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Exploring the Impact of Medicare's Post-Acute Care Transfer Payment Policy on Rural Hospitals

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Beginning in October 1998, Medicare began to pay acute-care hospital cases in 10 DRGs as transfers instead of discharges when the patient is discharged to a targeted post-acute care (PAC) provider after a short inpatient stay. These PAC providers currently include skilled nursing facilities (SNFs), home health agencies, and PPS-excluded facilities and distinct-part units. In October 2003, after several years of debate, this policy was extended to an additional 21 DRGs, and 2 of the original 10 DRGs were excluded. The Secretary is authorized to extend the policy to additional DRGs and PAC settings in future years.

The PAC transfer policy was enacted in response to concerns that the Medicare program had begun paying twice for some services, as services that had traditionally been provided in the inpatient setting (and captured in the inpatient base payment rates) have moved to PAC settings (generating separate Medicare payments). This policy attempts to recognize these shifts in the site of care, and to better align Medicare's inpatient payments with the scope of services now being provided in that setting.

The hospital industry has been critical of the transfer policy since its inception, saying that it undermines the averaging principle of inpatient PPS by reducing the profit potential for short stays while leaving the risk of losses from long stays. Rural advocates have noted that the detrimental financial impact of an expensive, long-stay case may be even greater for many rural hospitals due to their lower volume of cases over which to average any losses. Additionally, rural hospitals are more dependent on Medicare, so that any reductions in Medicare revenue are harder to offset through other sources.

Observers have also noted that the transfer policy may affect rural hospitals differently because of geographic variation in the types of patients treated

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and their average length of stay, as well as differences in the availability and use of PAC providers. The net impact of these influences is not known, however, and is not necessarily detrimental to rural hospitals. In general, rural areas have a lower supply of traditional PAC providers (apart from swing beds), but the mean length of stay (LOS) in 1998 was lower in rural hospitals for 8 of the 10 original DRGs targeted by this policy. Thus, it appears that rural hospitals will be somewhat less likely to discharge patients to PAC settings, but that any such discharges may be more likely to occur after a short hospital stay.

Of further potential concern for small rural hospitals is the possibility that the Secretary may extend the policy to cover discharges to swing beds. While the proposed rules for initial implementation of the policy included swing beds, the Secretary responded to concerns about a possible adverse impact on small rural hospitals and decided not to include swing beds at that time. In the final rules for FY2003, however, the Secretary reiterated the Department's intent to re-evaluate this decision.

Study Methods

We used the 100% MEDPAR files from CY 1998 through 2001 to examine behavioral and payment changes resulting from the initial 10-DRG policy, and to investigate the likely financial impact of an expansion of this policy to additional DRGs or to swing beds. Discharges to a SNF, PPS-excluded facility/unit, or swing bed were confirmed by matching the hospital discharge with a corresponding PAC admission on the same day. Only patients for whom a match could be found were included in this study. Due to data constraints, we relied exclusively on the hospital's discharge coding to identify discharges to home health care. Patients were flagged as 'short-stay' patients if their inpatient LOS was more than one day shorter than the geometric mean LOS for the DRG. Given the way payments are calculated under the PAC transfer policy, only these short-stay cases receive less than the full DRG amount – hence, these cases are referred to as transfer cases. All other discharges from the targeted DRGs receive the full DRG payment, even when the patient is sent to a PAC provider. Hospitals were classified as urban or rural based on the 1995 rural/urban continuum code corresponding to the hospital's county.

We used the first 9 months of data from 1998 (before the policy was implemented) and corresponding periods for each of the three years after the policy went into effect to examine pre/post trends in hospital discharge behavior. Trends for the 10 target DRGs were compared with 11 other 'control' DRGs exhibiting high PAC use and previously considered as possible targets for the PAC transfer policy. We used FY 1998 data to simulate the changes in Medicare revenue that would have been expected if the transfer policy had been in effect in that year (assuming hospitals made no behavioral adjustments), and data from 1998 through 2001 to examine the pre/post trends in actual Medicare revenue for the 10 target DRGs. To predict the effects of possible policy expansions, we used FY 2001 data to simulate the payments that would have been made if the transfer policy had applied to additional DRGs or to discharges to swing beds. Consistent with

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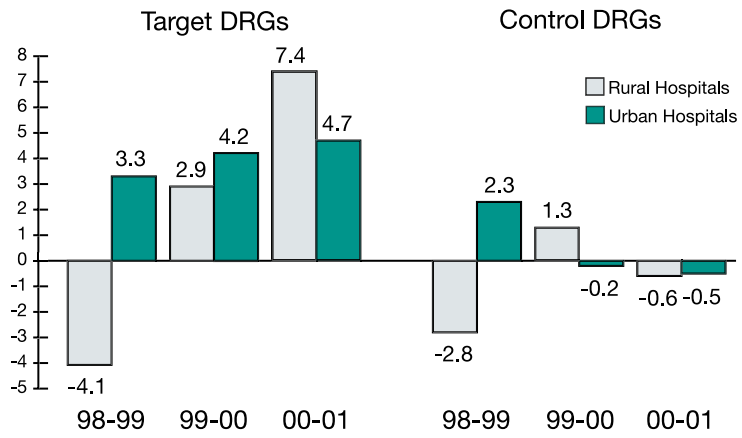
the policy options under consideration at the time this analysis was completed, we considered expansion to 19 additional DRGs and to all DRGs. For the investigation of a swing-bed expansion, we considered swing-bed transfers from the original 10 DRGs, the 19 possible expansion DRGs, and all DRGs.

