November 2009

Analysis of Post Acute Care Episode Definitions

Data Chart Book

Prepared for

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This report was produced under the direction of Susan Bogasky, Project Officer, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Office of Health Policy. The findings and conclusions of this report are those of the authors and do not necessarily represent the views of ASPE or HHS.

RTI INTERNATIONAL

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INTRODUCTION

ANALYSIS OF POST ACUTE CARE EPISODE DEFINITIONS DATA CHART BOOK

In 2008, the Medicare program spent $49.9 billion on post-acute care (PAC) services including skilled nursing facility (SNF), home health agency (HHA), inpatient rehabilitation facility (IRF), and long-term care acute hospitals (LTCH) (MedPAC, June 2009). This represents an increase of 8 percent over 2007 Medicare spending on PAC and much of the increase was driven by spending on HHA and SNF (MedPAC, June 2009). Given the payment silos for each provider type in the current post-acute care payment systems, there is little incentive for providers to work across settings to improve coordination of care and achieve efficiencies over a beneficiary's course of illness.

One idea that has recently been raised by policymakers to improve incentives for coordination and efficiency is "bundled payment." Under a bundled payment, one payment would be made per episode of care. An accountable entity (i.e., a hospital, an insurer, a PAC provider, groups of providers, or other organization) would then be at risk for the care patients receive over the episode. Recently, several Medicare "bundled payment" have been discussed.[1,2,3,4,5] Each propose making a bundled payment for hospital and PAC services, although they differ in which PAC services are included and the number of days' services included. These options vary in terms of the types of PAC services included and in terms of how the 30 day end point is defined (i.e., any claim initiating within 30 days versus 30 calendar days after discharge).

The goal of the work presented here is to inform this discussion of bundled payments by providing data on the implications of different episode definitions, including difference in average program costs when you include/exclude hospital readmissions or use different end points for the episode. The episode definitions explored in this work include both fixed episodes (30 days, 60 days, or 90 days) and variable length episodes defined as ending with a gap in service use (30-day gap, 45-day gap, or 60-day gap). Average Medicare payments per episode and per service are calculated for 18 different definitions of an episode. These definitions are based on analysis of Medicare claims data reflecting actual utilization patterns of acute, HHA, IRF, SNF, LTCH, and hospital outpatient department therapy services. In addition, this work explores differences in PAC payments across geographic areas in order to give more context to discussions regarding PAC use and payments nationally.

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1 Office of Management and Budget. A New Era of Responsibility: Renewing America's Promise, 2009. Retrieved July 2009 from http://www.whitehouse.gov/omb/assets/fy2010_new_era/A_New_Era_of_Responsibility2.pdf

2 Senate Finance Committee. Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs, April 29, 2009. Retrieved July 2009 from http://finance.senate.gov/sitepages/leg/LEG%202009/042809%20Health%20Care%20Description%20of%20Policy%20Option.pdf

3 Congressional Budget Office. Budget Options Volume 1 Health Care, December 2008. Retrieved July 2009 from http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf

4 The Commonwealth Fund. A Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way, February 2009. Retrieved July 2009 from http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Feb/The%20Path%20to%20a%20High%20Performance%20US%20Health%20System/1237_Commission_path_high_perform_US_hlt_sys_WEB_rev_03052009.pdf

5 Medicare Payment Advisory Commission. Report to the Congress: Reforming the Delivery System, June 2008. Retrieved October 2009 from http://www.medpac.gov/documents/Jun08_EntireReport.pdf

In this work, we use a beneficiary-level data file of 2006 Medicare claims constructed in prior work for ASPE examining patterns of PAC use for Medicare beneficiaries (Gage et al., 2009). This file is unique in its ability to track beneficiary service use across settings following an index acute hospital admission. Here, we expand our analyses to explore fixed post-acute care episode definitions (30 day, 60 day, and 90 day) and variable length episodes defined by a gap in service use (30 day gap, 45 day gap, or 60 day gap). For each of the fixed definitions, we examine alternative methods of treating the *last* claim in an episode by including all days and dollars associated with a claim that initiates within the fixed time period versus prorating days and dollars based on the portion of services that occur within the fixed time period. Another alternative end point examined for each of the fixed and variable length episode definitions is acute hospital readmission. In total, our analyses compare the use of post-acute care services under 18 different post-acute care episode definitions (**Table 1**). Analyses of these episodes will demonstrate the effect of different definitions as we examine options for potential payment bundles based on episodes of care.

Each of the alternative episode definitions is compared on the following:

- Percent of beneficiaries with a claim for specific settings of PAC;
- Length of stay associated with the use of specific settings of PAC; and
- Medicare payments associated with the use of specific settings of PAC.

In addition to analyzing the services included under different episode definitions, we examine variations in PAC episode payments in across geographic areas. These analyses are presented at the national and state level, as well as at the core based statistical area (CBSA) level which includes both metropolitan and micropolitan areas. In order to allow for comparison of Medicare payments across these geographic areas, we standardized the PAC payments to remove payment variation related to geography including wage differences and urban/rural location, as well as other policy considerations that affect payments such as indirect medical education (IME) and disproportional share (DSH) payments. By comparing standardized payments, we are able to learn more about differences in patterns of use in the absence of payment adjustments.

In examining differences in episode payments across geographic areas, beneficiary episodes were assigned using two methods. First, based on the location of the index acute hospital, and second, based on beneficiary state of residence. The results of both methods are presented here to inform thinking about how episodes of care might be attributed – based on where a beneficiary lives or based on where they receive their care. This is applicable to discussion of payment based on geography and in thinking about situations where “snowbirds” reside in one geographic area and winter in another geographic area where supply of services, practice patterns, and payments may differ. The results of both episode assignment methods are presented here.

