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Summary on Medicare Transfer DRGs

The Medicare Prospective Payment System (PPS) was introduced by the federal government in October 1983, as a way to change hospital behavior through financial incentives that encourage more cost-efficient management of medical care. Under PPS, hospitals are paid a pre-determined rate for each Medicare admission. Each patient is classified into a Diagnosis Related Group (DRG) on the basis of clinical information. Except for certain patients with exceptionally high costs (called outliers), the hospital is paid a flat rate for the DRG, regardless of the actual services provided. Each Medicare patient is classified into a Diagnosis Related Group (DRG) according to information from the Medical Record that appears on the bill:

- Principal Diagnosis (why the patient was admitted)
- Complications and Comorbidities (CCs - other secondary diagnoses)
- Surgical Procedures
- Age
- Gender
- Discharge Disposition (routine, transferred, or expired)

There are 559 DRG categories defined by the Centers for Medicare and Medicaid Services (CMS, formerly known as HCFA). Each category is designed to be "clinically coherent." In other words, all patients assigned to a DRG are deemed to have a similar clinical condition. The Prospective Payment System is based on paying the average cost for treating patients in the same DRG.

Each year CMS makes technical adjustments to the DRG classification system that incorporates new technologies such as laparoscopic procedures and refine its use as a payment methodology. CMS also initiates changes to the ICD-9-CM coding scheme. The DRG assignment process is computerized in a program called the Grouper that is used by hospitals and fiscal intermediaries.

Each year CMS also assigns a relative weight to each DRG. These weights indicate the relative costs for treating patients during the prior year. The national average charge for each DRG is compared to the overall average. This ratio is published annually in the Federal Register for each DRG. A DRG with a weight of 2.0000 means that charges were historically twice the average; a DRG with a weight of 0.5000 was half the average.

Top 10 DRGs

The ten highest volume Medicare DRGs represent about 30% of total Medicare patients. Each of these higher volume DRGs represent about 2% to 6% of total Medicare volume:

	DRG	DRG Description	% Total	Rel Wt
1	127	Heart Failure & Shock	5.99	1.0234
2	089	Simple Pneumonia & Pleurisy Age>17 w/CC[1]	3.85	1.1447
3	014	Specific Cerebrovascular Disorders except TIA	3.18	1.2056
4	430	Psychoses	3.18	0.9153
5	088	Chronic Obstructive Pulmonary Disease	3.11	1.0067
6	209	Major Joint & Limb Reattachment Procedures, Lower Extremity	2.78	2.3491
7	140	Angina Pectoris	2.33	0.6241
8	182	Esophagitis, Gastroent & Misc Digest Disorders Age>17 w/CC[1]	2.09	0.7617
9	174	G.I. Hemorrhage w/CC[1]	2.07	0.9657
10	296	Nutritional & Misc Metabolic Disorders Age>17w/CC[1]	1.93	0.9313

Note: "CC" signifies a significant complication or comorbidity
Source: Health Care Financing Administration, 1994.

Transfer DRGs

For some DRGs, special rules have been created for patients who are discharged immediately following their hospitalization to a rehabilitation hospital, SNF or home health care. These DRGs are what are referred to as "Transfer DRGs," an outgrowth of the "Balance Budget Act" of 1997. Initially, there were only 10 Transfer DRGs beginning in FY 1999. This was increased to 29 Transfer DRGs in FY 2004 before being expanded to 182 Transfer DRGs as of October 1, 2005. As per information provided by the Center for Medicare and Medicaid Services ("CMS"), there are approximately 12 million Medicare discharges per year nationally, with about 52% being Transfer DRGs.

CMS has access to the inpatient datasets, which it acquires from the Medicare fiscal intermediaries. CMS and CMS contracted researchers identified several DRGs, which contained the highest percentage of patients transferred from an acute hospital to alternative sites for post-acute care. One example quoted by CMS was the need for most patients with a stroke to have rehabilitation in a long term care setting.

A hospital is financially penalized by CMS through Medicare for an "early transfer" of a patient classified in one of the Transfer DRGs. An early transfer patient is one who is discharged more than one day sooner than the geometric mean LOS ("GMLOS") of patients in that DRG. Hospitals are given financial incentives to minimize Medicare patient's LOS under the prospective payment system. However, these early transfers actually increase Medicare costs because Medicare was paying for care in both the acute and post-acute settings.

The reduction in payment to hospitals for early transfer follows a complicated formula, depending on the patients actual LOS and the GMLOS for that DRG. It is impossible for a hospital to increase Medicare revenues, the best they can do is minimize its reduction in payments. To avoid improperly billing for discharges, hospitals should pay particular attention to the CMS post-acute care transfer policy and keep an accurate list of all designated DRGs subject to that policy (OIG 2005, 13-14).

The per diem rate paid to a transferring hospital is calculated by dividing the full DRG payment by the geometric mean length of stay for the DRG. Based on an analysis that showed that the first day of hospitalization is the most expensive (60 FR 45804), the CMS policy provides for payment that is double the per diem amount of the first day (Section 412.4(f)(1)). The purpose of the IPPS transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital early in their stay in order to minimize costs while still receiving the full DRG payment. The transfer policy adjusts the payment to approximate the reduced costs of transfer cases. See 70 FR 23411 (May 4, 2005). Therefore, for both early transfers and patients that exceed the reimbursed LOS, the hospital has an incentive to discharge patients as soon as clinically appropriate in light of the Transfer Discharge Policy since the reimbursement is capped and expenses continue for as long as the patient remains at the hospital. Transfer cases are also eligible for outlier payments. The outlier threshold for transfer cases is equal to the fixed-loss outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the case, plus one day.

Again, hospitals are "penalized", or revenues are lessened, for the early transfer of a patient in a Transfer DRG. This is a complex calculation by CMS, applicable to 169 of the current 182 Transfer DRGs.

It has been estimated that the changes from FY 2004 Medicare to FY 2006 have reduced Medicare revenue by $10 million per hospital nationwide. Addressing early transfers, based on FY 2004 Medicare revenues of $10 million, projecting a 2% reduction would result in $200,000 savings to the hospital.

Conclusion

Improving Post Acute discharge options through expanded relationships with other providers will result in substantial savings on expenses for early transfers and patients whose stay exceeds the targeted LOS reimbursed for a particular DRG, as evidenced by separate analysis by Senior Consulting (see other summary information).