

Section 1886(d)(5)(J) of the Act directed the Secretary to select 10 DRGs based upon a high volume of discharges to postacute care and a disproportionate use of postacute care services. As discussed in the July 31, 1998 final rule, these 10 DRGs were selected in 1998 based on the MedPAR data from FY 1996. Using that information, we identified and selected the first 20 DRGs that had the largest proportion of discharges to postacute care (and at least 14,000 such transfer cases). In order to select 10 DRGs from the 20 DRGs on our list, we considered the volume and percentage of discharges to postacute care that occurred before the mean length of stay and whether the discharges occurring early in the stay were more likely to receive postacute care. We identified the following DRGs to be subject to the special 10 DRG transfer rule:

- DRG 14 (Intracranial Hemorrhage and Stroke with Infarction (formerly "Specific Cerebrovascular Disorders Except Transient Ischemic Attack"));
- DRG 113 (Amputation for Circulatory System Disorders Except Upper Limb and Toe);
- DRG 209 (Major Joint Limb Reattachment Procedures of Lower Extremity);
- DRG 210 (Hip and Femur Procedures Except Major Joint Procedures Age ≤17 With CC);
- DRG 211 (Hip and Femur Procedures Except Major Joint Procedures Age ≤17 Without CC);
- DRG 236 (Fractures of Hip and Pelvis);
- DRG 263 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis With CC);
- DRG 264 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis Without CC);
- DRG 429 (Organic Disturbances and Mental Retardation); and
- DRG 483 (Tracheostomy With Mechanical Ventilation 96 + Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses (formerly "Tracheostomy Except for Face, Mouth, and Neck Diagnoses"))).

Similar to the policy for transfers between two acute care hospitals, the transferring hospital in a postacute care transfer for 7 of the 10 DRGs receives twice the per diem rate the first day and the per diem rate for each following day of the stay before the transfer, up to the full DRG payment. However, 3 of the 10 DRGs exhibit a disproportionate share of costs very early in the hospital stay in postacute care transfer situations. For these 3 DRGs, hospitals receive 50 percent of the full DRG payment plus the single per diem (rather than double

the per diem) for the first day of the stay and 50 percent of the per diem for the remaining days of the stay, up to the full DRG payment. This is consistent with section 1886(d)(5)(J)(i) of the Act, which recognizes that in some cases "a substantial portion of the costs of care are incurred in the early days of the inpatient stay."

Section 1886(d)(5)(J)(iv) of the Act authorizes the Secretary to expand the postacute care transfer policy beyond 10 DRGs. In the May 9, 2002 IPPS proposed rule, we discussed the possibility of expanding this policy to either all DRGs or a subset of additional DRGs (we identified 13 additional DRGs in that proposed rule) (67 FR 31455). However, as discussed further in the August 1, 2002 final rule (65 FR 50048), we did not expand the postacute care transfer provision to additional DRGs for FY 2003. The commenters on the options in the May 9, 2002 proposed rule raised many issues regarding the impact of expanding this policy that we needed to consider further before proceeding. In particular, due to the limited time between the close of the comment period and the required publication date of August 1, we were unable to completely analyze and respond to all of the points that were raised. We indicated that we would continue to conduct research to assess whether further expansion of this policy may be warranted and, if so, how to design any such refinements.

Many commenters on the May 9, 2002 proposed rule argued that, in a system based on averages, expansion of the postacute care transfer policy negatively influences, and in fact penalizes, hospitals for efficient care. They claimed that this policy indiscriminately penalizes hospitals for efficient treatment and for ensuring that patients receive the right care at the right time in the right place. They believed that the postacute care transfer provision creates an inappropriate incentive for hospitals to keep patients longer.

Commenters also expressed concern that the expansion of the transfer provision violates the fundamental principle of the IPPS. The DRG system is based on payments that will, on average, be adequate. These commenters argued that expansion of the postacute care transfer policy would give the IPPS a per-diem focus and would mean that hospitals would be paid less for shorter than average lengths of stay, although they would not be paid more for the cases that are longer than average (except for outlier cases).

We agree that the transfer policy should not hamper the provision of

effective patient care. We also agree that any future expansion must consider both 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. Therefore, we have assessed the extent to which the current postacute care transfer policy balances these objectives.

The table below displays the results of our analysis. We first examined whether the 10 DRGs included in the policy continue to exhibit a relatively high percentage of cases transferred to postacute care settings, particularly 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 care 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 care 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