Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE COULD SAVE MILLIONS IF IT IMPLEMENTS AN EXPANDED HOSPITAL TRANSFER PAYMENT POLICY FOR EARLY DISCHARGES TO POST ACUTE CARE

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Report in Brief
Date: October 2023
Report No. A-01-21-00504

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Medicare Could Save Millions if It Implements an Expanded Hospital Transfer Payment Policy for Early Discharges to Post Acute Care

Why OIG Did This Audit

In a 2022 report, the Trustees of the Part A Hospital Insurance Trust Fund projected a Medicare Part A deficit of $7.3 billion by 2028 and urged policymakers to take timely and effective action to address this projected deficit. We performed this audit because data analysis indicated that significant cost savings could be realized for the Medicare program if CMS expanded the hospital transfer policy for discharges to postacute care (PAC).

Our objective was to determine how the hospital transfer policy for discharges to PAC would financially affect Medicare and hospitals if CMS expanded the policy to include all Medicare Severity Diagnosis-Related Groups (MS-DRGs).

How OIG Did This Audit

We reviewed a stratified random sample of 100 acute-care inpatient hospital claims for Medicare enrollees who were discharged early to PAC from 2017 through 2019. These claims were billed with specified MS-DRGs that are not subject to the hospital transfer policy for discharges to PAC. We calculated the savings that the Medicare program would have realized if the hospital transfer payment policy for discharges to PAC had been expanded to include all MS-DRGs. In addition, we compared the payments that would have been made under an expanded transfer policy with the hospitals' calculated costs to provide care.

What OIG Found

An expanded hospital transfer policy for discharges to PAC would result in significant cost savings to the Medicare program, and Medicare transfer payments would exceed hospital costs to provide care for most of the claims hospitals submit to Medicare. Of the 100 claims in our sample, 99 could have had transfer payments that were based on a reduced per diem rate (rather than the full payment) that would have resulted in net Medicare cost savings of $1 million. This amount represents the difference between the amount paid to the hospitals under the current policy for discharges to PAC and the amount that would have been paid if the policy had been expanded to include the MS-DRGs associated with our sampled claims. This policy change might negatively impact hospitals' revenues, but the transfer payment would have exceeded hospital costs for an estimated 65 percent of all claims that hospitals submit to Medicare.

CMS officials stated that CMS had not conducted an updated analysis of claims data since 2005. This analysis could have provided updated information in support of adding MS-DRGs or expanding the hospital transfer policy to include all MS-DRGs. On the basis of our sample results, we estimated that Medicare could have saved approximately $694 million, or an average of $6,407 per claim, from 2017 through 2019 if it had expanded its hospital transfer policy to include all MS-DRGs.

What OIG Recommends and CMS Comments

We recommend that CMS conduct an analysis of its hospital transfer payment policy for discharges to PAC and expand the policy as necessary.

In written comments on our draft report, CMS did not explicitly state whether it concurred with our recommendation but stated that it will examine the data relative to the current list of MS-DRGs that are subject to the policy to potentially assist in the identification of additional MS-DRGs for future rulemaking.

The full report can be found at https://oig.hhs.gov/oas/reports/region1/12100504.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

In a 2022 report, the Trustees of the Part A Hospital Insurance Trust Fund projected a Medicare Part A deficit of $7.3 billion by 2028 and urged policymakers to take timely and effective action to address this projected deficit.[1] The report stated that the sooner significant reforms were enacted, the more flexible and gradual the reforms could be. We performed this audit because data analysis indicated that significant cost savings could be realized for the Medicare program if the Centers for Medicare & Medicaid Services (CMS) expanded the hospital transfer policy for discharges to postacute care (PAC).[2] Our prior audit work resulted in Congress enacting a hospital early discharge to hospice policy that went into effect on October 1, 2018.[3] Furthermore, another prior audit resulted in CMS taking action to implement our recommendation to expand the transfer payment policy for inpatient rehabilitation facilities to apply to early discharges to home health care.[4]

OBJECTIVE

The objective of our audit was to determine how the hospital transfer policy for discharges to PAC would financially affect Medicare and hospitals if CMS expanded the policy to include all Medicare Severity-Diagnosis Related Groups (MS-DRGs).