This Data Chart Book provides more detailed information on each of the episode definitions explored in our analysis across all MS-DRGs and for the top 20 MS-DRGs by volume of discharges to PAC. In addition, the data presented here includes information on PAC episodes at both the state and CBSA level using standardized payments. The final report provides summary information based on our findings and focuses on a subset of the episode definitions. The final report on this work also contains details on the

methods used to develop alternative episode definitions and to standardize episode payments. The final report can be found in **Appendix A**.

Table 1. Episode Definitions

Definition A	30 Day Fixed: Any Claim Starting Within 30 Days After Hospital Discharge
Definition B	30 Day Fixed: Any Claim Starting Within 30 Days After Hospital Discharge Excluding Acute Hospital Readmissions.
Definition C	30 Day Fixed Following Hospital Discharge (pro rated)
Definition D	30 Day Fixed Following Hospital Discharge (pro rated) Excluding Acute Hospital Readmissions
Definition E	60 Day Fixed: Any Claim Starting Within 60 Days After Hospital Discharge
Definition F	60 Day Fixed: Any Claim Starting Within 60 Days After Hospital Discharge Excluding Acute Hospital Readmissions
Definition G	60 Day Fixed Following Hospital Discharge (pro rated)
Definition H	60 Day Fixed Following Hospital Discharge (pro rated) Excluding Acute Hospital Readmissions
Definition I	90 Day Fixed: Any Claim Starting Within 90 Days After Hospital Discharge
Definition J	90 Day Fixed: Any Claim Starting Within 90 Days After Hospital Discharge Excluding Acute Hospital Readmissions
Definition K	90 Day Fixed Following Hospital Discharge (pro rated)
Definition L	90 Day Fixed Following Hospital Discharge (pro rated) Excluding Acute Hospital Readmissions
Definition M	30 Day Variable Length
Definition N	30 Day Variable Length Excluding Acute Hospital Readmission
Definition O	45 Day Variable Length
Definition P	45 Day Variable Period Excluding Acute Hospital Readmission
Definition Q	60 Day Variable Length
Definition R	60 Day Variable Length Excluding Acute Hospital Readmission

Section 1
Medicare Post-Acute Care Episode Payments, By MS-DRG, Top 20 MS-DRGs by Volume of Discharges to PAC

The tables in this section include data on Medicare post-acute care (PAC) utilization and payments for the top 20 MS-DRGs for beneficiaries discharged to PAC (by volume of discharges). Utilization and payment data are presented separately for each of the 18 PAC episode definitions included in our analysis (Tables 1 -18). See Introduction, Table 1 for a complete list of episode definitions.

Data shown here include total live index acute hospital discharges, percent of beneficiaries discharged to PAC, and number of PAC users for the top 20 MS-DRGs. Total Medicare spending on PAC and rank by total Medicare spending on PAC are also calculated by MS-DRG for each of the episode definitions. Payments include mean index acute hospital payment and mean PAC episode payments calculated per beneficiary discharged from an index acute hospital stay regardless of discharge to PAC (per index acute hospital discharge), and also for beneficiaries using PAC services (per PAC user). Total Medicare spending on acute plus PAC episodes are also presented for each MS-DRG and the rank by total Medicare acute plus PAC spending is presented both per index acute hospital discharge and per PAC user.

Key findings

- Looking across all MS-DRGs, 35.2 percent of beneficiaries with index acute hospitals stays are discharged to PAC. MS-DRG 470 Major joint replacement or reattachment of lower extremity w/o MCC is the most common MS-DRG among PAC users and 87.7 percent of beneficiaries in this MS-DRG are discharged to PAC. The second most frequent MS-DRG among PAC users is MS-DRG 194 Simple pneumonia & pleurisy w CC and 34.2 percent of beneficiaries in this MS-DRG are discharged to PAC.

- These tables allow us to compare mean payments across episode definitions by MS-DRG. In Episode Definition A (30 Day Fixed), the mean PAC payment per PAC user across all MS-DRGs is $9,907. Mean PAC payment per PAC user across all MS-DRGs in Episode Definition B (30 Day Fixed Excluding Readmission) decreases to $7,591 due to the exclusion of readmissions and subsequent PAC use from the episode definition.

- In comparing mean PAC payment per PAC user in Episode Definition A (30 Day Fixed) to mean PAC payment per PAC user in Episode Definition C (30 Day Fixed-pro rated), we see that mean PAC payment decreases when we pro rate the last claim in an episode rather than allowing any claim initiating during a fixed time period to be included in an episode ($9,907 in Episode Definition A versus $7,567 in Episode Definition C). Similarly, mean PAC payment per index acute hospital discharge also decreases from Episode Definition A ($4,592) to Episode Definition C ($3,585).

- At the MS-DRG level, mean PAC payment per PAC user for MS-DRG 470 is $7,951 compared to a mean PAC payment of $7,721 for MS-DRG 194 in Episode Definition A (30 Fixed). In Episode Definition B (30 Day Fixed Excluding Readmissions), mean PAC payments per PAC user for MS-DRG 470 are $7,065 and mean PAC payments for MS-DRG are $5,631. The effect of excluding readmissions in Episode Definition B has a greater impact in MS-DRG 194 due to the fact that beneficiaries in this MS-DRG are more likely to have acute hospital readmissions compared to beneficiaries in MS-DRG 470.

