2 Descriptive Analysis of PAC Policy Change

Acknowledging the increased utilization of services provided through a postacute care setting, the Balanced Budget Act of 1997 authorized HCFA to implement a new payment methodology for patients discharged under any of 10 Diagnosis Related Groups (DRGs) directly to a postacute care provider. This chapter provides a descriptive analysis of the postacute care transfer payment policy. First, it outlines the acute-to-acute care transfer policy, which served as a model for the postacute care transfer policy. This is followed by a discussion of the motivation for expanding the transfer policy to include postacute care services, as well as a presentation of evidence supporting the rationale behind the policy change. Finally, there is a general description of the postacute care transfer payment policy, including the selection of the pilot DRGs, postacute care settings, and the postacute care reimbursement methodology.

2.1 Background of the Acute-to-Acute Transfer Policy under Inpatient PPS

Prior to the enactment of the federal Balanced Budget Act of 1997, the only cases that were designated as transfers for purposes of reimbursement under inpatient PPS were those that were discharged from one acute care facility and readmitted at another short-term acute care facility on the same day. The transfer payment policy was based on the belief that it was inappropriate to pay the sending hospital the full DRG payment for less than the full course of treatment (Buczko, 1993). Moreover, policy makers felt that

paying the sending hospital the full DRG amount for transfer cases would create financial incentives for hospitals to transfer cases prematurely.

Under the original PPS rules, when a Medicare patient was transferred from one PPS acute care hospital to another the transferring hospital received a uniform per diem payment up to the full DRG payment amount. The per diem is calculated as the hospital-specific DRG amount (the adjusted standardized rate times the DRG weight) divided by the national geometric mean length of stay across all discharges under that DRG. Historically, two transfer DRGs existed: DRG 385, *Neonates that Died or were Transferred*; and DRG 456, *Burn Cases that are Transferred*. For cases assigned to either of these two transfer-related DRGs, the sending facility received the full DRG payment regardless of the inpatient length of stay. However, DRG 456 was eliminated at the beginning of fiscal year 1999, following the implementation of the postacute care transfer payment policy.

Subsequent studies have shown that acute care transfer cases are expensive to both the transferring and receiving hospitals and that the uniform per diem rate tended to under-compensate the sending provider. The level of under-compensation to the transferring hospital was greatest during the first few days of the inpatient stay (Carter and Rumpel, 1993; ProPAC, 1993). An analysis using 1991 MedPAR data by Carter and Rumpel (1993) found that for medical cases transferred within three days of initial hospitalization, Medicare costs for the first day were roughly twice the per diem payment rate. Costs for the second day were also greater, but to a lesser degree, than the costs incurred on subsequent days. By the third day of the inpatient stay and after, incremental costs were constant. However, for surgical cases, only the first day's cost was found to be significantly greater than subsequent days.

Recognizing the high cost of the first day of hospitalization, in the early 1990s Medicare implemented a graduated per diem to all sending hospitals up to the full DRG payment amount. Under the current acute-to-acute transfer payment policy, the sending hospital is paid twice the DRG per diem for the first day and the per diem for all remaining days up to the full DRG payment amount. The final discharging hospital still receives the full DRG payment amount. Each phase of the PPS inpatient treatment is assigned a DRG based upon the principal and secondary diagnoses and surgical procedures performed during the respective phase of hospitalization. Both sending and receiving hospitals remain eligible to receive cost outlier payments, disproportionate share payments and adjustments for direct and indirect medical education expenses for acute-to-acute care transfer cases.

2.2 Rationale for Including Postacute Care Transfers under the Per Diem Policy

Patients discharged from an acute care hospital to a postacute care facility or unit were not included under HCFA's initial PPS transfer payment policy. When PPS was first designed, most health analysts commonly believed that acute and postacute care services represented separate and non-substitutable types of care. Postacute care services were considered to be a complement of, not a substitute for, the types of services historically administered in an inpatient acute care setting. Given the traditional separability of the services provided in the two sites of care, under PPS reimbursement rules acute care hospitals received the full DRG amount for patients who were transferred to a postacute care facility, transferred within the hospital to a postacute care distinct part unit, or discharged home with a plan for follow-up services to be provided by a home health agency.