BACKGROUND

The Medicare Program

The Medicare program provides health insurance coverage to people aged 65 years and older, people with disabilities, and people with end-stage renal disease. CMS administers Medicare. Medicare Part A helps cover inpatient care in hospitals, rehabilitation facilities, psychiatric facilities, hospice care, skilled nursing facilities, and some home health care services.

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[1] *2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 2, 2022, pp. 6, 43, 44, and 224.

[2] An acute-care hospital transfers a person with Medicare to a PAC setting when the person's acute condition is stabilized, and the person requires further treatment. PAC settings include inpatient rehabilitation facilities, long-term care hospitals, inpatient psychiatric hospitals, skilled nursing facilities, home care, and hospice.

[3] *Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care* (A-01-12-00507), issued May 28, 2013.

[4] *Medicare Could Have Saved Approximately $993 Million in 2017 and 2018 if It Had Implemented an Inpatient Rehabilitation Facility Transfer Payment Policy for Early Discharges to Home Health Agencies* (A-01-20-00501), issued Dec. 7, 2021.

Medicare Part A Payments to Acute-Care Hospitals

The Social Security Act (the Act) established a Medicare prospective payment system (PPS) for inpatient hospital services (the Act §§ 1886(d) and (g)). Under PPS, Medicare pays acute-care hospital costs at predetermined rates for patient discharges. CMS's payment rates vary according to the MS-DRG to which a Medicare enrollee's stay is assigned. The MS-DRG payment is, with certain exceptions, intended to be payment in full to the acute-care hospital for all inpatient costs associated with the person's stay, regardless of whether the hospital's costs are covered by the payment. The PPS payment rates are intended to cover costs that reasonably efficient providers would incur in furnishing high quality care.

Medicare also makes outlier payments to compensate hospitals for cases involving extraordinarily high costs.[5] A hospital qualifies for an outlier payment if the cost-adjusted charges for an inpatient stay exceed the outlier threshold.[6, 7] The outlier payment amount for a claim is 80 percent of cost-adjusted charges that exceed the outlier threshold.[8] CMS uses a reduced outlier threshold to determine the eligibility for, and the amount of, outlier payments for transfer claims under the transfer policy.[9]

Hospital Transfer Payment Policy for Discharges to Postacute Care

The hospital transfer policy, which was established in 1998, reduces hospital payments for discharges from hospitals to PAC settings that are made sooner than a Medicare-established

[5] 42 CFR § 412.80(a)(3). Unlike predetermined Medicare payment amounts for most hospital claims, outlier payments are directly influenced by hospital charges. The term "charges" is defined as the "regular rates established by the provider for services rendered to both beneficiaries and to other paying patients" (*The Provider Reimbursement Manual*, Pub. No. 15–1, part I, chapter 22, § 2202.4). Charges should be related consistently to the cost of the services and uniformly applied to all inpatients and outpatients. Medicare does not dictate to a hospital what its charges or charge structure should be (*The Provider Reimbursement Manual*, Pub. No. 15–1, part I, chapter 22, § 2203).

[6] MACs determine the cost-adjusted charges for inpatient stays by multiplying two values: (1) the hospital's total charges for the inpatient stay and (2) the hospital's cost-to-charge ratio (68 Fed. Reg. 34494, 34495 (June 9, 2003)). The MACs determine a hospital's cost-to-charge ratio annually by dividing the hospital's yearly total Medicare costs by its yearly total charges for services provided to Medicare patients (42 CFR § 412.84(h); *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 3, Inpatient Hospital Billing, § 20.1.2.1).

[7] The Act § 1886(d)(5)(A)(ii) defines the outlier threshold as "the sum of the applicable DRG prospective payment rate plus any [DSH adjustment and IME adjustment] amounts payable . . . plus a fixed dollar amount determined by the Secretary."

[8] 42 CFR § 412.84(k).

