

situations in which a patient leaves an acute-care hospital after receiving complete treatment, and "transfers," situations in which the patient is transferred to another acute-care hospital for related care. If a full DRG payment were made to each hospital involved in a transfer situation irrespective of the length of time the patient spent in the "sending" hospital before transfer, this would create a strong incentive to increase transfers, thereby unnecessarily endangering patients' health. Therefore, the regulations at § 412.4(d) provide that, in a transfer situation, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

Currently, the per diem rate paid to a transferring hospital is determined by dividing the full DRG payment that would have been paid in a nontransfer situation by the geometric mean length-of-stay for the DRG into which the case falls. Transferring hospitals are also eligible for outlier payments for cases that meet the cost outlier criteria established for all cases (nontransfer and transfer cases alike) classified to the DRG. They are not, however, eligible for day outlier payments. Two exceptions to the transfer payment policy are transfer cases classified into DRG 385 (Neonates, Died or Transferred to Another Acute Care Facility) or DRG 456 (Burns, Transferred to Another Acute Care Facility), which are not paid on a per diem basis but instead receive the full DRG payment.

In the May 27, 1994 proposed rule, we proposed to revise our payment methodology for transfer cases. Under the proposal, for the first day of a transfer, the per diem amount would be doubled, while a flat per diem amount would be paid for each succeeding day, up to the full DRG payment (59 FR 27734). We also proposed at that time to change our definition of a transfer case to include cases transferred from an acute-care setting paid under the prospective payment system to a hospital or unit excluded from the prospective payment system. When we published the September 1, 1994 final rule with comment period, we withdrew these proposals for FY 1995 (59 FR 45362) based on negative comments and further analysis. In that final rule, however, we stated our intention to continue to evaluate the appropriateness of our transfer policy.

For FY 1996, we again proposed to adopt a graduated per diem payment

methodology for transfer cases. Again, under this methodology, we would pay double the per diem amount for the first day and the per diem amount for subsequent days (up to the full DRG amount). We did not propose to revise our definition of transfers. However, we noted that we were concerned about an accelerating trend toward earlier discharges to postacute settings. Therefore, we solicited public comments regarding this trend and the implications this has for the design of our payment systems. In its March 1, 1995 report, ProPAC supported our proposed payment methodology (Recommendation 11) and expressed its concern "about the continuity of care across treatment settings." The Commission also indicated its willingness to work with the Secretary to explore this issue. The following discussion describes our change to the transfer payment methodology and some of the issues identified by our further analysis of transfer cases.

1. Payment for Transfer Cases

As part of a study of Medicare transfer cases funded by HCFA ("Transfers of Medicare Hospital Patients under the Prospective Payment System", PM-191-HCFA, January 1994), RAND found that among cases transferred before reaching the geometric mean length-of-stay, 1-day stays cost 2.096 times the per diem payment amount for cases in nonsurgical DRGs and 2.576 times the per diem for surgical DRGs (based on FY 1991 data). Among nonsurgical transfer cases, the costs of 2-day stays were about 1.215 times the per diem payment amount, and cases transferred after 2 days cost about 10 percent more than the applicable per diem amount. Among surgical cases, the costs of stays of 2 or more days were actually about 7 percent below the applicable per diem amount.

In order to pay hospitals more appropriately for the treatment they furnish to patients before transfer, we proposed to revise § 412.4(d)(1) to pay transfers twice the per diem amount for the first day of any transfer stay plus the per diem amount for each of the remaining days before transfer, up to the full DRG amount. (Our concerns about basing the gradation of the per diem scale on the actual coefficients as estimated by RAND were described in last year's proposed and final rules, as referenced above.) This change will apply uniformly for both medical and surgical transfer cases; although surgical transfer cases appear to be more costly on average for the first day, they are relatively less costly for the second day and beyond.

If the patient is transferred again before final discharge, then, under this change, all sending hospitals involved would be paid using the graduated per diem methodology rather than the flat per diem rate they currently receive. For example, a case transferred from a community hospital to a tertiary care hospital for a procedure that is not performed at the community hospital, may subsequently be transferred back to the community hospital, which ultimately discharges the patient home. In such a case, the community hospital and the tertiary care hospital would be paid using the transfer payment methodology for the first two phases of the hospitalization, and the community hospital would also receive a DRG amount for the final phase when it discharges the patient. This is our current policy, as well. Each phase of the hospitalization is assigned a DRG based on the diagnosis and procedures applicable to that particular phase; therefore, a different DRG could be assigned to each phase.

Transfer cases would continue to be eligible for additional payments as cost outliers. In the September 1, 1993 final rule, we set forth revised qualifying criteria for transfer cases to be eligible for cost outlier payments (58 FR 46305). Before that change, transfer cases were required to meet the same criteria to qualify for cost outliers as were discharges. The revised policy adjusts the outlier threshold for transfer cases to reflect the fact that transfer cases were receiving a reduced payment amount under the per diem methodology. Last year, when we revised the cost outlier qualifying criteria so that it was based on a fixed loss threshold, the qualifying criteria for transfers continued to reflect the fact that their payment amounts are reduced relative to the full DRG amount. Although we did not state this explicitly in the September 1, 1994 final rule, it is the policy we have employed, and intend to continue to employ, since the fixed loss threshold was implemented October 1, 1994. In the proposed rule, we described the cost outlier threshold for transfer cases as equal to the fixed loss amount (for FY 1995, the prospective payment rate for the DRG plus \$20,500), divided by the geometric mean for the DRG, multiplied by the length of stay before transfer. In order to maintain the correct relationship between the payment received under the new graduated per diem methodology and the outlier threshold, for FY 1996, the per diem outlier threshold should be multiplied by the length of stay before transfer plus one day. Of course, the threshold is limited