Fundamental changes in the health care market over the past decade, however, have caused health policy analysts to rethink the traditional distinction between acute and postacute care services (Lee, Ellis and Merrill, 1996). Imposed largely by managed care companies, mounting financial pressures for acute care hospitals to reduce per admission costs have caused these hospitals to seek new ways to shift the distribution of services away from expensive acute care inpatient settings to less costly outpatient postacute care environments. Simultaneously, an increase in the number of postacute care providers, as well as technological advances in medicine, have allowed postacute care centers to treat a wider range and severity of conditions, thereby permitting patients to be discharged from acute care to postacute care earlier in their hospitalization (MedPAC, 1998; Federal Register, 1998).

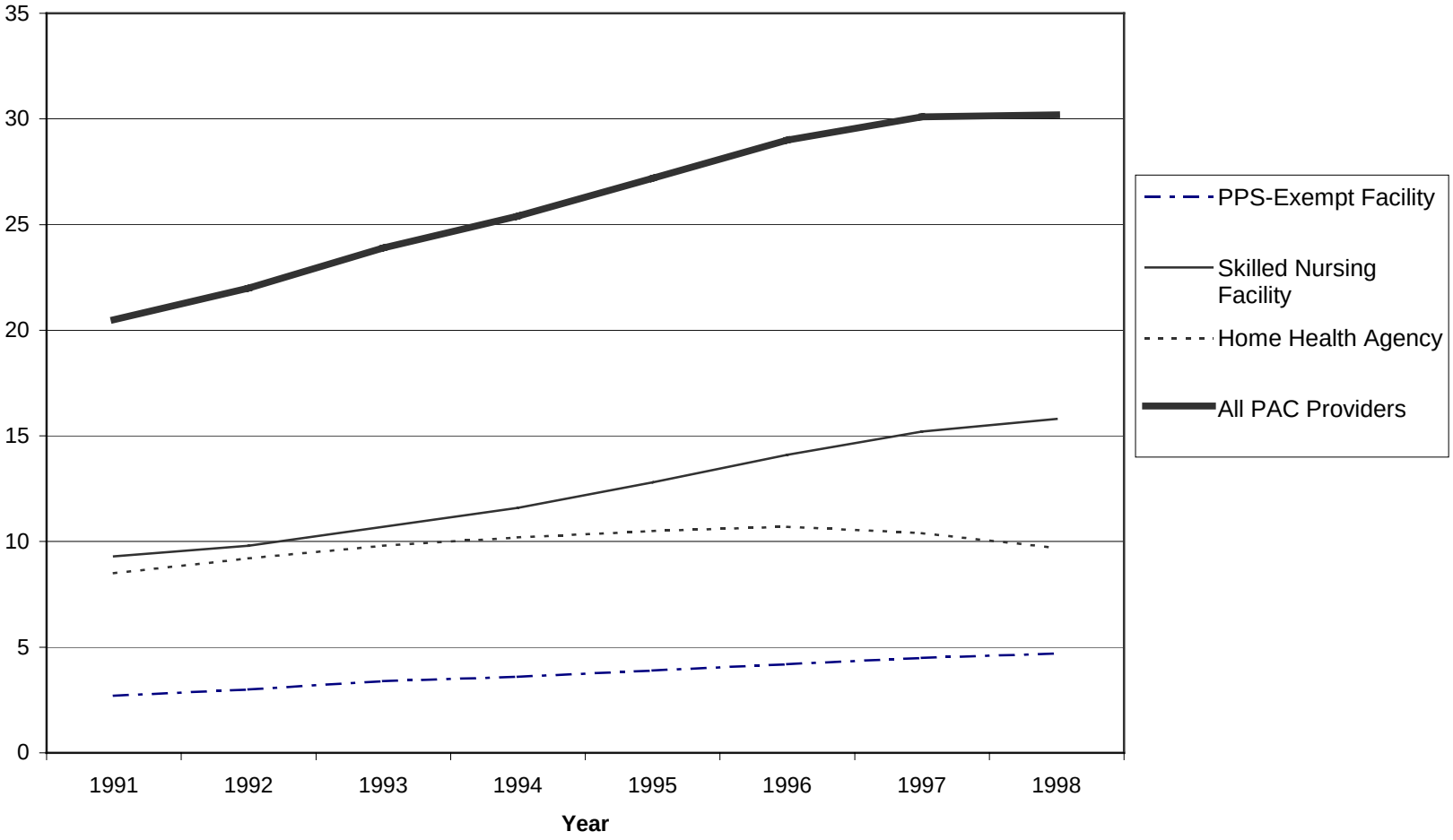
Past payment policies, such as Medicare's combination of a fixed, prospectively-determined payment rate for inpatient services and a retrospective cost-based reimbursement system for postacute care services, have also created strong incentives to enroll patients in postacute care as early as possible. Acute care facilities that are organizationally and financially associated with postacute care facilities have an even stronger incentive to transfer patients within their hospital system early and receive both the full DRG payment for the inpatient care, as well as the cost-based payments for the postacute care treatment. For these reasons, as evidence presented below shows, postacute care transfer rates have been climbing steadily throughout the 1990s.

