Inpatient PACT Adjustment Analysis

Federal Fiscal Years 2021–2026 | Version 1

Analysis Description

This analysis is intended to show the estimated impact on Medicare inpatient fee-for-service (FFS) payments, and corresponding Medicare Severity-Diagnosis Related Group (MS-DRG) volumes from the inpatient prospect payment system (IPPS) post-acute care transfer (PACT) adjustment policy for discharges during Federal Fiscal Years (FFY) 2021–2026 to the following post-acute settings:

- Skilled Nursing Facilities
- Inpatient Rehabilitation Facilities
- Long-Term Care Hospitals
- Inpatient Psychiatric Facilities
- Cancer and Children's hospitals
- Home with a Home Health plan of care that begins within three days of discharge
- Hospice care

An inpatient PACT adjustment occurs when a Medicare beneficiary in an IPPS hospital is transferred to a post-acute setting and the inpatient length of stay (LOS) is less than the geometric mean LOS defined for that FFY by the Centers for Medicare and Medicaid Services (CMS). The transferring hospital is paid per-diem for that beneficiary and capped at the full MS-DRG amount for the discharge. High-cost MS-DRGs may be flagged by CMS as eligible for a special payment methodology under which the transferring hospital receives 50% of the full MS-DRG payment plus a per diem payment, with the total capped at the full MS-DRG amount.

The upper section in the PACT Analysis tab shows the estimated impacts on the inpatient facility for discharges to each of the post-acute settings that would flag a PACT adjustment in the FFY under study, as well as the estimated percent decrease this impact has on the provider's yearly total non-transfer adjusted DRG payments. The bottom section shows total yearly DRG volumes for all claims compared to those flagged as post-acute DRGs in IPPS Table 5, by their corresponding discharge setting in both report and chart format. The percentages in the report are a comparison of the number of PACT DRGs per setting to the total number of claims.

The Major Diagnostic Category (MDC) Report tab shows the number of claims and potential impact of the PACT policy for each MDC category. The control on the left side of the tab can be used to filter by year.

Claim volumes less than 11 are redacted where necessary due to CMS privacy rules. Due to this, some providers may see revenue impacts without associated DRG volumes.

Data Sources

This analysis uses the most recently published IPPS Table 5 from FFYs 2021–2026 to identify MS-DRGs subject to the PACT adjustment, whether the MS-DRG is a special payment DRG, which MDC grouping the MS-DRG belongs

to, and the MS-DRG geometric mean LOS for each year. A copy of each year's Table 5, filtered to show DRGs subject to the PACT policy can be found at https://calhospital.org/file/table-5-ffy-2021-2026/.

Beneficiary LOSs, discharge settings, and DRG usage during FFYs 2021–2024 are identified using data from the calendar years 2020–2024 Medicare 100% Inpatient Standard Analytic File (SAF). Projections for FFYs 2025 and 2026 are held at FFY 2024 SAF claims volume and case-mix.

Providers included in this analysis, as well as federal and hospital specific rates (HSRs), are based on the FFY 2026 IPPS Final Rule Impact File. For FFYs 2021–2025, standard federal and HSRs are calculated by deflating FFY 2026 rates by yearly adjustment factors. Yearly determinations of whether a provider is paid using the federal standard IPPS rate or HSR are based on payments reported in the Medicare Cost Report, Worksheet E Part A, lines 47 and 48.

Methods

For a non-transfer adjusted claim, the provider's payment for that claim is calculated by multiplying that provider's non-wage adjusted payment rate by the weight for the DRG associated with the claim. The sum of all non-transfer adjusted claims, regardless of whether the claim would be subject to the PACT policy, is calculated for each hospital.

Whether or not a claim is transferred to a post-acute setting is determined for each claim during FFYs 2021–2024. For FFYs 2025 and 2026, payments are calculated using 2024 claim volume, adjusted to reflect updates in DRG weights and PACT status using each year's respective IPPS table 5. The per diem payment rate for each MS-DRG that is subject to PACT payments is calculated by dividing the MS-DRG weight by the geometric mean LOS.

For claims with a LOS less than the geometric mean LOS, payments are calculated by multiplying the provider's rate by the per diem rate and the claim's LOS, to a maximum of what the provider would be paid if the claim was not transfer adjusted. For claims which are not subject to special payment, the first day of the claim is paid at twice the per diem rate since CMS analysis has shown that the first day of a LOS is typically the most expensive. Special pay DRGs, which CMS has determined to have higher costs, have payments calculated as 50% of the total non-transfer adjusted DRG payment plus a per diem rate for each day in the LOS, to a maximum of the full DRG payment.

Once transfer adjusted and non-transfer adjusted payments are determined for each claim that would be subject to the PACT adjustment, the difference between the two is calculated, resulting in an impact of the PACT policy for that claim. This difference is then aggregated by transfer destination to estimate the total impact of this policy by setting.

This analysis does not include estimates for outlier payments, payments for services provided to Medicare Advantage patients, electronic health record incentive payments, or modifications in FFS payments as a result of hospital participation in new payment models being tested under Medicare demonstration/pilot programs.

Dollar impacts in this analysis may differ from those provided by other organizations/associations due to differences in source data and analytic methods. Individual percentages and dollars shown in this analysis may not add to total due to compounding and rounding. Dollar amounts less than $50 and percentages less than 0.05% will appear as zeros due to rounding. Impact percentages are derived by comparing values of individual impacts to base year DRG payments.