Reduced Transfer Adjustments Forecasted Under New MS-DRGs

Changes to the Medicare Inpatient Prospective Payment System (IPPS) significantly affect how hospitals will be reimbursed for FY 2008. 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 redistribute revenues among medical services and may profoundly affect the bottom line for some hospitals.

Since the new MS-DRGs definitions 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 FY 2006 MedPAR file that CMS used in promulgating the final regulations for FY 2008. More than 3,400 short term acute care hospitals were included representing more than $100 billion in IPPS payments per year. IPPS payment was computed on a patient-by-patient basis under existing and new payment regulations for respective fiscal years. Each component of reimbursement was included in calculating payment: the respective DRG definitions, relative weights, hospital blended rates, 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.

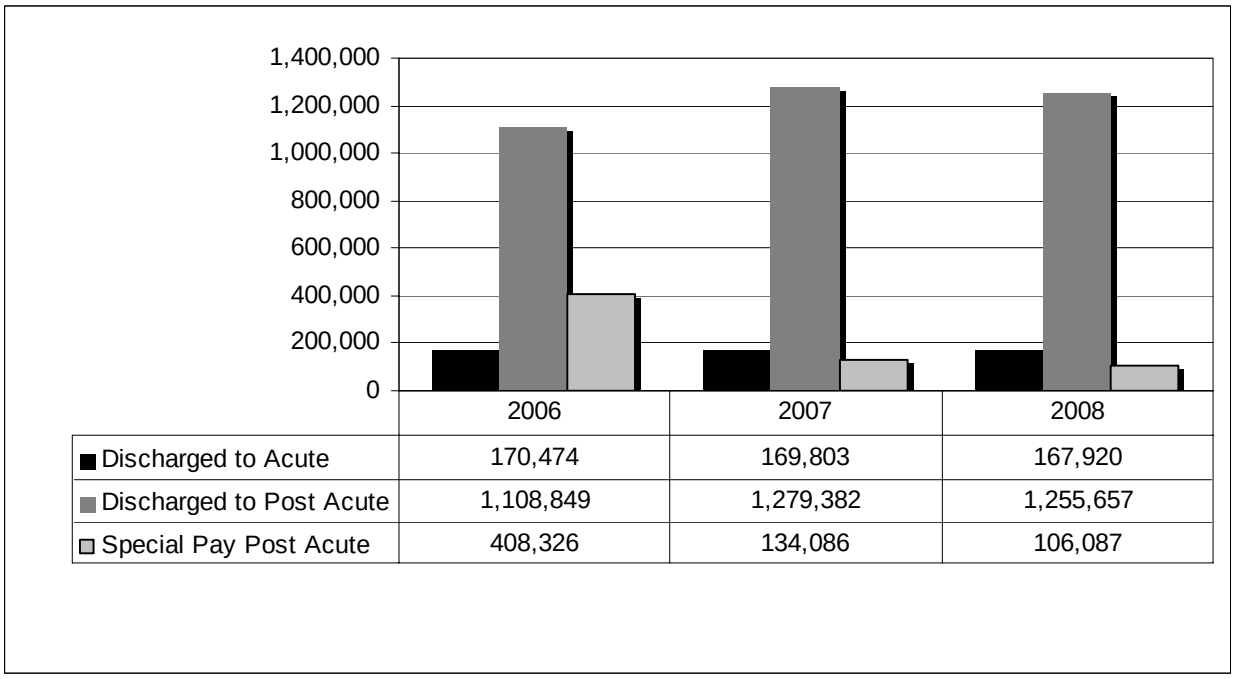
There are three types of effected transfers. For these cases, reimbursement is reduced on a case if the covered days preceding the transfer are less than the published Geometric Mean Length of Stay (GMLOS) of the assigned DRG. Reimbursement is based on a per diem rate that is calculated as a hospital's 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 half the total IPPS payment plus the per diem rate for the first day and then one-half the per diem rate for each subsequent day prior to the transfer. (For all three types of transfers, the transfer payment cannot exceed the full MS–DRG payment amount.)