2.3 Evidence of a Substitution of Postacute Care for Acute Care Services

The long-term trend in the transfer of certain types of medical services out of the acute inpatient setting and into less intensive inpatient and ambulatory postacute care environments can be seen from a quick review of the data on patient treatment and discharge patterns. For example, Figure 2-1 below tracks the share of patients discharged from an acute care hospital to a postacute care provider, defined here as a skilled nursing facility, a home health agency, or another short-term facility exempted from PPS reimbursement. PPS-exempt facilities include psychiatric hospitals or units; rehabilitation facilities or units; and children's, cancer and other specialty care hospitals or units. Based on discharge destination codes reported on the MedPAR files, postacute care transfer rates have risen steadily during the 1990s, from 20.5 percent in 1991 to 30.2 percent in 1998, representing an average annual increase in the postacute care transfer rate of 5.7 percent.

The average annual percentage increase was greatest for patients transferred to PPS-exempt facilities and skilled nursing facilities. The share of acute care patients transferred to a PPS-exempt facility or unit nearly doubled from 2.7 percent in 1991 to 4.7 percent in 1998, representing an average increase of 8.3 percent annually. Similarly, the share of patients transferred to skilled nursing facilities rose on average 7.9 percent annually during the same period, from 9.3 percent in 1991 to 15.8 percent seven years later. Acute care transfers to skilled nursing facilities accounted for the largest share of postacute care transfers. In contrast, the share of patients discharged home with follow-up care to be administered by a home health agency rose on average only 2.0 percent annually, from 8.5 percent in 1991 to 10.7 percent in 1996, before dropping again slightly to 9.7 percent in 1998.

Figure 2-1
Share of Postacute Care Transfers By Provider Type, 1991-1998



The percent increase in the share of postacute care transfers is even greater among those DRGs with the highest incidence of postacute care use. Table 2-1 below uses MedPAR discharge destination codes to track the trend in postacute care transfers among the 20 DRGs with the highest share of postacute care utilization. The overall share of postacute care transfers for these DRGs was 37.5 percent in 1991 and 53.5 percent in 1998, representing an average annual increase of over five percent during the eight year period under review. Postacute care transfers appear to be concentrated in selected DRGs. For example, DRG 210, *Hip and Femur Procedures Except Major Joint, Age Greater Than 17 with Complicating Conditions*, had a postacute care utilization rate of 64.1 percent in 1991. By 1998, its share of postacute care transfer had reached nearly 80 percent, achieving an overall increase of 24.1 percent.

During a time when the share of postacute care transfers was rising, the average inpatient length of stay of postacute care users relative to non-postacute users was declining, further suggesting a long-term substitution of care. As illustrated in Figure 2-2 below, the average length of stay for non-postacute care discharges dropped during the 1991 through 1998 period by 2.4 days. However, the average inpatient length of stay of postacute care transfers declined by almost twice this amount, 4.5 days, representing a 37 percent overall decrease.