[9] CMS set forth a computation methodology at 42 CFR § 412.80(b) to reduce the outlier threshold.

average length of stay.[10] Specifically, for certain MS-DRGs Medicare pays transferring hospitals a graduated per diem rate when people enrolled in Medicare (Medicare enrollees) are discharged early to certain PAC settings, including inpatient rehabilitation facilities, long-term care hospitals, inpatient psychiatric hospitals, skilled nursing facilities, home care,[11] and hospice care.[12] The sum of the per diem is not to exceed the full MS-DRG payment that would have been made had the Medicare enrollee not been transferred. The policy assumes that hospitals should not receive full payment for Medicare enrollees who are discharged early and then admitted for additional care in other clinical settings.[13] By contrast, Medicare pays full prospective payments to hospitals that discharge Medicare enrollees early to PAC settings for MS-DRGs that are not subject to the policy, based on average lengths of stay.

A per diem rate payment is calculated by dividing the full payment by the geometric mean length of stay (GMLOS)[14] for an applicable MS-DRG. A total transfer payment to a hospital is the per diem rate multiplied by a number equal to the length of stay plus 1 day, not to exceed the full payment. Consistent with Medicare's existing transfer policies, we define an early discharge as being more than 1 day earlier than the Medicare-established GMLOS for an applicable MS-DRG.

Specified MS-DRGs Subject to the Hospital-to-PAC Transfer Policy

The hospital-to-PAC transfer payment policy was originally applicable to 10 MS-DRGs. The Act required CMS to select MS-DRGs based upon a high volume of discharges to PAC and a disproportionate use of postacute services.[15] The Act authorized, but did not require, CMS to expand the policy (for fiscal year (FY) 2001 or subsequent FYs).[16] The number of MS-DRGs

[10] Section 4407 of the Balanced Budget Act of 1997, P.L. No. 105-33, added subparagraph 1886(d)(5)(J) to the Act to establish the Medicare PAC transfer policy, and CMS promulgated implementing regulations at 42 CFR §§ 412.4(c), (d), and (f).

[11] The transfer payment policy from acute-care hospitals to home health care applies when home health services begin within 3 days of discharge (42 § CFR 412.4(c)(3)).

[12] Prior to Oct. 1, 2018, the regulation limited PAC transfers to those in which the Medicare enrollee was transferred to a hospital or distinct part of a hospital unit excluded from PPS, skilled nursing facility, or home health agency. Effective for inpatient discharges on or after Oct. 1, 2018, section 53109 of the Bipartisan Budget Act of 2018, P.L. No. 115-123, modified the law to require that discharges to hospice care would also qualify as a PAC transfer. As a result of this Act, CMS revised the PAC transfer policy to include discharges to hospice care.

[13] 63 Fed. Reg. 40954, 40974-75 (July 31, 1998).

[14] GMLOS is the national mean length of stay for an MS-DRG as determined and published by CMS.

[15] The Act § 1886(d)(5)(J)(iii)(I).

[16] The Act §§ 1886(d)(5)(J)(i), (iii), and (iv).

included in this policy increased over several years to 280 for discharges occurring in FY 2019. (The total number of MS-DRGs was 761 for FY 2019.)[17]

CMS has multiple times revised its regulations for determining which MS-DRGs qualify for PAC transfer payments.[18] In 2005, CMS established the current criteria,[19] effective for FY 2006, and applied the policy only to MS-DRGs that had a high prevalence of early discharges to PAC.[20] Since 2005, CMS has not made any significant change to the criteria for determining which MS-DRGs qualify for PAC transfer payments.[21]

HOW WE CONDUCTED THIS AUDIT

Our audit covered Medicare Part A acute-care inpatient hospital claims for which discharge dates matched the start date of the PAC claims for Medicare enrollees who were discharged early to PAC from 2017 through 2019. These claims were billed with specified MS-DRGs that are not subject to the hospital transfer policy for discharges to PAC. Our sampling frame consisted of 108,290 acute-care inpatient hospital claims with payments totaling $2,556,653,608. We selected for review a stratified random sample of 100 acute-care inpatient claims totaling $5,717,420.

For each of the 100 statistically sampled claims, we calculated the savings that the Medicare program would have realized if the hospital transfer payment policy for discharges to PAC had been expanded to include all MS-DRGs. In addition, to determine whether transfer payments

[17] The PAC MS-DRGs are reflected in Table 5 and listed in section VI of the addendum to the FY 2019 Final Rule (83 Fed. Reg. 41144 (Aug. 17, 2018)). Accessed on Jan. 23, 2023.