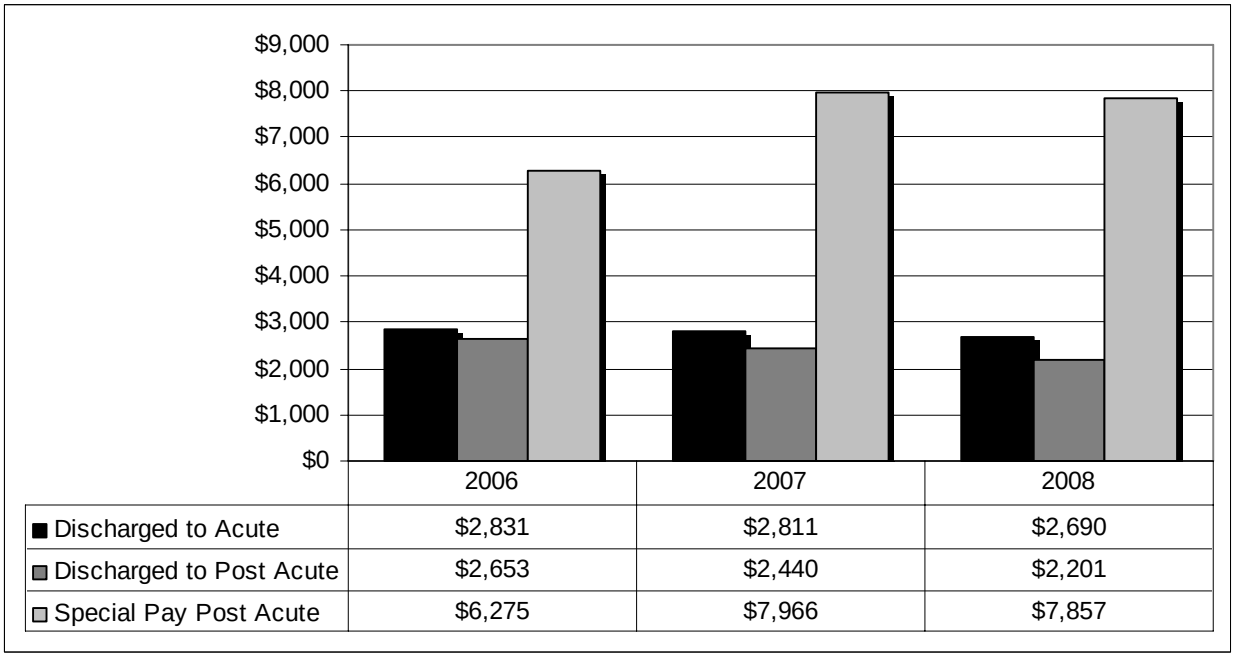
The difference between the normal DRG payment and the per-diem payment is referred to as the *transfer adjustment*. The study revealed that from FY 2007 to FY 2008 there are reductions in both the number of cases receiving transfer adjustments and in the average transfer adjustment amount for each of the three types of transfers.

Exhibit 1 - National trend in number of transfers by type



	2006	2007	2008
Discharged to Acute	170,474	169,803	167,920
Discharged to Post Acute	1,108,849	1,279,382	1,255,657
Special Pay Post Acute	408,326	134,086	106,087

Exhibit 2 - National trend in average transfer adjustment amount per case by type



	2006	2007	2008
Discharged to Acute	$2,831	$2,811	$2,690
Discharged to Post Acute	$2,653	$2,440	$2,201
Special Pay Post Acute	$6,275	$7,966	$7,857

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 3 - Projected adjustments for transfers (all types) by Medical Service

	FY2007				FY2008				
	Total	Adjusted Transfers			Total	Adjusted Transfers			
	Discharges	#	%	$ (millions)	Discharges	#	%	$ (millions)	% Chg
Medical Service									
Surgery	888,230	140,663	15.8%	-$1,350.3	901,010	125,055	13.9%	-$1,165.3	-13.7%
Orthopedic Surgery	1,052,965	325,054	30.9%	-$1,170.6	1,052,965	318,858	30.3%	-$920.7	-21.4%
Cardiovascular Surg	828,030	50,003	6.0%	-$481.9	828,030	54,752	6.6%	-$473.9	-1.7%
Pulmonology	1,479,441	161,361	10.9%	-$350.5	1,479,465	190,901	12.9%	-$326.6	-6.8%
Medicine	2,424,584	240,617	9.9%	-$332.6	2,424,856	225,975	9.3%	-$311.0	-6.5%
Cardiology	2,029,936	240,394	11.8%	-$309.7	2,029,979	227,162	11.2%	-$274.5	-11.4%
Urology	729,769	115,309	15.8%	-$124.3	730,178	106,561	14.6%	-$120.6	-3.0%
Neurology	691,287	130,123	18.8%	-$137.0	691,298	106,955	15.5%	-$117.8	-14.0%
Neurosurgery	73,545	13,329	18.1%	-$82.5	73,620	11,572	15.7%	-$86.0	4.2%
Orthopedics	325,888	52,409	16.1%	-$50.0	325,891	75,316	23.1%	-$60.0	20.0%
Oncology	244,095	21,405	8.8%	-$48.2	243,922	13,659	5.6%	-$33.9	-29.7%
Vascular Surgery	264,160	17,115	6.5%	-$71.6	264,085	4,587	1.7%	-$23.1	-67.8%
Psychiatry	169,758	19,969	11.8%	-$23.7	169,763	14,432	8.5%	-$11.4	-51.9%
Surgery for Malig	110,097	1,120	1.0%	-$5.3	94,950	214	0.2%	-$1.2	-76.6%
Gynecology	90,593	176	0.2%	-$0.3	92,356	200	0.2%	-$0.4	27.1%
TOTAL	11,423,559	1,529,290	13.4%	-$4,539.0	11,423,559	1,476,438	12.9%	-$3,926.9	-13.5%

The table shows reclassification of patients among Medical Services that are projected to occur due to changing regulations. It further shows significant changes in the number of transfers for some medical services due to changing transfer thresholds associated with the new MS-DRGs.

Though the study does not reveal any onerous changes in transfer reimbursement under the IPPS regulations for FY 2008 it may be useful for hospitals to compare their own experiences to the approximately $4 billion in transfer adjustments projected for FY 2008. 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, March 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 2/28/2007. This is the same file used by CMS in promulgating the final 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. 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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