The decline in inpatient length of stay is even more pronounced among the 20 DRGs with the highest rate of postacute care utilization (see Table 2-2). Among these DRGs, the average inpatient length of stay for postacute care transfers dropped 7.1 days, from 17.7 days in 1991 to 10.6 days in 1998. In contrast, the average inpatient length of stay among these same 20 DRGs for non-postacute care users dropped 5.6 days, from 13.5 days in 1991 to 7.9 days in 1998. The similar annual percentage decline in PAC and

Table 2-1

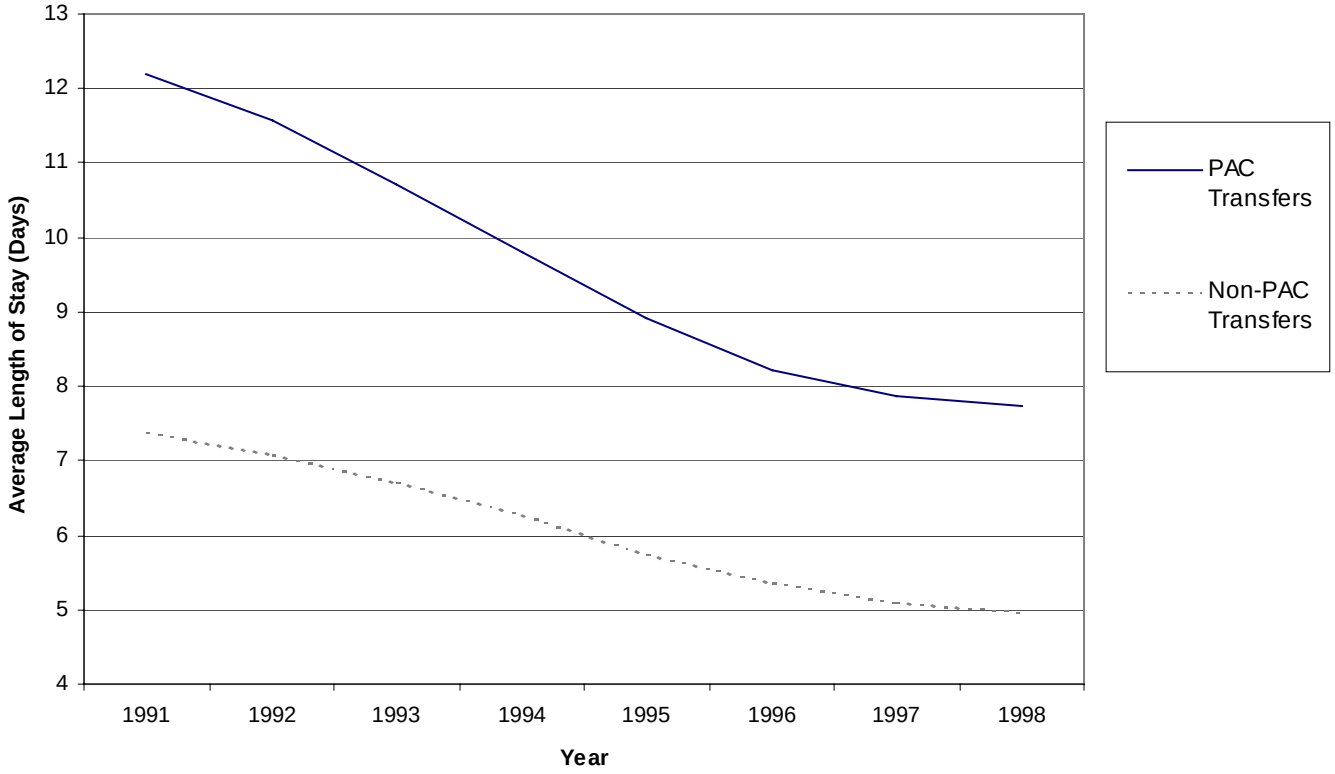
Percent of Postacute Care (PAC) Utilization for Top 20 DRGs**, 1991-1998