- There is little difference in mean PAC payment per index acute hospital discharge and mean PAC payment per PAC user for MS-DRG 470 ($7,134 versus $7,951 in Episode Definition A (30 Day Fixed)) due to the high proportion of beneficiaries discharged to PAC (87.7 percent). In contrast in MS-DRG 194 there is a much larger difference in mean PAC payment per index acute hospital discharge and mean PAC payment per PAC user ($3,682 versus $7,721 in Episode Definition A) due to the fact that a smaller proportion of beneficiaries are discharged to PAC (34.2 percent). Note that comparing mean payments across these two different denominators is an important policy consideration and setting a payment per hospital discharge versus per PAC user will have different implications for different MS-DRGs depending on the proportion of beneficiaries in the MS-DRG discharged to PAC.

- The data presented in this set of tables also indicate which MS-DRGs are in the top 30 percent of PAC spending under each of the episode definitions included in our analyses. For example, in Episode Definition A (30 Day Fixed), seven MS-DRGs fall within the top 30 percent of PAC spending. The percent of MS-DRGs in the top 30 percent of PAC spending varies by Episode Definition.

- Note that the top 20 MS-DRGs by volume of discharges to PAC are not the same MS-DRGs that rank in the top 20 by total acute plus PAC spending. For example, though MS-DRG 195 Simple pneumonia & pleurisy w/o CC/MM ranks 11th in terms of the MS-DRGs among beneficiaries discharged to PAC, it ranks 26th among MS-DRGs for total acute plus PAC spending. Total acute plus PAC spending is a function of both the volume of discharges in an MS-DRG plus the per beneficiary payments for acute care plus PAC. Similarly, MS-DRG 192 Chronic obstructive pulmonary disease w/o CC/MCC ranks 18th by volume of discharges to PAC, but ranks 47th for Medicare spending on acute plus PAC. The distinction between the top MS-DRG by volume versus spending (either mean spending or total spending) is an important distinction to note in thinking about potential phase in options by MS-DRG.

- Results examining Episode Definitions D through R are also included in this section allowing for comparison of results across each of the fixed and variable length episode definitions included in our analyses. In general, we see that longer episode definitions (60 day fixed, 90 day fixed, 30 day variable length, 45 day variable length, and 60 day variable length are associated with higher PAC payments per acute hospital discharge and per PAC user.

Section 1 - Table 1
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition A: 30 Day Fixed: Any Claim Starting Within 30 Days After Hospital Discharge

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$1,082,246,101**	-	-	**$8,287**	**$4,592**	**$12,879**	**$4,000,523,485**	-	**$10,297**	**$9,907**	**$20,205**	**$2,207,060,931**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$114,874,781	1	Y	$10,434	$7,134	$17,568	$289,467,332	1	$10,463	$7,951	$18,415	$266,036,952	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$20,545,582	7	Y	$5,028	$3,682	$8,710	$67,716,960	4	$5,107	$7,721	$12,828	$34,135,080	7
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$40,869,977	2	Y	$6,291	$12,851	$19,142	$63,801,354	5	$6,307	$17,685	$23,992	$55,445,808	4
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$35,117,363	3	Y	$9,739	$15,032	$24,771	$59,326,152	6	$9,698	$16,448	$26,146	$55,821,660	3
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$19,347,671	9	Y	$3,896	$4,445	$8,342	$45,695,070	13	$4,025	$9,105	$13,130	$27,901,416	12
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$23,011,472	5	Y	$6,044	$8,045	$14,089	$43,801,354	16	$5,985	$13,075	$19,060	$33,544,980	8
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$14,877,715	12	N	$3,457	$4,080	$7,537	$37,657,165	21	$3,700	$9,033	$12,733	$20,971,356	18
292	Heart failure & shock w CC	4,387	37.0	1,622	$13,345,973	14	N	$5,179	$4,882	$10,061	$44,136,405	15	$5,299	$8,228	$13,527	$21,941,301	16
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$17,213,011	10	N	$9,217	$6,741	$15,958	$47,970,249	10	$9,475	$11,062	$20,537	$31,955,940	10
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$23,383,301	4	Y	$8,288	$13,711	$21,999	$38,454,853	18	$8,304	$15,323	$23,628	$36,055,966	6
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$9,554,837	22	N	$4,368	$2,688	$7,057	$36,948,935	22	$4,512	$6,328	$10,839	$16,367,330	26
552	Medical back problems w/o MCC	2,803	51.1	1,433	$14,405,011	13	N	$3,795	$6,254	$10,049	$28,168,192	30	$3,827	$10,052	$13,880	$19,889,723	20
603	Cellulitis w/o MCC	3,814	33.5	1,277	$8,961,564	25	N	$3,759	$3,058	$6,818	$26,002,507	32	$3,905	$7,018	$10,922	$13,947,629	35
291	Heart failure & shock w MCC	2,962	42.3	1,252	$12,638,821	15	N	$5,621	$6,091	$11,713	$34,693,528	24	$5,884	$10,095	$15,979	$20,005,183	19
312	Syncope & collapse	5,218	23.9	1,245	$9,017,248	24	N	$3,352	$2,503	$5,854	$30,547,584	27	$3,595	$7,243	$10,838	$13,493,337	37
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$8,261,674	27	N	$3,498	$1,901	$5,399	$49,169,703	9	$3,849	$6,706	$10,554	$13,003,098	39
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$8,065,035	30	N	$4,978	$3,521	$8,499	$37,954,935	19	$4,987	$6,638	$11,625	$14,123,924	33
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$6,340,213	40	N	$4,134	$2,370	$6,503	$34,982,039	23	$4,288	$5,774	$10,062	$11,048,410	47
683	Renal failure w CC	2,821	38.4	1,082	$10,307,751	20	N	$6,649	$4,883	$11,532	$32,531,549	25	$6,590	$9,527	$16,116	$17,437,982	23
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$11,768,947	16	N	$3,422	$11,184	$14,606	$15,920,974	66	$3,416	$12,737	$16,153	$14,924,994	31

NOTES:
1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235)

Section 1 - Table 2

Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC

Episode Definition B: 30 Day Fixed: Any Claim Starting Within 30 Days After Hospital Discharge Excluding Acute Hospital Readmissions.