[18] 68 Fed. Reg. 45346, 45469 (Aug. 1, 2003) and 70 Fed. Reg. 47278, 47484 (Aug. 12, 2005).

[19] FY 2006 Inpatient Prospective Payment System Final Rule (70 Fed. Reg. 47278 (Aug. 12, 2005)).

[20] In the FY 2006 PPS final rule (70 Fed. Reg. 47278, 47419 (Aug. 12, 2005)), CMS established the criteria set forth in 42 CFR § 412.4(d) for determining which MS-DRGs qualify for PAC transfer payments. For FYs beginning with FY 2006, qualifying MS-DRGs must have a GMLOS greater than 3 days and must have at least 2,050 PAC transfer cases. Additionally, at least 5.5 percent of the cases in the MS-DRG are discharged to PAC prior to the GMLOS for the MS-DRG. Finally, if the MS-DRG is one of a paired set of MS-DRGs based on the presence or absence of a comorbidity or complication, both paired MS-DRGs are included if either one meets the three criteria above. When a new or revised MS-DRG first becomes effective, the MS-DRG will be subject to the PAC transfer policy if its total number of discharges and proportion of short-stay discharges to PAC exceed the 55th percentile for all MS-DRGs.

[21] In 2005, CMS avoided applying the policy to MS-DRGs with only a small number or proportion of cases transferred to PAC. CMS also stated that its analysis indicated that it was appropriate to maintain the requirement that a MS-DRG have a GMLOS of at least 3 days because hospitals under the transfer payment methodology receive the entire payment for these MS-DRGs in the first two days of the stay. CMS stated that lowering the limit below 3 days would have little or no effect on payment for MS-DRGs with GMLOS in this range (70 Fed. Reg. at 47278, 47415 (Aug. 12, 2005)).

exceeded hospital-reported costs, we compared the payments that would have been made under an expanded transfer policy with the hospitals' calculated costs to provide care. To do so, we calculated the hospitals' transfer payments and compared them with the hospitals' costs to provide care.[22]

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains our audit scope and methodology, Appendix B describes our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

An expanded hospital transfer policy that includes all MS-DRGs for discharges to PAC would result in significant cost savings to the Medicare program, and Medicare transfer payments would exceed hospital-reported costs to provide care for most of the claims hospitals submit to Medicare.[23] Of the 100 acute-care inpatient hospital claims in our sample, 99 could have had transfer payments that were based on a reduced per diem rate (rather than the full payment) that would have resulted in net Medicare cost savings of $1,033,520.[24] This amount represents the difference between the amount paid to the hospitals under the current policy for discharges to PAC and the amount that would have been paid if the policy had been expanded to include the MS-DRGs associated with our sampled claims. This policy change might negatively impact hospitals' revenues, but the transfer payment would have exceeded hospital-reported costs for an estimated 65 percent of claims that hospitals billed to Medicare with MS-DRGs not subject to the transfer policy for enrollees who were discharged early to PAC.[25]

[22] The hospitals' covered costs were calculated by converting the hospitals' total charges to costs using CMS's latest published cost-to-charge ratios. The cost-to-charge ratio is the factor applied to hospitals' charges to determine hospitals' estimated costs. Because hospitals have different cost reporting periods (i.e., fiscal years), CMS updates the annual files on a quarterly basis.

[23] Although we expect hospitals' revenues to decrease under an expanded transfer policy, our calculations assume no change in hospital billing practices if such a policy were adopted. Specifically, we assume hospitals would not change their service and billing activities to counter a revenue decrease or avoid transferring Medicare enrollees to avoid a decrease. Our estimate cannot account for these possible changes in hospital billing practices.

[24] For one other claim, the hospital billed the claim incorrectly and had already received a transfer payment instead of the full payment.

[25] Although transfer payments would not have fully covered hospital-reported costs for some claims, Medicare requires that payment decreases to some hospitals be "offset" by proportional Medicare payment increases to other hospitals. As such, net payments to hospitals nationwide will not decrease due to reduced Medicare payments to some hospitals.

In the early years of the hospital transfer policy for discharges to PAC, CMS multiple times revised its regulations pertaining to qualifying MS-DRGs and even explored the option of expanding the policy to include all MS-DRGs.[26] However, CMS officials stated that CMS had not conducted an updated analysis of claims data since 2005.

