

included what it called a site-of-service substitution adjustment to account for the shifting of portions of inpatient care to other settings.

We disagree that the postacute care transfer policy creates a perverse incentive to keep patients in the hospital longer than necessary. Our view is the policy simply responds to changing medical practice and addresses the appropriate level of payment once clinical decisions about the most appropriate care in the most appropriate setting have been made. The validity of this position is substantiated by the finding that the geometric mean length of stay for 6 of the 10 DRGs currently included in the policy have continued to fall since the policy was implemented.

In regard to the comment that the policy fails to recognize that the DRG base payments reflect some degree of postacute care, we note that the policy is intended to recognize that, since the implementation of the IPPS, the use of postacute care has generally increased. For many DRGs, the use of postacute care continues to increase at a high rate. However, an increase in the frequency of the use of postacute care does not, by itself, necessitate a policy response. If patients continue to receive the full course of acute care in the IPPS setting prior to transfer, a full DRG payment is warranted. However, if patients begin to be transferred to postacute care settings to receive care that, during the IPPS base period, was provided in the IPPS setting, paying a full DRG would not be appropriate because some of the care on which the full DRG payment is based is now being provided in the postacute care setting.

This shift in the setting where care is provided is not accounted for through DRG recalibration. During recalibration, reductions in the relative weights of certain DRGs result in increases in the weights of other DRGs. Therefore, there is no net reduction in the IPPS payments to hospitals, even though some of the care that used to be provided in the acute inpatient setting is now provided elsewhere.

Comment: Commenters took issue with our evaluation of the impact of the postacute care transfer policy on the averaging aspects of the IPPS if the policy were expanded. Pointing to our statement in the August 1, 2002 **Federal Register** that we intended to undertake a more comprehensive analysis of this issue, some commenters stated that we did not provide such a comprehensive analysis or include a discussion of the topic in the proposed rule.

However, other commenters expressed appreciation for our analysis

of the impacts of the existing policy in the proposed rule. One commenter noted that we had made some interesting and potentially valid points that an expanded transfer policy would eliminate or reduce some of the problems caused by making national average payments to all hospitals, regardless of treatment patterns and patient-mix within specific DRGs (although this commenter suggested that we address the payment inequities caused by expensive short-stay cases, or “inliers”).

Several commenters noted that the recalculation of weights in the affected DRGs is unfair because, in the system of averages, transfers are accounted for as only partial cases but the remaining cases are not adjusted upward. The commenter wrote: “[i]f a DRG’s length of stay is declining, doesn’t that suggest recalibration of the relative weight?” The commenter believed inclusion of reduction in length of stay criteria “begs the question of what is the true average length of stay for these particular DRGs. If these DRGs are experiencing a large percentage of cases transferred prior to the average length of stay, it logically follows that the average length of stay would be less.”

Response: We regret that commenters perceived that we neglected to address this important issue. Our point in evaluating the DRG relative weights for the 10 DRGs that are currently included in the policy was to make the point that reducing the contribution of transfer cases in the DRG relative weight recalibration enhances the averaging mechanism for these DRGs. By treating transfer cases as less than a full discharge (reducing the denominator), we effectively inflate the charges (the numerator) to reflect the higher charges that would have occurred if the patient had been transferred. This increases, rather than decreases, the average charges (and thus the relative weights) for the affected DRGs.

For example, the DRG weights for each of these 10 DRGs declined over the 5-year period (FYs 1993 through 1998) immediately preceding the implementation of this policy. However, as shown in the table above, the DRG weights for all but three of these DRGs have increased during the 5-years since implementation of this policy. Payments for all cases in these DRGs were declining as the number of cases being transferred to postacute care increased and the average length of the inpatient acute stay decreased. However, since implementation of the policy, payments for the cases that are not implicated under this policy are rising in most of the 10 DRGs. In those DRGs where the

relative weight has declined in over the 5-year period since implementation of this policy, the geometric mean length of stay has continued to decline.

As discussed above, the premise of the postacute care transfer policy is that hospitals have shifted some of the acute care formerly provided in the hospital into the postacute care setting. This distorts the averaging principle of the IPPS because the average case is now less expensive without a corresponding adjustment to the base rate. However, a high percentage of postacute care utilization by cases in a particular DRG does not, by itself, create a distortion if the high postacute care utilization was also reflected in the calculation of the base rate.

Therefore, to ensure that any proposed expansion of the postacute care transfer policy did not improperly distort the averaging principles of the IPPS, we evaluated the change in the mean lengths of stay for the DRGs we proposed to add to the policy to identify those in which the high postacute care utilization is resulting in shorter lengths of stay and lower costs. These shorter stays represent a shift in the site (and costs) of care relative to the base period, and, thus, a distortion in the averaging principle of the IPPS.

Comment: Several commenters argued that the postacute care transfer policy is no longer necessary, as lengths of stay have stabilized and Medicare spending on postacute care has slowed. In particular, commenters pointed to the transition of postacute care provider types to prospective payment systems, which reduces the incentives for postacute care providers to agree to admit very sick patients from an acute care hospital. One commenter argued that the concept of duplicate payment for the same care is a misconception when both the acute and the postacute care providers are paid under a prospective payment system.

Commenters claimed the policy puts an undue burden on them to be required to track patients after they are discharged to another setting. They claimed this creates an “unworkable” situation for them by making hospitals track patients and requiring frequent payment and claim readjustments. They noted the relatively small payment impact for all hospitals (only 0.2 percent) compared to the administrative burden hospitals will incur to administer the expansion of the policy.

Response: We agree that postacute care providers are likely to be less willing to admit very sick patients under prospective payment systems than they were under cost reimbursement payment methodologies.