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$829,222,115**	-	-	**$8,287**	**$2,717**	**$11,004**	**$3,418,155,723**	-	**$10,297**	**$7,591**	**$17,888**	**$1,954,036,946**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$102,070,895	1	Y	$10,434	$6,248	$16,682	$274,871,406	1	$10,463	$7,065	$17,528	$253,233,066	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$14,985,009	9	N	$5,028	$1,974	$7,002	$54,438,339	5	$5,107	$5,631	$10,738	$28,574,507	9
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$35,314,840	2	Y	$6,291	$10,728	$17,020	$56,726,362	4	$6,307	$15,281	$21,588	$49,890,671	4
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$30,290,444	3	Y	$9,739	$12,782	$22,521	$53,938,349	6	$9,698	$14,188	$23,885	$50,994,741	3
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$15,110,313	8	N	$3,896	$2,823	$6,719	$36,808,059	15	$4,025	$7,111	$11,136	$23,664,058	13
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$19,379,218	5	Y	$6,044	$6,284	$12,328	$38,326,577	13	$5,985	$11,011	$16,996	$29,912,726	8
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$11,036,099	12	N	$3,457	$2,297	$5,754	$28,748,479	22	$3,700	$6,701	$10,401	$17,129,740	19
292	Heart failure & shock w CC	4,387	37.0	1,622	$8,762,080	18	N	$5,179	$2,039	$7,218	$31,666,260	19	$5,299	$5,402	$10,701	$17,357,408	18
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$12,278,936	10	N	$9,217	$4,139	$13,356	$40,148,164	12	$9,475	$7,891	$17,366	$27,021,865	10
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$20,846,115	4	Y	$8,288	$12,040	$20,328	$35,533,599	16	$8,304	$13,661	$21,965	$33,518,780	6
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$7,508,968	21	N	$4,368	$1,490	$5,858	$30,674,321	20	$4,512	$4,973	$9,484	$14,321,461	26
552	Medical back problems w/o MCC	2,803	51.1	1,433	$10,812,426	13	N	$3,795	$3,933	$7,729	$21,663,069	34	$3,827	$7,545	$11,373	$16,297,138	20
603	Cellulitis w/o MCC	3,814	33.5	1,277	$6,606,605	26	N	$3,759	$1,782	$5,542	$21,135,301	36	$3,905	$5,174	$9,078	$11,592,670	38
291	Heart failure & shock w MCC	2,962	42.3	1,252	$8,274,830	19	N	$5,621	$2,847	$8,468	$25,082,338	27	$5,884	$6,609	$12,493	$15,641,192	23
312	Syncope & collapse	5,218	23.9	1,245	$7,379,414	22	N	$3,352	$1,437	$4,789	$24,989,764	28	$3,595	$5,927	$9,522	$11,855,503	36
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$6,060,026	27	N	$3,498	$695	$4,193	$38,187,673	14	$3,849	$4,919	$8,767	$10,801,450	42
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$5,204,380	34	N	$4,978	$1,212	$6,190	$27,644,967	24	$4,987	$4,283	$9,270	$11,263,269	40
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$4,506,046	41	N	$4,134	$873	$5,007	$26,933,829	25	$4,288	$4,104	$8,392	$9,214,243	50
683	Renal failure w CC	2,821	38.4	1,082	$7,192,045	23	N	$6,649	$2,603	$9,252	$26,100,032	26	$6,590	$6,647	$13,237	$14,322,276	25
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$9,756,296	14	N	$3,422	$9,055	$12,477	$13,600,128	67	$3,416	$10,559	$13,974	$12,912,343	31

NOTES:

1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235)

Section 1 - Table 3
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition C: 30 Day Fixed Following Hospital Discharge (pro rated)