Key Findings

Behavioral Response to the Initial Policy

Most of our investigations indicate that hospitals' discharge behavior did not change significantly in ways that would suggest a strategic response to the PAC transfer payment policy. While *Figure 1* shows that rural hospitals decreased the share of short-stay PAC transfer cases in the 10 target DRGs by 4 percent in the first year after the payment change took effect, a similar pattern was observed for the control DRGs, suggesting that something other than the PAC transfer policy was responsible for these declines. Furthermore, after this initial decline, the proportion of rural short-stay PAC transfers began to climb for the target DRGs, while the share for control DRGs increased at a slower pace or even declined. Urban hospitals saw their short-stay PAC use for the target DRGs grow continually throughout the post-implementation period, outpacing the changes for control DRGs in every year. Thus, neither rural nor urban hospitals appear to have reduced their short-stay PAC transfers in an attempt to avoid payment reductions under the new policy.

Figure 1. Annual Percent Change in Discharges to PAC Settings after a Short Stay



Financial Impact of the Initial Policy

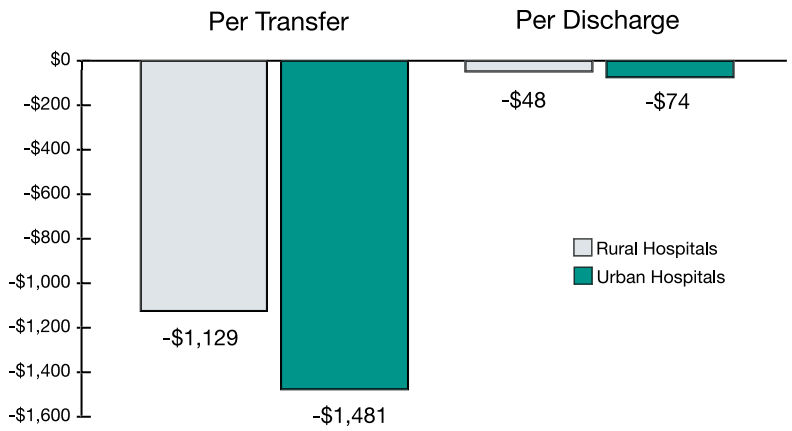
Our simulation of the financial impact of the initial policy indicates that, absent any behavioral response, rural hospitals could expect their Medicare revenue to fall by more than $1,200 for each transfer from these 10 DRGs, and by nearly $300 for each discharge (including non-transfers). The anticipated reductions for urban hospitals were larger in absolute terms, but fairly similar in relative terms. Analysis of actual Medicare revenue trends confirmed these large revenue declines in the period immediately following the payment change, in approximately the magnitude that was projected based on our simulations (supporting the finding of a minimal strategic behavioral response by hospitals). In particular, rural hospitals received an average of $1,275 less in Medicare revenue for each PAC transfer case in 1999 than in 1998, and about $200 less for each discharge from the 10 DRGs. The comparable figures for urban

hospitals were $1,600 per transfer and about $400 per case.

Expected Impact of Expanding Policy to Additional DRGs

Our simulation analysis permits us to make an educated guess regarding the likely impact of the recent expansion of the PAC transfer policy to 21 additional DRGs; 17 of the 19 DRGs studied were included among the 21 DRGs targeted by the expansion. Based on FY 2001 patterns of care, we estimated that less than 5 percent of all cases discharged from these 19 DRGs would receive the PAC transfer payment instead of the full DRG payment. The proportion of transfer cases was slightly lower in rural hospitals than in urban hospitals (4.3 vs. 5.0 percent), reflecting the lower availability and use of PAC providers in rural areas. We expect the Medicare revenue earned by rural hospitals to fall by more than $1,100 for each transfer case (*Figure 2*). Due to the relatively small number of transfer cases, however, the average revenue decline per discharge is expected to be under $50. While larger absolute declines are expected for urban hospitals, the relative drop in revenue per discharge is similar.

