

among cases with lengths of stay shorter than the geometric mean for the DRG (these cases would be affected by the reduced payments for transfers). The table shows that these DRGs continue to contain high percentages of cases transferred to postacute care settings similar to those we reported in the FY 1999 final rule (63 FR 40975). These results would appear to demonstrate that the postacute transfer policy has not greatly altered hospitals' treatment patterns for these cases.

This similarity in treatment patterns is further evidenced by the fact that, for 6 of the 10 DRGs, the geometric mean length of stay has continued to decline in the 5 years since the policy was implemented. Accordingly, hospitals have continued to transfer many patients in these DRGs before the mean length of stay, despite the transfer

policy. As we stated in the July 31, 1998 final rule, the transfer provision adjusts payments to hospitals to reflect the reduced lengths of stay arising from the shift of patient care from the acute care setting to the postacute setting (63 FR 40977). This policy does not require a change in physician clinical decisionmaking nor in the manner in which physicians and hospitals practice medicine: it simply addresses the appropriate level of payments once those decisions have been made.

With respect to whether this policy alters the fundamental averaging principles of the IPPS, we believe the current policy, which targets specific DRGs where evidence shows hospitals have aggressively moved care to postacute care settings, does not alter the averaging principles of the system. In fact, it could be said to enhance those

principles because a transfer case is counted as only a fraction of a case toward DRG recalibration based on the ratio of its transfer payment to the full DRG payment for nontransfer cases. This methodology ensures the DRG weight calculation is consistent with the payment policy for transfer cases. The last column of the table below indicates that all but three of these DRGs have experienced increases in DRG weights since the policy was implemented. By reducing the contribution of transfer cases to the calculation of the DRG average charge, the relative weights (the result of dividing the DRG average charge by the national average charge per case) are higher than they would otherwise be. This is because transfers, particularly short-stay transfers, have lower total charges, on average.

DRG	DRG title	All transfer cases	Percent of all cases transferred to postacute care setting	Percent of all cases transferred prior to mean length of stay	Percent change in mean length of stay FYs 92–98	Percent change in mean length of stay FYs 98–03	Percent change in DRG relative weight FYs 98–03
14	Intracranial Hemorrhage and Stroke with Infarction.	143,649	48.88	11.74	–29.17	–5.88	8.53
113	Amputation for Circulatory System Disorders Except Upper Limb and Toe.	24,470	66.57	30.12	–32.17	7.22	9.21
209	Major Joint and Limb Reattachment Procedures of Lower Extremity.	244,969	66.66	19.76	–47.52	–15.09	–8.09
210	Hip and Femur Procedures Except Major Joint Age >17 With CC.	87,253	76.26	35.67	–42.98	–6.15	0.1
211	Hip and Femur Procedures Except Major Joint Age >17 Without CC.	20,239	72.38	15.89	–44.44	–8.00	1.39
236	Fractures of Hip and Pelvis	26,583	69.86	11.20	–34.85	–6.98	–1.43
263	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC.	13,158	62.00	31.35	–41.45	4.49	9.36
264	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis Without CC.	1,759	49.97	18.81	–37.21	1.85	5.36
429	Organic Disturbances and Mental Retardation.	30,349	53.25	15.22	–28.95	–12.96	–5.27
483	Tracheostomy With Mechanical Ventilation 96 + Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses.	21,818	52.93	27.34	–15.29	2.37	1.38

After determining the current 10 DRG postacute care transfer policy appears to be appropriately balancing the objectives to reduce payments to reflect cost-shifting due to reductions in length of stay attributable to early postacute care transfers and to ensure that payments, on average, remain adequate to ensure effective patient care, we once again undertook the analysis to identify additional DRGs to which the policy may be expanded. However, it should be noted that, at this time, we have decided not to expand the policy to all DRGs. Although we still believe expanding the postacute care transfer policy to all DRGs might be the most equitable approach because a policy that is limited to certain DRGs may result in

disparate payment treatment across hospitals, at this time, we believe an incremental expansion is appropriate. That is, we believe further analysis is necessary to assess whether it would be appropriate to apply a reduced payment for postacute care transfers across all DRGs. In particular, it is important to attempt to distinguish between DRGs where the care is increasingly being shifted to postacute care sites versus DRGs where some patients have always been discharged to postacute care early in the stay. For the latter DRGs, it may not be appropriate to reduce payment for these DRGs if the base payment already reflects a similar postacute care utilization rate (for example, in these cases there would be no cost shifting).

As described below, we have identified an additional 19 DRGs, based on declining mean lengths of stay and high percentages of postacute transfers, for which an expansion of the current policy appears warranted.

MedPAC has also conducted analysis on the current postacute care transfer policy. Most recently, in its March 2003 Report to Congress, MedPAC recommended adding 13 additional DRGs to the 10 DRGs covered under the current policy (page 46). The 13 DRGs were the same DRGs included in one of our proposals to expand the postacute care transfer policy in last year's IPPS proposed rule. MedPAC did not recommend expanding the policy to include all DRGs at this time, noting