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$827,595,091**	-	-	**$8,287**	**$3,585**	**$11,872**	**$3,687,707,063**	-	**$10,297**	**$7,576**	**$17,873**	**$1,952,409,921**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$98,742,794	1	Y	$10,434	$6,109	$16,543	$272,582,054	1	$10,463	$6,835	$17,298	$249,904,965	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$15,449,904	6	Y	$5,028	$2,811	$7,838	$60,944,330	4	$5,107	$5,806	$10,913	$29,039,402	8
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$30,902,827	2	Y	$6,291	$9,714	$16,006	$53,346,966	5	$6,307	$13,372	$19,679	$45,478,658	3
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$24,678,852	3	Y	$9,739	$10,528	$20,267	$48,539,673	7	$9,698	$11,559	$21,257	$45,383,149	4
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$13,857,947	8	Y	$3,896	$3,241	$7,138	$39,099,511	15	$4,025	$6,521	$10,547	$22,411,692	13
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$18,158,606	4	Y	$6,044	$6,354	$12,397	$38,543,235	16	$5,985	$10,317	$16,302	$28,692,114	9
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$10,612,535	13	N	$3,457	$3,016	$6,474	$32,341,734	22	$3,700	$6,444	$10,143	$16,706,176	20
292	Heart failure & shock w CC	4,387	37.0	1,622	$9,582,115	15	N	$5,179	$3,601	$8,780	$38,516,627	17	$5,299	$5,908	$11,207	$18,177,443	18
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$12,536,861	10	N	$9,217	$5,003	$14,220	$42,745,372	12	$9,475	$8,057	$17,532	$27,279,790	10
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$17,202,107	5	Y	$8,288	$10,046	$18,334	$32,048,546	23	$8,304	$11,273	$19,577	$29,874,772	7
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$7,249,307	23	N	$4,368	$2,036	$6,405	$33,534,692	20	$4,512	$4,801	$9,312	$14,061,800	30
552	Medical back problems w/o MCC	2,803	51.1	1,433	$10,922,301	12	N	$3,795	$4,830	$8,625	$24,177,255	33	$3,827	$7,622	$11,449	$16,407,013	21
603	Cellulitis w/o MCC	3,814	33.5	1,277	$6,324,247	27	N	$3,759	$2,219	$5,978	$22,800,993	38	$3,905	$4,952	$8,857	$11,310,312	39
291	Heart failure & shock w MCC	2,962	42.3	1,252	$9,604,364	14	N	$5,621	$4,759	$10,381	$30,747,241	24	$5,884	$7,671	$13,555	$16,970,726	19
312	Syncope & collapse	5,218	23.9	1,245	$6,839,256	24	N	$3,352	$1,983	$5,334	$27,834,505	28	$3,595	$5,493	$9,089	$11,315,345	38
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$6,263,115	28	N	$3,498	$1,526	$5,024	$45,755,468	10	$3,849	$5,084	$8,932	$11,004,539	40
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$6,112,035	29	N	$4,978	$2,826	$7,804	$34,851,780	19	$4,987	$5,030	$10,017	$12,170,924	34
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$4,875,097	41	N	$4,134	$1,884	$6,018	$32,370,100	21	$4,288	$4,440	$8,728	$9,583,294	52
683	Renal failure w CC	2,821	38.4	1,082	$7,328,593	21	N	$6,649	$3,645	$10,295	$29,041,481	27	$6,590	$6,773	$13,363	$14,458,824	25
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$8,909,685	17	N	$3,422	$8,454	$11,877	$12,945,740	72	$3,416	$9,643	$13,058	$12,065,732	35

NOTES:
1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235).

Section 1 - Table 4
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition D: 30 Day Fixed Following Hospital Discharge (pro rated) Excluding Acute Hospital Readmissions

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$635,651,866**	-	-	**$8,287**	**$2,066**	**$10,354**	**$3,216,108,034**	-	**$10,297**	**$5,819**	**$16,116**	**$1,760,466,697**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$88,350,135	1	Y	$10,434	$5,388	$15,822	$260,693,171	1	$10,463	$6,115	$16,579	$239,512,306	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$11,214,525	8	N	$5,028	$1,465	$6,492	$50,478,558	4	$5,107	$4,214	$9,321	$24,804,023	9
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$27,085,754	2	Y	$6,291	$8,185	$14,476	$48,248,220	6	$6,307	$11,720	$18,028	$41,661,585	4
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$21,455,907	3	Y	$9,739	$9,013	$18,752	$44,910,671	7	$9,698	$10,050	$19,747	$42,160,204	3
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$10,681,757	9	N	$3,896	$1,978	$5,874	$32,178,639	17	$4,025	$5,027	$9,052	$19,235,502	14
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$15,439,365	4	Y	$6,044	$4,990	$11,034	$34,304,483	15	$5,985	$8,772	$14,757	$25,972,873	8
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$7,844,781	13	N	$3,457	$1,602	$5,059	$25,273,936	25	$3,700	$4,763	$8,463	$13,938,422	21
292	Heart failure & shock w CC	4,387	37.0	1,622	$6,280,879	17	N	$5,179	$1,449	$6,628	$29,075,982	19	$5,299	$3,872	$9,172	$14,876,207	19
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$8,778,230	11	N	$9,217	$2,944	$12,161	$36,555,983	12	$9,475	$5,642	$15,116	$23,521,159	12
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$15,317,920	5	Y	$8,288	$8,808	$17,096	$29,884,445	18	$8,304	$10,038	$18,342	$27,990,585	7
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$5,610,651	21	N	$4,368	$1,099	$5,467	$28,627,425	20	$4,512	$3,716	$8,227	$12,423,144	29
552	Medical back problems w/o MCC	2,803	51.1	1,433	$8,305,732	12	N	$3,795	$2,992	$6,788	$19,025,850	37	$3,827	$5,796	$9,623	$13,790,444	22
603	Cellulitis w/o MCC	3,814	33.5	1,277	$4,660,425	27	N	$3,759	$1,246	$5,005	$19,090,060	36	$3,905	$3,650	$7,554	$9,646,490	40
291	Heart failure & shock w MCC	2,962	42.3	1,252	$6,105,683	20	N	$5,621	$2,083	$7,705	$22,821,836	30	$5,884	$4,877	$10,760	$13,472,045	23
312	Syncope & collapse	5,218	23.9	1,245	$5,519,921	24	N	$3,352	$1,067	$4,418	$23,054,154	29	$3,595	$4,434	$8,029	$9,996,010	38
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$4,537,668	28	N	$3,498	$509	$4,007	$36,491,389	13	$3,849	$3,683	$7,532	$9,279,092	43
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$3,717,712	36	N	$4,978	$853	$5,831	$26,040,015	23	$4,987	$3,060	$8,047	$9,776,601	39
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$3,357,147	39	N	$4,134	$641	$4,774	$25,681,403	24	$4,288	$3,058	$7,345	$8,065,344	52
683	Renal failure w CC	2,821	38.4	1,082	$5,109,456	26	N	$6,649	$1,832	$8,481	$23,925,323	26	$6,590	$4,722	$11,312	$12,239,687	30
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$7,439,980	15	N	$3,422	$6,863	$10,285	$11,211,104	73	$3,416	$8,052	$11,468	$10,596,027	36

NOTES:
1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235).

