

percent of the full DRG payment plus 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 specified in existing regulations under § 412.4(f). To identify the DRGs that might qualify, we compared the average charges for all cases with a length of stay of 1 day to the average charges of all cases in a particular DRG. To qualify for the alternative methodology, we indicated that the average charges of 1-day discharge cases must be at least 50 percent of the average charges for all cases in the DRG.

Based on this analysis, we determined that 5 out of the proposed 19 DRGs would qualify for this payment method (DRGs 25, 122, 131, 297, and 321). However, the fact that the average charges of 1-day stays equal at least 50 percent of the average charges for all cases in these DRGs is due to the very short lengths of stay for these DRGs. Therefore, we did not propose to include them in the alternative payment methodology. For example, for a DRG with a 3-day geometric mean length of stay, full DRG payment will be made on the second day of the stay, regardless of which payment methodology is used. Therefore, in the May 19, 2003 proposed rule, we proposed that none of the 19 additional DRGs that we were proposing to add to the postacute care transfer policy would be paid under the alternative payment methodology.

We also analyzed the 10 DRGs that are currently subject to the postacute care transfer policy. Of the three DRGs that are receiving payments under the special payment (transfers after 1 day incur charges equal to at least 50 percent of the average charges for all cases). Unlike the five DRGs that would otherwise meet this criterion, the geometric mean length of stay of both DRG 209 and 211 is over 4 days. In addition, DRG 210 is currently paid under the special payment methodology, but our current analysis indicates average charges for 1-day stays are less than 50 percent of the average charges for all cases in the DRG. Nonetheless, DRG 210 is paired with DRG 211, which meets the criteria. Therefore, we proposed that DRG 210 would continue to be paid under the special payment methodology. Similar to our rationale for including both paired DRGs when one qualifies for inclusion in the postacute care transfer policy, we proposed to include both DRGs in this pair under the special payment methodology. Accordingly, we proposed that only DRGs 209, 210, and 211 that are currently paid under the alternative transfer payment

methodology would continue to be paid under this methodology.

Finally, we noted that the OIG has prepared several reports that examined hospitals' compliance with proper coding of patients' discharge status as transferred under our guidelines, and has found substantial noncompliance leading to excessive payments.<sup>6</sup> Specifically, the OIG found hospitals submitting claims indicating the patient had been discharged when, in fact, the patient was transferred to a postacute care setting. As we indicated in the May 8, 1998 *Federal Register* (63 FR 25593), hospitals found to be intentionally engaging in such practices may be investigated for fraudulent or abusive billing practices. We intend to work with the OIG to develop the most appropriate response to ensure all hospitals are compliant with our guidelines.

*Comment:* Many commenters argued that any expansion of the postacute care transfer policy, and even the policy itself, undermines clinical decisionmaking and penalizes hospitals for providing the right care at the right time and in the right setting. Commenters further argued that the policy itself violates the original premise of the IPPS, because it makes it difficult or impossible for hospitals to break-even on patients who receive postacute care after discharge. One commenter argued that hospitals lose if patients are discharged prior to the mean length of stay, and they lose if patients are discharged after the mean length of stay.

Commenters also argued the postacute care transfer policy is not good policy because it may create a perverse incentive for hospitals to increase patients' lengths of stay. One commenter expressed concern that longer lengths of stay would result from a shift in focus from per-case cost control to per-day cost control. The commenter suggested that this policy sends a conflicting message to hospital administrators who have taken steps recently to reduce their hospitals' average lengths of stay.

Some commenters pointed out that the postacute care transfer policy fails to acknowledge or recognize that, for many patients, postacute care is already reflected in the IPPS base payment rate for many DRGs. In particular, hospitals in certain regions of the country have historically had lower average lengths of stay, and therefore, these hospitals are

disproportionately impacted by this policy.

Other commenters suggested the DRG relative weights are self-adjusting, and as patients spend less time in the acute care setting and costs decrease, the DRG relative weights will begin to fall. Therefore, there is no need for a postacute care transfer policy.

Commenters also noted the increasing costs of dealing with these higher cost cases, and that transfer payments do not adequately cover the costs of the newer and better treatment that is resulting in shorter lengths of stay. Commenters objected to the expansion of the policy due to the current financial pressure that many hospitals are currently under because of nursing shortages, inadequate Medicare payment for services they provide, and increasing costs associated with malpractice and insurance costs and increasing costs of pharmaceuticals and equipment. They also noted the financial burden in preparing to treat the aging "baby boomer" generation and costs associated with emergency management preparation.

Commenters argued that many hospitals are suffering as a result of not receiving the full market basket update (accounting for inflation each year), and further expansion of the postacute care transfer policy will further limit their resources. In addition, they argued, Congress already addresses the issues of shorter lengths of stay when it determines the market basket update each year. In effect, they claimed, hospitals whose lengths of stay decline significantly are not praised, but penalized—twice—for their efforts to provide better care. One commenter wrote to "respectfully submit that to deal with fraudulent providers in this sweeping manner is inconsistent and inappropriate."

*Response:* We disagree that the postacute care transfer policy is contrary to the fundamental theory of the IPPS. Concern that hospitals would shift a portion of the acute care services to other providers in response to the incentives of the IPPS has been an ongoing concern. In fact, in response to a comment during the first year of the IPPS on the hospital-to-hospital transfer policy, we stated that "(t)he rationale for per diem payments as part of our transfer policy is that the transferring hospital generally provides only a limited amount of treatment. Therefore, payment of the full prospective payment rate would be unwarranted" (49 FR 244). We also note that in its earliest update recommendations, the Prospective Payment Assessment Commission (a predecessor to MedPAC)

<sup>6</sup> The OIG report identification numbers are: A-04-00-02162, A-04-00-01210, A-04-0122, and A-04-02-07005.