DRG	Description	1991 PAC Transfer	1991 PAC Share (%)	1992 PAC Share (%)	1993 PAC Share (%)	1994 PAC Share (%)	1995 PAC Share (%)	1996 PAC Share (%)	1997 PAC Share (%)	1998 PAC Share (%)	Average Annual % Change in PAC Share (%)
209	**Joint/Limb Reattchment of the Lower Extremity**	**136,924**	**49.7**	**54.3**	**58.8**	**61.8**	**65.5**	**69.1**	**71.9**	**73.5**	**5.8**
14	**Cerebrovascular Disorders**	**136,593**	**40.9**	**43.0**	**45.3**	**46.9**	**48.7**	**50.0**	**51.0**	**51.3**	**3.3**
210	**Hip/Femur Proc. Exc. Major Joint, > 17w/CC**	**76,657**	**64.1**	**67.2**	**70.1**	**72.1**	**74.7**	**77.0**	**78.8**	**79.6**	**3.1**
79	Resp. Infec. And Inflam. >17 w/CC	50,243	34.7	36.4	37.9	39.5	41.2	43.5	45.9	47.7	**4.7**
296	Nutr. And Misc Metabolic Disorders, >17w/CC	64,709	30.2	32.0	33.7	35.1	36.4	37.4	38.6	39.0	**3.7**
148	Major Bowel Proc w/CC	37,436	26.4	27.8	29.8	31.7	33.7	35.6	36.7	37.4	**5.2**
243	Medical Back Problems	21,666	21.3	24.4	27.7	30.4	33.5	36.1	37.9	39.5	**9.3**
113	**Amp for Circ System Disorder Exc. Upper Limb & Toe.**	**19,421**	**54.1**	**56.4**	**59.0**	**60.7**	**63.4**	**64.7**	**67.1**	**68.6**	**3.4**
239	Path Fractures, Muscoskeletal & Connective Tissue Malignancy	20,958	35.4	39.3	42.3	45.9	49.0	51.7	53.7	54.6	**6.4**
106	Coronary Bypass w/ PTCA	13,297	17.1	19.8	22.7	25.3	29.6	34.1	36.5	36.6	**11.6**
236	**Fractures of Hip and Pelvis**	**18,741**	**49.0**	**52.6**	**55.3**	**57.9**	**61.4**	**63.8**	**65.6**	**67.1**	**4.6**
107	Coronary Bypass w/ Cardiac Cath	7,739	14.9	17.5	20.2	23.6	27.6	31.2	33.6	35.6	**13.3**
468	Extensive OR Proc Unrelated to Principal Diag.	17,898	28.7	30.6	32.6	33.8	36.4	38.6	40.5	40.8	**5.2**
211	**Hip/Femur Proc. Exc. Major Joint, > 17 w/o CC**	**15,990**	**58.0**	**59.9**	**63.2**	**65.7**	**69.8**	**72.3**	**74.2**	**76.7**	**4.1**
483	**Tracheostomy Except Face, Mouth, Neck**	**10,912**	**31.1**	**33.7**	**37.6**	**40.5**	**43.1**	**46.6**	**48.5**	**50.2**	**7.1**
415	OR Proc for Infect/Parasitic Disease	10,543	35.2	37.2	40.3	42.5	45.3	47.6	49.2	50.1	**5.2**
429	**Organic Dist. And Mental Retardation**	**13,011**	**42.1**	**44.5**	**47.0**	**49.4**	**52.8**	**55.1**	**56.2**	**56.1**	**4.2**
1	Craniotomy, >17 Exc. Trauma	9,817	34.1	35.2	37.2	38.7	39.3	40.0	42.4	42.7	**3.3**
263	**Skin Graft/Debridement for Skin Ulcer/Cellulitis w/CC**	**13,956**	**48.3**	**49.9**	**51.9**	**52.7**	**54.3**	**56.2**	**58.0**	**59.9**	**3.1**
264	**Skin Graft/Debridement for Skin Ulcer/Cellulitis w/o CC**	**1,375**	**34.7**	**36.8**	**38.6**	**39.7**	**41.5**	**43.2**	**46.8**	**50.5**	**5.5**
214	Back/Neck Proc. w/CC	9,974	23.1	25.2	27.5	28.8	32.2	34.4	36.5		**-7.5**
TOTAL		**707,860**	**37.5**	**40.1**	**42.9**	**45.2**	**47.7**	**50.0**	**51.9**	**53.5**	**5.2**

NOTE:
PAC utilization was idenitifed using the following MedPAR discharge destination codes: 03, skilled nursing facility, 05, PPS-exempt, and 06, home health agency.
Bold denotes the original DRGs chosen by HCFA for the PAC transfer policy
** These 20 DRGs were used by HCFA when choosing 10 pilot DRGs for the PAC transfer policy.