Section 1 - Table 5
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition E: 60 Day Fixed: Any Claim Starting Within 60 Days After Hospital Discharge

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$1,291,929,921**	-	-	**$8,287**	**$6,020**	**$14,307**	**$4,444,126,733**	-	**$10,297**	**$11,827**	**$22,124**	**$2,416,744,752**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$126,195,193	1	Y	$10,434	$7,884	$18,318	$301,833,379	1	$10,463	$8,735	$19,198	$277,357,364	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$24,685,162	7	Y	$5,028	$4,983	$10,010	$77,831,440	4	$5,107	$9,277	$14,384	$38,274,660	7
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$46,813,429	2	Y	$6,291	$14,971	$21,262	$70,867,475	5	$6,307	$20,257	$26,564	$61,389,260	3
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$39,667,486	3	Y	$9,739	$17,093	$26,832	$64,262,079	6	$9,698	$18,580	$28,277	$60,371,783	4
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$23,350,688	8	Y	$3,896	$5,783	$9,679	$53,022,783	12	$4,025	$10,989	$15,014	$31,904,433	11
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$26,114,612	4	Y	$6,044	$9,533	$15,576	$48,426,866	15	$5,985	$14,838	$20,823	$36,648,120	8
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$18,010,203	12	N	$3,457	$5,507	$8,964	$44,783,344	18	$3,700	$10,935	$14,635	$24,103,844	17
292	Heart failure & shock w CC	4,387	37.0	1,622	$16,836,302	14	N	$5,179	$6,931	$12,110	$53,126,022	11	$5,299	$10,380	$15,679	$25,431,630	15
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$21,003,851	10	Y	$9,217	$8,751	$17,968	$54,011,970	10	$9,475	$13,499	$22,974	$35,746,780	9
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$25,926,316	5	Y	$8,288	$15,316	$23,604	$41,259,260	23	$8,304	$16,990	$25,294	$38,598,981	6
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$11,697,278	21	N	$4,368	$3,714	$8,083	$42,321,689	20	$4,512	$7,747	$12,258	$18,509,771	25
552	Medical back problems w/o MCC	2,803	51.1	1,433	$17,163,472	13	N	$3,795	$7,838	$11,634	$32,609,054	28	$3,827	$11,977	$15,805	$22,648,184	19
603	Cellulitis w/o MCC	3,814	33.5	1,277	$11,007,041	24	N	$3,759	$4,180	$7,939	$30,281,197	34	$3,905	$8,619	$12,524	$15,993,106	33
291	Heart failure & shock w MCC	2,962	42.3	1,252	$15,726,476	15	N	$5,621	$8,387	$14,009	$41,494,229	22	$5,884	$12,561	$18,445	$23,092,838	18
312	Syncope & collapse	5,218	23.9	1,245	$11,171,072	23	N	$3,352	$3,515	$6,867	$35,829,693	26	$3,595	$8,973	$12,568	$15,647,161	34
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$10,594,846	27	N	$3,498	$3,013	$6,511	$59,291,420	7	$3,849	$8,600	$12,448	$15,336,270	37
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$10,483,629	28	N	$4,978	$5,297	$10,275	$45,887,511	17	$4,987	$8,629	$13,615	$16,542,518	32
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$8,129,752	36	N	$4,134	$3,692	$7,826	$42,097,573	21	$4,288	$7,404	$11,692	$12,837,949	45
683	Renal failure w CC	2,821	38.4	1,082	$12,948,136	18	N	$6,649	$6,744	$13,393	$37,781,355	25	$6,590	$11,967	$18,557	$20,078,367	22
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$13,467,906	16	N	$3,422	$12,861	$16,284	$17,749,372	63	$3,416	$14,576	$17,991	$16,623,953	31

NOTES:
1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235).

Section 1 - Table 6
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition F: 60 Day Fixed: Any Claim Starting Within 60 Days After Hospital Discharge Excluding Acute Hospital Readmissions