Figure 2. Projected Reductions in Medicare Revenue from Expansion of Transfer Policy to 19 Additional DRGs



Expected Impact of Expanding Policy to Cover Discharges to Swing Beds

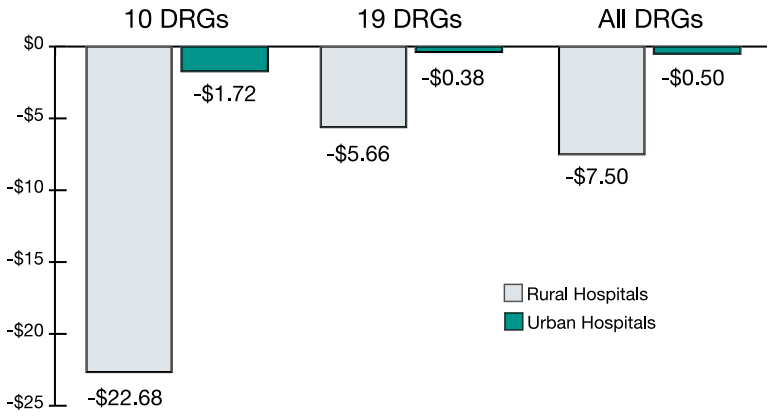
We project relatively small financial impacts if the Secretary ever extends the transfer policy to cover discharges to swing beds. These small impacts arise primarily because the use of swing beds is low for most hospitals—particularly following a short inpatient stay.

Across all hospitals and all DRGs, we found that only 0.2 percent of discharges would be paid as swing-bed transfers under an expanded policy. Although swing bed use is higher among rural hospitals and hospitals with fewer than 50 beds, even these types of facilities discharge a very small proportion of their total patients to swing beds after a short stay. Under a policy that expands the transfer policy to swing bed discharges from all DRGs, for example, we estimate that less than 1 percent of the cases treated in rural hospitals, and less than 2 percent of the cases in hospitals with under 50 beds, would be paid as swing-bed transfers.

Depending on the DRG, revenue reductions were estimated to range from several hundred to several thousand dollars for each swing-bed transfer. The reductions expected for the average discharge were projected to be extremely small, however, since so few discharges are swing-bed transfers (*Figure 3*). The relatively higher

rate of swing-bed transfers for rural hospitals means that these hospitals would expect larger reductions in Medicare revenue per case than their urban counterparts. Even then, however, the reductions for rural hospitals still amount to only 0.1 to 0.3 percent of the total revenue that would have been received in the absence of a swing-bed transfer policy (depending on the DRG group under consideration). Of course, small rural hospitals that make heavy use of their swing-bed capacity after short acute-care stays would expect to see larger reductions in revenue per case.

Figure 3. Projected Reductions in Medicare Revenue per Discharge under an Expansion to Swing Bed Discharges



Discussion

Neither rural nor urban hospitals appear to have changed their discharge behavior significantly in response to the initial PAC transfer policy, and both types of facilities experienced similar relative declines in their Medicare revenue as a result of that payment change. If anything, rural hospitals have seen slightly smaller drops in revenue relative to their urban counterparts. We expect both types of hospitals to be affected similarly by the newly-expanded policy, as well.

While a possible expansion to cover discharges to swing beds would have a larger financial impact on small rural hospitals, even those impacts will be quite muted, on average. Since swing bed discharges must be preceded by an inpatient stay of at least 3 days, and because PAC discharges are paid as transfers only when their inpatient LOS is more than 1 day shorter than the GMLOS for the DRG, only patients in DRGs with a GMLOS above 4 days would ever be paid as swing-bed transfers. In FY 2004, only about one-third of all DRGs have a GMLOS above 4 days. Thus, only hospitals that make extremely heavy use of swing beds early in the acute-care episode for patients in these DRGs would expect to see appreciable reductions in Medicare revenue.

Under the PAC transfer policy, the annual recalibration of DRG weights treats transfer cases as partial cases. Since transfer cases have lower inpatient costs, on average, this recalibration usually results in a higher DRG weight – and a higher DRG payment – for non-transfer cases.

It is also worth noting that although the hospital earns less Medicare revenue when a case receives a transfer payment rather than the full DRG payment, an analysis of the initial 10 DRGs showed that the per diem payments were still generally sufficient to cover the hospital's costs. Thus, this policy does not result in absolute losses so much as it reduces the profitability of treating transferred patients.

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For hospitals already facing severe financial pressures, such as many rural hospitals, any reduction in revenue will add to the pressure, even if the payments are, on average, covering costs. However, in thinking about the financial implications of the PAC transfer policy, it is important to consider not only the reduced payments for transfer patients, but also the likelihood of enhanced DRG payments for non-transfer patients arising through the recalibrated weights.

Future expansions of the PAC transfer policy are uncertain at this time. Regardless of the direction taken, it does not appear that rural hospitals will be disproportionately harmed by any such expansion. One may even expect an expanded policy to benefit rural hospitals by implicitly recognizing their lower use of post-acute care and readjusting DRG payment weights so that they are paid more appropriately when providing the full course of inpatient care.

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