On the basis of our sample results, we estimated that Medicare could have saved approximately $694 million, or an average of $6,407 per claim, from 2017 through 2019 if it had expanded its hospital transfer policy to include all MS-DRGs. Although our statistical sample measured savings that could have been achieved over a prior time period, we expect the Medicare program could achieve similar cost savings in the future if CMS would expand the policy to include all MS-DRGs and hospital billing practices would remain the same.

AN EXPANDED HOSPITAL TRANSFER POLICY FOR DISCHARGES TO PAC WOULD RESULT IN SIGNIFICANT COST SAVINGS TO THE MEDICARE PROGRAM

An expanded hospital transfer policy to include all MS-DRGs for discharges to PAC would result in significant cost savings to the Medicare program. Of the 100 acute-care inpatient hospital claims in our sample, 99 could have had transfer payments that were based on a reduced per diem rate (rather than a full payment) that would have resulted in net Medicare cost savings of $1,033,520. This amount represents the difference between the amount paid to a hospital under the current policy for discharges to PAC and the amount that would have been paid if the policy had been expanded to include MS-DRGs associated with our sampled claims. For another claim, a hospital billed a claim incorrectly and already received a transfer payment instead of the full payment.[27]

Of the 99 sampled claims, 8 contained outlier payments that increased when the claim was repriced at the transfer payment rate. For these claims, Medicare's reduced outlier threshold for transfer claims resulted in an increase to the hospitals' total payment. For example, for one claim, the per diem rate decreased the hospital's payment by $14,094 and the outlier payment increased the hospital's payment by $18,832, resulting in an overall payment increase of $4,738 ($18,832 minus $14,094). For the remaining 91 claims, the reduced per diem rate payments resulted in Medicare cost savings. The following example (on the next page) shows the cost savings for a representative hospital stay.

[26] In the FY 2000 inpatient prospective payment system (IPPS) final rule (65 Fed. Reg. 47054, 47082 (Aug. 1, 2000)), CMS summarized the results of a contracted study which analyzed the impact of a potential expansion of the PAC transfer policy to all MS-DRGs. Additionally, in the FY 2003 IPPS final rule (67 Fed. Reg. 49982, 50049 (Aug. 1, 2002)), CMS stated that it believed such an expansion might be the most equitable approach (since a policy that is limited to certain DRGs may result in disparate payment treatment across hospitals depending on the types of cases treated).

[27] There were no cost savings associated with this claim because the hospital billed an incorrect discharge status code (i.e., discharge to an acute-care hospital). As a result, the hospital received a transfer payment instead of a full payment.

Example 1: Payment for an Early Hospital Discharge to PAC Under the Expanded Transfer Policy

A hospital admitted a Medicare enrollee on July 24, 2017, and discharged the person on July 31, 2017 (for a total stay of 8 days). The Medicare enrollee began hospice services on August 1, 2017. The hospital billed Medicare for MS-DRG 823 (lymphoma and nonacute leukemia with other operating room procedures with major complication or comorbidity) with a GMLOS of 10.8 days. Medicare made a full payment of $24,352 to the hospital. If Medicare's expanded hospital transfer payment policy had been applied using a per diem rate, Medicare would have paid the hospital $17,837, a difference of $6,515 ($24,352 minus $17,837).

TRANSFER PAYMENTS UNDER AN EXPANDED HOSPITAL TRANSFER POLICY FOR DISCHARGES TO PAC WOULD GENERALLY COVER COSTS OF PROVIDING CARE

We estimated transfer payments under an expanded hospital transfer policy would exceed hospital-reported costs to provide care for approximately 65 percent of all claims that hospitals submit to Medicare. For the remaining 35 percent of claims, payments would not fully cover hospital-reported costs. Our sampled claims showed that this happens with MS-DRGs that are typically billed with exceptionally high hospital costs or claims that involve outlier payments.

The following example shows a hospital transfer payment for a hospital early discharge that exceeded the hospital's cost of providing care.

