

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 1992–1998	Percent change in mean length of stay FYs 1998–2003	Percent change in DRG relative weight FYs 1998–2003
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

We indicated in the proposed rule that we believe 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. Therefore, we once again undertook the analysis to identify additional DRGs to which the policy might be expanded.

However, we did not propose to expand the policy to all DRGs. Although we indicated that 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. It may not be appropriate to reduce payment for these latter 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 proposed 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 appeared warranted.

We also noted that MedPAC has 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 that this expansion might reduce payments to some hospitals by as much as 4 percent. Rather, it suggested evaluating the impact of a limited expansion before extending the policy to more DRGs.

MedPAC's report cites several reasons for expanding the postacute care transfer policy beyond the current 10 DRGs. First, it notes the continuing shifts in services from the acute care setting to the postacute care setting. Second, the report points to different postacute care utilization for different hospitals, particularly based on geographic location. Third, the report states: "the expanded transfer policy provides a better set of incentives to protect beneficiaries from potential premature discharge to postacute care." Fourth, MedPAC notes that the policy improves payment equity across hospitals by: reducing payments to hospitals that transfer patients to postacute care while making full payments to hospitals that provide all of the acute inpatient services in an acute care setting; and maintaining more accurate DRG weights that reflect the