SOURCE: MedPAR file 1991-1998, Output T45MED.Y94 - T45MED.Y98

Figure 2-2
Average Length of Stay PAC Transfers vs. Non-PAC Transfers, 1991-1998



NOTES:
PAC utilization was identified using the following MedPAR destination codes: 03, skilled nursing facility; 05, PPS-exempt; and 06, home health agency.
SOURCE: MedPAR, 1991 - 1998.

Table 2-2

Mean Length of Stay for Top 20 Postacute Care Transfer DRGs, Postacute Care Users vs. Non-Users, 1991-1998

DRG	Description	1991		1998		Average Annual Percent Change, 1991-1998	
		PAC Transfers	Non-PAC Transfer	PAC Transfers	Non-PAC Transfer	PAC Transfers	Non-PAC Transfer
1	Craniotomy, >17 Exc. Trauma	20.7	13.2	11.9	7.15	-7.5	-8.3
14	Cerebrovascular Disorders	12.5	8.5	7.4	5.1	-7.2	-7.2
79	Resp. Infec. And Inflam. >17 w/CC	13.8	10.6	9.5	7.6	-5.1	-4.5
106	Coronary Bypass w/ PTCA	19.4	14.3	12.1	9.5	-6.4	-5.6
107	Coronary Bypass w/ Cardiac Cath	15.1	10.9	10.0	7.8	-5.4	-4.6
113	Amp for Circ System Disorder Exc. Upper Limb & Toe.	19.0	19.2	11.7	12.6	-6.7	-5.8
148	Major Bowel Proc w/CC	19.6	14.5	14.5	10.7	-4.3	-4.3
209	Joint/Limb Reattachment of the Lower Extremity	10.6	10.1	5.1	5.2	-9.9	-9.0
210	Hip/Femur Proc. Exc. Major Joint, > 17w/CC	12.6	13.3	6.6	7.2	-8.7	-8.3
211	Hip/Femur Proc. Exc. Major Joint, > 17 w/o CC	9.3	9.3	4.9	4.9	-8.7	-8.8
214	Back/Neck Proc. w/CC	14.2	8.8	n/a	n/a	-10.7	-10.5
236	Fractures of Hip and Pelvis	10.6	8.1	7.1	4.5	-5.4	-7.7
239	Path Fractures, Musculokeletal & Connective Tissue Malignancy	11.5	9.3	6.8	5.8	-7.3	-6.5
243	Medical Back Problems	9.3	6.2	6.1	4.2	-5.8	-5.4
263	Skin Graft/Debridement for Skin Ulcer/Cellulitis w/CC	21.8	19.8	12.0	11.0	-8.1	-7.9
264	Skin Graft/Debridement for Skin Ulcer/Cellulitis w/o CC	12.2	10.9	7.3	6.7	-6.9	-6.7
296	Nutr. And Misc Metabolic Disorders, >17w/CC	10.5	7.4	6.4	4.6	-6.7	-6.6
415	OR Proc for Infect/Parasitic Disease	24.1	18.6	15.4	12.8	-6.1	-5.2
429	Organic Dist. And Mental Retardation	17.5	10.9	11.8	5.9	-5.3	-7.6
468	Extensive OR Proc Unrelated to Principal Diag.	24.6	16.7	16.1	11.3	-5.8	-5.4
483	Tracheostomy Except Face, Mouth, Neck	62.7	55.7	39.2	28.4	-6.4	-8.8
Average		**17.7**	**13.5**	**10.6**	**7.9**	**-7.1**	**-7.3**

NOTE:

PAC utilization was idenitifed using the following MedPAR discharge destination codes: 03, skilled nursing facility, 05, PPS-exempt, and 06, home health agency.
DRG 214 eliminated in 1998. Percent changes based on 1991-1997.
Totals represent weighted average of DRG, weighted by DRG share of total cases.

SOURCE: MedPAR, 1991-1998

non-PAC lengths of stay (i.e., -7.1 percent and -7.3 percent) is deceiving as non-PAC cases had much shorter stays to begin with. Fourteen of twenty DRGs actually saw PAC LOS fall faster than for non-PAC cases.