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment [5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$861,344,349**	-	-	**$8,287**	**$2,847**	**$11,134**	**$3,458,618,471**	-	**$10,297**	**$7,885**	**$18,182**	**$1,986,159,181**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$105,451,034	1	Y	$10,434	$6,468	$16,902	$278,493,709	1	$10,463	$7,299	$17,762	$256,613,205	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$15,380,487	9	N	$5,028	$2,040	$7,068	$54,951,303	6	$5,107	$5,780	$10,887	$28,969,985	9
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$37,050,298	2	Y	$6,291	$11,296	$17,587	$58,617,350	4	$6,307	$16,032	$22,339	$51,626,129	4
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$31,759,845	3	Y	$9,739	$13,433	$23,172	$55,496,769	5	$9,698	$14,876	$24,573	$52,464,142	3
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$15,592,256	8	N	$3,896	$2,943	$6,840	$37,467,711	15	$4,025	$7,338	$11,363	$24,146,001	13
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$20,176,183	5	Y	$6,044	$6,564	$12,608	$39,198,627	13	$5,985	$11,464	$17,449	$30,709,691	8
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$11,471,525	12	N	$3,457	$2,439	$5,896	$29,457,143	21	$3,700	$6,965	$10,665	$17,565,166	19
292	Heart failure & shock w CC	4,387	37.0	1,622	$9,058,816	18	N	$5,179	$2,137	$7,316	$32,093,734	19	$5,299	$5,585	$10,884	$17,654,144	18
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$12,638,594	11	N	$9,217	$4,285	$13,501	$40,585,191	12	$9,475	$8,122	$17,597	$27,381,523	10
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$21,739,266	4	Y	$8,288	$12,597	$20,885	$36,506,483	16	$8,304	$14,246	$22,550	$34,411,931	6
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$7,720,520	22	N	$4,368	$1,554	$5,923	$31,010,426	20	$4,512	$5,113	$9,625	$14,533,013	26
552	Medical back problems w/o MCC	2,803	51.1	1,433	$11,250,352	13	N	$3,795	$4,113	$7,908	$22,166,519	35	$3,827	$7,851	$11,678	$16,735,064	20
603	Cellulitis w/o MCC	3,814	33.5	1,277	$6,820,425	26	N	$3,759	$1,869	$5,628	$21,465,003	36	$3,905	$5,341	$9,245	$11,806,490	37
291	Heart failure & shock w MCC	2,962	42.3	1,252	$8,473,015	19	N	$5,621	$2,941	$8,563	$25,363,314	28	$5,884	$6,768	$12,651	$15,839,377	23
312	Syncope & collapse	5,218	23.9	1,245	$7,781,856	21	N	$3,352	$1,538	$4,889	$25,512,105	27	$3,595	$6,250	$9,846	$12,257,945	36
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$6,265,441	28	N	$3,498	$737	$4,235	$38,569,959	14	$3,849	$5,086	$8,934	$11,006,865	42
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$5,321,841	35	N	$4,978	$1,267	$6,245	$27,890,668	23	$4,987	$4,380	$9,367	$11,380,730	40
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$4,596,517	41	N	$4,134	$917	$5,050	$27,166,324	25	$4,288	$4,186	$8,474	$9,304,714	50
683	Renal failure w CC	2,821	38.4	1,082	$7,405,231	24	N	$6,649	$2,736	$9,386	$26,477,151	26	$6,590	$6,844	$13,434	$14,535,462	25
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$10,280,620	14	N	$3,422	$9,589	$13,011	$14,182,149	64	$3,416	$11,126	$14,542	$13,436,667	31

NOTES:
1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235).

Section 1 - Table 7
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition G: 60 Day Fixed Following Hospital Discharge (pro rated)

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$1,169,173,965**	-	-	**$8,287**	**$5,451**	**$13,738**	**$4,267,483,834**	-	**$10,297**	**$10,703**	**$21,000**	**$2,293,988,796**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$120,474,133	1	Y	$10,434	$7,515	$17,949	$295,748,928	1	$10,463	$8,339	$18,802	$271,636,304	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$22,424,478	6	Y	$5,028	$4,465	$9,492	$73,803,328	4	$5,107	$8,427	$13,534	$36,013,976	6
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$41,586,105	2	Y	$6,291	$13,294	$19,585	$65,276,909	5	$6,307	$17,995	$24,302	$56,161,936	3
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$35,023,671	3	Y	$9,739	$15,057	$24,796	$59,385,966	6	$9,698	$16,405	$26,102	$55,727,968	4
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$20,509,920	8	Y	$3,896	$5,131	$9,027	$49,452,249	12	$4,025	$9,652	$13,677	$29,063,665	12
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$23,801,846	4	Y	$6,044	$8,566	$14,609	$45,420,322	16	$5,985	$13,524	$19,509	$34,335,354	8
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$15,957,693	12	N	$3,457	$4,873	$8,330	$41,615,156	19	$3,700	$9,689	$13,389	$22,051,334	17
292	Heart failure & shock w CC	4,387	37.0	1,622	$14,960,530	14	N	$5,179	$6,181	$11,360	$49,834,929	11	$5,299	$9,224	$14,523	$23,555,858	15
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$18,276,869	10	Y	$9,217	$7,607	$16,824	$50,572,389	10	$9,475	$11,746	$21,221	$33,019,798	10
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$23,317,995	5	Y	$8,288	$13,761	$22,049	$38,541,252	24	$8,304	$15,280	$23,585	$35,990,660	7
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$10,589,494	21	N	$4,368	$3,324	$7,692	$40,275,553	20	$4,512	$7,013	$11,524	$17,401,987	25
552	Medical back problems w/o MCC	2,803	51.1	1,433	$15,476,175	13	N	$3,795	$7,089	$10,885	$30,509,372	29	$3,827	$10,800	$14,627	$20,960,887	20
603	Cellulitis w/o MCC	3,814	33.5	1,277	$9,734,284	25	N	$3,759	$3,725	$7,485	$28,546,310	34	$3,905	$7,623	$11,527	$14,720,349	34
291	Heart failure & shock w MCC	2,962	42.3	1,252	$14,425,176	15	N	$5,621	$7,679	$13,301	$39,397,447	22	$5,884	$11,522	$17,405	$21,791,538	18
312	Syncope & collapse	5,218	23.9	1,245	$10,053,121	23	N	$3,352	$3,182	$6,533	$34,090,407	26	$3,595	$8,075	$11,670	$14,529,210	35
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$9,588,336	28	N	$3,498	$2,707	$6,204	$56,504,349	7	$3,849	$7,783	$11,631	$14,329,760	37
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$9,614,291	27	N	$4,978	$4,862	$9,840	$43,944,545	17	$4,987	$7,913	$12,900	$15,673,180	31
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$7,364,630	37	N	$4,134	$3,314	$7,448	$40,061,914	21	$4,288	$6,707	$10,995	$12,072,827	46
683	Renal failure w CC	2,821	38.4	1,082	$11,562,259	18	N	$6,649	$6,034	$12,683	$35,778,756	25	$6,590	$10,686	$17,276	$18,692,490	22
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$12,336,545	16	N	$3,422	$11,746	$15,169	$16,533,885	67	$3,416	$13,351	$16,767	$15,492,592	32

NOTES:
1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235).