Example 2: Payment Under the Expanded Transfer Policy for an Early Hospital Discharge to PAC That Exceeded the Hospital's Cost

Continuing with the representative stay in Example 1 that showed the hospital would have received $17,837 if the hospital transfer payment policy had been applied to all MS-DRGs, we determined the hospital's costs would have been $11,616 (an amount equal to the hospital's billed charges of $61,462 multiplied by the hospital's cost-to-charge ratio of 0.189 percent). Thus, the reduced payment to the hospital would have exceeded its costs by $6,221 ($17,837 minus $11,616).

CMS HAS NOT CONDUCTED AN UPDATED ANALYSIS OF CLAIMS DATA

In the early years of the hospital transfer policy for discharges to PAC, CMS multiple times revised its regulations pertaining to qualifying MS-DRGs and even explored the option of expanding the policy to include all MS-DRGs. However, CMS officials stated that CMS had not conducted an updated analysis of claims data since 2005. CMS does not have current data to support whether the policy should be expanded nor determine which MS-DRGs should be

included if it is expanded. For example, CMS could identify MS-DRGs that are typically billed with exceptionally high hospital costs or claims that involve outlier payments.[28]

ESTIMATES OF SAVINGS REALIZED IF THE HOSPITAL TRANSFER POLICY FOR DISCHARGES TO PAC HAD BEEN EXPANDED

On the basis of our sample results, we estimated that Medicare could have saved approximately $694 million, or an average of $6,407 per claim, from 2017 through 2019 if it had expanded its hospital transfer payment policy to include all MS-DRGs. (See Appendix C.) Although our statistical sample measured savings that could have been achieved over a prior time period, we expect the Medicare program could achieve similar cost savings in the future if CMS would expand the policy to include all MS-DRGs and hospital billing practices would remain the same.

CONCLUSION

A Medicare Part A deficit of $7.3 billion is projected by 2028. One reform CMS could implement to help partly alleviate this deficit would be to expand its hospital transfer policy for discharges to PAC to include all MS-DRGs. If an expanded policy had been in place, Medicare could have saved approximately $694 million from 2017 through 2019. This policy would be consistent with the transfer payment policy currently in effect for early discharges from one acute-care hospital to another acute-care hospital.[29] Implementing such a policy would result in immediate and significant Medicare savings.

A revised policy could also promote greater payment equity among hospitals, as stated in CMS's rulemaking.[30] Under the current policy, hospitals that disproportionately bill claims for MS-DRGs that are subject to the transfer policy may be at a greater financial disadvantage than hospitals that persistently bill early discharges for MS-DRGs that are not subject to the policy.

RECOMMENDATION

We recommend that the Centers for Medicare & Medicaid Services conduct an analysis of its hospital transfer payment policy for discharges to PAC and revise the policy as necessary.

[28] Our sample results showed that payments for some of these types of claims do not always cover hospital costs.

[29] The hospital transfer payment policy for discharges from an acute-care hospital to another acute-care hospital applies to all MS-DRGs (unless the re-admission is unrelated to the initial discharge) (42 CFR 412.4(b); *Medicare Claims Processing Manual*, Publication 100-04, Chapter 3, Section 40.2.4).

[30] 67 Fed. Reg. 31404, 31456 (May 9, 2002) and 67 Fed. Reg. 50049 (Aug. 1, 2002).

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS did not explicitly state whether it concurred with our recommendation but stated that it will examine the data when they are available, relative to the current list of MS-DRGs that are subject to the hospital transfer payment policy, to potentially assist in the identification of additional MS-DRGs (with disproportionate rates of discharges to PAC) for future rulemaking. CMS also stated that its longstanding policy is limited to MS-DRGs with a high volume of discharges to PAC. CMS's comments are included in their entirety as Appendix D.

We maintain that CMS should conduct an analysis of its hospital transfer payment policy for discharges to PAC and revise the policy as necessary. We acknowledge that the Act requires CMS to select MS-DRGs based upon a high volume of discharges to PAC; however, CMS has previously used its rulemaking process to analyze the impact of the policy and explore the option of expansion beyond these high-volume MS-DRGs. CMS has not conducted an updated analysis since 2005. A new analysis could provide information to support whether the policy should be revised. A revised policy could help alleviate the Medicare Part A deficit, result in immediate and significant Medicare savings, and promote greater payment equity among hospitals.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered Medicare Part A acute-care inpatient hospital claims for Medicare enrollees who were discharged early to PAC from 2017 through 2019. These claims were billed with specified MS-DRGs that were not subject to the hospital transfer policy for discharges to PAC. Our sampling frame consisted of 108,290 Medicare Part A acute-care inpatient hospital claims with payments totaling $2,556,653,608. We selected for review a stratified random sample of 100 hospital claims totaling $5,717,420.