The long-term shift in the provision of selected medical services from acute to postacute facilities, coupled with dramatic declines in inpatient LOS, prompted HCFA to reconsider its policy of paying the full DRG rate for patients transferred to postacute care providers early in their inpatient length of stay.

2.4 Description of the Postacute Care Transfer Payment Policy

In 1997, Congress formally responded to the increasing rate of acute care discharges to postacute care providers by directing HCFA to identify ten DRGs to test the feasibility of extending the PPS acute care transfer payment policy to postacute care settings. The policy change went into effect on October 1, 1998. Hospitals reimbursed under the rules of PPS would no longer receive the full DRG payment amount for patients transferred to postacute care providers early in their inpatient stay. The primary intent of the new postacute care transfer policy under inpatient PPS was to bring Medicare payments in line with the evolving treatment and cost patterns. The new policy was also designed to reduce the risk of premature postacute care transfers from acute care settings.

Under the final rules published in the 1998 Federal Register, postacute care transfers were defined as all discharges from an acute care hospital followed by an admission to a PPS-exempt or skilled nursing facility or a visit from a home health agency. To qualify as a postacute care transfer, inpatient admissions to postacute care facilities must occur on the same calendar day as the acute care hospital discharge. However, a direct acute-to-postacute care transfer that spans midnight and results in a

one-day difference in the discharge and admission dates will also be considered a transfer for purposes of the payment policy. Home health transfers must occur within a three-day period subsequent to acute care discharge. The inpatient readmission or home health visits must also be related to the acute care stay, although the burden of proving otherwise lies with the sending hospital.

2.4.1 Two-Stage Selection of 10 DRGs

The DRGs included in the postacute care transfer policy were chosen by HCFA "based upon a high volume of discharges classified within such group and a disproportionate use of certain post-discharge services" (Federal Register, July 31, 1998). HCFA began by selecting the 20 DRGs with the highest share of postacute care discharges, subset first on those DRGs with no fewer than 14,000 cases being discharged to a postacute care provider. HCFA subsequently identified 10 pilot DRGs based on the volume and percent of discharges occurring early in the inpatient stay. The volume and shares used to select the pilot DRGs were based on acute-postacute episode-level files created by HCFA using 1996 MedPAR data.

Table 2-3 identifies the 10 DRGs selected for the postacute care transfer policy. It also provides the percent of postacute care utilization and the number of postacute care cases for each DRG. Unlike in Table 2-1, PAC rates were calculated by HCFA using PAC claims rather than inpatient discharge destination codes. The overall average rate of postacute care utilization for these 10 pilot DRGs was roughly 57 percent, ranging from 39.3 percent for DRG 264, *Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without Complicating Conditions*, to 77.8 percent for DRG 210, *Hip and Femur Procedures Except Major Joint, Age > 17 with Complicating Conditions*. The volume of

Table 2-3

DRGs Included in the PAC Transfer Policy

DRG	Title and Type of DRG	Percent of PAC Utilization	Number of PAC Cases
14	Specific Cerebrovascular Disorders Except Transient Ischemic Attack[b]	49.5	186,845
113	Amputation for Circulatory System Disorders Excluding Upper Limb and Toe[a]	59.0	28,402
209	Major Joint Limb Reattachment Procedures of Lower Extremity[a]	71.9	257,875
210	Hip and Femur Procedures Except Major Joint Age >17 with CC[a]	77.8	111,799
211	Hip and Femur Procedures Except Major Joint Age >17 without CC[a]	74.2	19,548
236	Fractures of Hip and Pelvis[b]	61.2	24,498
263	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC[a]	49.4	14,499
264	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC[a]	39.3	1,328
429	Organic Disturbances and Mental Retardation[b]	45.4	19,314
483	Tracheostomy Except for Face, Mouth and Neck Diagnosis[a]	45.3	18,254

NOTE:

[a] Surgical DRGs, [b] Medical DRGs

SOURCE: Federal Register Friday July, 31, 1998, page 40975.

postacute care cases ranged from a high of 257,875 to a low of 14,499, excluding DRG 264. Despite having only 1,328 cases discharged to a postacute care provider, DRG 264 was included for the pilot program because of its close clinical association with DRG 263, which satisfied HCFA's postacute care volume and share criteria. The only difference between the two DRGs is that, for DRG 264, the patient must also have a complicating condition. The potential for creating "pairs" of DRGs will have important implications for the expansion policy as discussed in Chapter 6 of this report.

