519,851	13.0%	-$4,376.3	-4.6%

Though the study did not identify any onerous changes in transfer reimbursement under the IPPS regulations proposed for FY2008 it may be useful for hospitals to compare their own experiences to the $4.4 billion in transfer adjustments projected for FY2008. It may also be useful to compare utilization differences among medical services and the relative frequency of various types of transfers.

TECHNICAL NOTES:
Data are based on the FY2006 MedPAR, December file. This is a file of 100% of all Medicare fee-for-service claims representing discharges during the 12 months ending September 30, 2006 and billed as of 12/31/2006. This is the same file used by CMS in promulgating the proposed IPPS regulations for FY2008. Only short-term acute care hospitals were included and hospitals were excluded if they did not have sufficient data to project IPPS for the periods studied. Hospitals were also excluded if their teaching status could not be determined from cost report information. No adjustments were made to the data to account for inflation among the periods and no adjustments were made to disregard the "behavioral offset" proposed by CMS for FY2008.

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