We limited our review of internal controls to CMS's controls related to implementing the hospital transfer policy for discharges to PAC. Specifically, we discussed with CMS officials how CMS determined which MS-DRGs qualify for transfer payments and which steps CMS has taken to expand the policy to include additional MS-DRGs.

We established reasonable assurance of the authenticity and accuracy of data obtained from CMS's National Claims History (NCH) file by comparing the NCH file with the Common Working File and medical records. But we did not assess the completeness of the NCH file.

We conducted our audit from April 2021 through May 2023.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations;
- held discussions with CMS officials to determine how CMS determined which MS-DRGs qualify for transfer payments and which steps CMS has taken to expand the policy;
- extracted Medicare Part A acute-care inpatient hospital claims from the NCH file for claims billed with MS-DRGs that were currently not subject to the hospital-to-PAC transfer policy, in which the discharge dates of the hospital claims matched the start date of the PAC claims and that had dates of service during our audit period;[31]
- identified 108,290 acute-care inpatient hospital claims billed during our audit period in which Medicare enrollees were discharged early to PAC settings;
- selected a stratified random sample of 100 acute-care inpatient hospital claims (Appendix B);

[31] For home health settings, we matched to services that began within 3 days after the date of hospital discharge.

- reviewed data from the Common Working File for the sampled hospital claims and the corresponding PAC claims to: (1) confirm discharges to PAC and (2) determine whether any Medicare payment relating to the sampled claims had been canceled or adjusted;

- sent questionnaires to 98 hospitals to determine what affect, if any, an expanded hospital transfer policy for early discharges to PAC would have on hospitals;[32]

- reviewed medical records, such as discharge summaries and progress notes, to confirm the discharges to PAC;

- repriced the sampled hospital claims based on a reduced per diem rate payment;

- calculated the potential net Medicare cost savings by subtracting each reduced payment from the full payment;

- estimated the total dollar value of potential net Medicare cost savings on the basis of our sample results (Appendix C);

- calculated hospital costs for the sampled hospital claims by converting the hospitals' total submitted charges to costs using CMS's cost-to-charge ratios;[33]

- estimated the percentage of payments that exceeded hospital costs; and

- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[32] We did not contact two of the sampled hospitals because they were under review by the Office of Inspector General's (OIG's) Office of Investigations.

[33] We calculated each hospital's costs by multiplying the submitted charges for each of the sampled claims by the hospital's cost-to-charge ratio. We then calculated the difference between the hospital's reduced per diem rate payment and its costs to identify whether the hospital's reduced payment amount would cover its costs. If the difference for each claim was more than $0, we considered the hospital's costs to be covered.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 108,290 Medicare Part A acute-care inpatient hospital claims, totaling $2,556,653,608, in which Medicare enrollees were discharged early to PAC from 2017 through 2019. These claims were billed with specified MS-DRGs that are not subject to the hospital transfer policy for discharges to PAC. Finally, the sampling frame includes claims that were paid under the IPPS and for which payment was made from the Medicare Trust Fund.

SAMPLE UNIT

The sample unit was a Medicare Part A acute-care inpatient hospital claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample as follows:

Stratum	Dollar Range	Number of Frame Units	Frame Dollar Value	Sample Size
1	$127.01 to $22,447.15	74,255	$882,473,503	34
2	$22,447.52 to $64,972.64	28,402	$1,031,531,552	33
3	$64,982.96 to $430,138.43	5,633	$642,648,552	33
	Total	**108,290**	**$2,556,653,608***	**100**

* Difference in total is due to rounding.

SOURCE OF RANDOM NUMBERS

The source of the random numbers was the statistical software of the Office of Inspector General (OIG), Office of Audit Services (OAS).