2.4.2 Two PAC Transfer Payment Methods

While the federal statute did not stipulate a payment method for postacute care transfers, the final rule did specify that the payment amount for a case may not exceed the "full DRG payment that would have been made if the patient had been discharged without being transferred" (Federal Register P.40974, July, 31, 1998). This payment constraint will meet, and be capped at, the full DRG amount one day before reaching the national geometric mean length of stay for the given DRG. Current policy allows for twice the per diem reimbursement rate on the first day of inpatient hospitalization and the per diem on each subsequent day until full DRG reimbursement is reached. The DRG-specific per diem is calculated using the hospital base rate and the national geometric mean length of stay. The geometric mean is calculated using a 100 percent sample of national PPS claims during the previous year and reported prior to the initiation of the new rate year in the Federal Register. Acute care facilities under both per diem payment methodologies are eligible to be reimbursed for the additional costs associated indirect medical education, disproportionate share casemix and cost outliers.

While the postacute care transfer policy applies to all transfer cases, hospitals will receive the lower per diem amounts only for those patients who are discharged to postacute care at least one day before reaching than the national geometric mean length of stay[1]. Based on the transfer reimbursement formula, patients transferred on or after one day below the national geometric mean will generate full DRG payments for the sending hospital.

HCFA's analysis of the 1996 claims data showed that three out of the 10 pilot DRGs (209, 210 and 211) incur a disproportionate percentage of total costs on the first day of hospitalization. As a result, HCFA developed an alternative per diem reimbursement formula designed to front-load total payments. On the first day of inpatient hospitalization, the sending hospital will receive the per diem rate (as opposed to double) plus one-half of the full DRG amount. On each of the remaining inpatient days before reaching the geometric mean, the acute care facility will receive only one-half the per diem. For the three DRGs being paid under the blended payment formula, the per diem payment formula has been constrained to be identical to the standard transfer payment formula when the patient's length of stay is one day less than the geo-mean.[2]

---

[1]1 Proof: In the standard transfer policy, per diem payment will be less than the full DRG payment (DRG) for a patient with LOS; if 2[DRG/GLOS] + (LOS - 1)[DRG/GLOS] < DRG
where GLOS = the geo-mean and DRG/GLOS = the per diem rate. Solving the inequality,
[DRG/GLOS](2 + LOS - 1) < DRG, or LOS +1 < GLOS.

[2]2 Proof: In the new blended transfer policy, blended payment will be less than the full DRG payment (DRG) for a patient with LOS if
.5 DRG + [DRG/GLOS] + .5(LOS -1)[DRG/GLOS] < DRG. These three components on the left-hand-side represent (a) half the full DRG rate, (b) a full per diem on day 1, and (c) half per diems for the rest of a patients stay, i.e., LOS -1.

Solving the inequality,
DRG [.5 + (1/GLOS) + .5(LOS -1)/GLOS] < DRG
(1/GLOS)[1+.5 LOS -.5] < 1-.5 = .5, or
(LOS + 1) < GLOS.

HCFA has estimated that the lower per diem payments for short-stay transfer cases (defined as one day less than the geometric mean LOS) will result in a 0.6 percent decrease in per case program payments. According to HCFA, the reduction in per case payments should, in turn, generate savings of approximately $480 million in overall Medicare payments (Federal Register, 1998). However, as will be discussed in Chapter 5, HCFA's estimated savings do not take into account changes in hospital treatment and discharge patterns in response to the new policy. When hospitals' behavioral response is considered, net program savings is expected to be only $100 million according to estimates made by the Congressional Budget Office and published in the Federal Register. More recently, MedPAC conducted a study of the impact of the postacute care transfer policy reform and found that it led to a 0.7 percent reduction in aggregate payments and a 4.9 percent reduction in total payments to the 10 pilot DRGs (MedPAC, Report to Congress, March 2000). By conducting a pre versus post-policy change analysis, MedPAC's study implicitly accounted for changes in PPS hospital treatment and discharge patterns.