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the items in each stratum by the Medicare enrollee identification number and Medicare claim payment amount. We then consecutively numbered the items in each stratum in the sampling frame. We generated the random numbers for our sample according to our sample design and then selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used OIG-OAS statistical software to estimate the total dollar value of potential net Medicare cost savings and the percentage of payments exceeding hospital costs for payments

made to acute-care hospitals for inpatient claims billed with specified MS-DRGs that are not subject to the transfer policy in which Medicare enrollees were discharged early from an acute-care hospital to PAC at the point estimate. We also used this software to calculate the lower and upper limits of the 90-percent confidence interval associated with this estimate.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Net Value of Cost Savings in the Sample	Number of Payments Exceeding Hospital Costs in the Sample
1	74,255	$882,473,503	34	$417,552	$144,768	22
2	28,402	$1,031,531,552	33	$1,156,520	$327,449	24
3	5,633	$642,648,552	33	$4,143,348	$561,303	12
Total	108,290	$2,556,653,608*	100	$5,717,420	$1,033,520	58

* Difference in total is due to rounding.

Table 2: Estimated Net Cost Savings in the Sampling Frame
Limits Calculated at the 90-Percent Confidence Level

	Total	Per Claim
Point Estimate	$693,806,123	$6,407
Lower Limit	$614,601,442	$5,676
Upper Limit	$773,010,803	$7,138

Table 3: Estimated Percentage of Claims Exceeding Hospital Costs in the Sampling Frame
Limits Calculated at the 90-Percent Confidence Level

	Percentage of Claims
Point Estimate	65.34%
Lower Limit	55.33%
Upper Limit	75.34%

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: August 23, 2023

TO: Juliet T. Hodgkins
Principal Deputy Inspector General
Office of Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Could Save Millions if It Implements an Expanded Hospital Transfer Payment Policy for Early Discharges to Postacute Care (A-01-21-00504)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to providing Medicare beneficiaries with high quality health care while, at the same time, serving as a good steward to the Medicare Trust Funds.

Section 1886(d)(5)(J) of the Social Security Act established the Medicare postacute care transfer policy. The policy requires the Secretary to make a transfer adjustment for cases assigned to specified Medicare severity diagnosis-related groups (MS-DRGs) for discharges to a postacute care setting. The purpose of the transfer policy is to approximate the reduced costs of transfer cases and to make adjustments to avoid duplicate payments for the care provided during a patient's episode of care.

CMS underwent notice and comment rulemaking to implement Section 1886(d)(5)(J) of the Social Security Act and set forth that when a patient is transferred and the length of stay is less than the geometric mean length of stay for the MS–DRG to which the case is assigned, the transferring hospital is generally paid based on a graduated per diem rate for each day of stay, not to exceed the full MS–DRG payment that would have been made if the patient had been discharged without being transferred.

CMS also established through rulemaking the criteria set forth in § 412.4(d) for determining which DRGs qualify for postacute care transfer payments in the FY 2006 IPPS final rule (70 FR 47419 through 47420). The statute directs CMS to identify MS–DRGs based on a high volume of discharges to postacute care facilities and a disproportionate use of postacute care services. As discussed in the FY 2006 IPPS final rule (70 FR 47416), CMS determined that the 55th percentile is an appropriate level at which to establish these thresholds. In that same final rule (70 FR 47419), CMS stated that we will not revise the list of DRGs subject to the postacute care transfer policy annually unless we are making a change to a specific MS–DRG.

While OIG's report states that Medicare could have saved millions of dollars if the postacute care transfer policy was expanded to include all MS-DRGs, CMS notes that any further expansion of the postacute care transfer policy would also need to consider other factors, such as the need to reduce payments to reflect cost-shifting out of the acute care setting due to reductions in length of stay attributable to early transfers to postacute care and the need to ensure that

payments, on average, remain adequate to ensure effective patient care, particularly in rural and underserved areas.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services conduct an analysis of its hospital transfer payment policy for discharges to PAC and revise the policy as necessary.

CMS Response

When sufficient data is available from after the end of the COVID-19 Public Health Emergency, CMS will examine the data relative to the current list of MS-DRGs subject to the hospital transfer payment policy to potentially assist in the identification of additional MS-DRGs with disproportionate rates of post-acute care discharges for future rulemaking. CMS reiterates that our longstanding policy in implementing section 1886(d)(5)(J) of the Social Security Act is to limit the hospital post-acute care transfer policy to MS-DRGs with a high volume of post-acute discharges.