Section 1 - Table 8
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition H: 60 Day Fixed Following Hospital Discharge (pro rated) Excluding Acute Hospital Readmissions

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$788,208,675**	-	-	**$8,287**	**$2,592**	**$10,879**	**$3,379,267,522**	-	**$10,297**	**$7,216**	**$17,513**	**$1,913,023,506**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$101,368,112	1	Y	$10,434	$6,210	$16,644	$274,241,297	1	$10,463	$7,017	$17,480	$252,530,283	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$14,049,588	9	N	$5,028	$1,856	$6,883	$53,518,683	5	$5,107	$5,280	$10,387	$27,639,086	9
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$33,343,774	2	Y	$6,291	$10,147	$16,439	$54,790,601	4	$6,307	$14,428	$20,735	$47,919,605	4
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$28,419,803	3	Y	$9,739	$12,008	$21,747	$52,084,241	6	$9,698	$13,311	$23,009	$49,124,100	3
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$14,052,053	8	N	$3,896	$2,636	$6,532	$35,783,151	15	$4,025	$6,613	$10,638	$22,605,798	13
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$18,578,431	5	Y	$6,044	$6,031	$12,075	$37,539,978	14	$5,985	$10,556	$16,541	$29,111,939	8
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$10,293,843	13	N	$3,457	$2,157	$5,614	$28,049,857	22	$3,700	$6,250	$9,950	$16,387,484	19
292	Heart failure & shock w CC	4,387	37.0	1,622	$8,064,656	18	N	$5,179	$1,889	$7,067	$31,004,756	19	$5,299	$4,972	$10,271	$16,659,984	18
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$11,316,287	11	N	$9,217	$3,822	$13,039	$39,195,893	12	$9,475	$7,273	$16,748	$26,059,216	11
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$19,652,397	4	Y	$8,288	$11,359	$19,647	$34,343,364	18	$8,304	$12,878	$21,183	$32,325,062	6
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$7,103,447	21	N	$4,368	$1,420	$5,789	$30,310,511	20	$4,512	$4,704	$9,216	$13,915,940	25
552	Medical back problems w/o MCC	2,803	51.1	1,433	$10,392,142	12	N	$3,795	$3,787	$7,582	$21,253,200	34	$3,827	$7,252	$11,079	$15,876,854	21
603	Cellulitis w/o MCC	3,814	33.5	1,277	$6,096,088	26	N	$3,759	$1,656	$5,416	$20,655,843	37	$3,905	$4,774	$8,678	$11,082,153	39
291	Heart failure & shock w MCC	2,962	42.3	1,252	$7,735,325	19	N	$5,621	$2,671	$8,292	$24,560,814	29	$5,884	$6,178	$12,062	$15,101,687	22
312	Syncope & collapse	5,218	23.9	1,245	$7,098,631	22	N	$3,352	$1,395	$4,747	$24,767,862	27	$3,595	$5,702	$9,297	$11,574,720	36
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$5,827,680	27	N	$3,498	$671	$4,169	$37,965,782	13	$3,849	$4,730	$8,579	$10,569,104	42
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$4,798,146	35	N	$4,978	$1,122	$6,100	$27,243,116	24	$4,987	$3,949	$8,936	$10,857,035	41
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$4,172,659	41	N	$4,134	$824	$4,958	$26,669,019	25	$4,288	$3,800	$8,088	$8,880,856	52
683	Renal failure w CC	2,821	38.4	1,082	$6,646,370	25	N	$6,649	$2,428	$9,077	$25,607,624	26	$6,590	$6,143	$12,733	$13,776,601	27
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$9,565,826	14	N	$3,422	$8,884	$12,306	$13,413,672	67	$3,416	$10,353	$13,768	$12,721,873	31

NOTES:

1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235).

Section 1 - Table 9
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition I: 90 Day Fixed: Any Claim Starting Within 90 Days After Hospital Discharge

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$1,452,885,764**	-	-	**$8,287**	**$7,063**	**$15,350**	**$4,768,158,157**	-	**$10,297**	**$13,300**	**$23,598**	**$2,577,700,594**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$134,408,420	1	Y	$10,434	$8,429	$18,863	$310,807,534	1	$10,463	$9,304	$19,767	$285,570,591	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$28,390,340	5	Y	$5,028	$5,989	$11,017	$85,656,330	3	$5,107	$10,669	$15,776	$41,979,838	6
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$50,774,812	2	Y	$6,291	$16,407	$22,698	$75,652,968	5	$6,307	$21,971	$28,278	$65,350,643	3
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$42,758,202	3	Y	$9,739	$18,500	$28,239	$67,631,535	6	$9,698	$20,027	$29,725	$63,462,499	4
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$26,404,512	8	Y	$3,896	$6,927	$10,823	$59,291,133	10	$4,025	$12,426	$16,451	$34,958,257	11
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$28,444,196	4	Y	$6,044	$10,590	$16,633	$51,713,062	16	$5,985	$16,161	$22,146	$38,977,704	8
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$20,423,930	12	N	$3,457	$6,632	$10,089	$50,405,873	17	$3,700	$12,401	$16,101	$26,517,571	16
292	Heart failure & shock w CC	4,387	37.0	1,622	$19,648,400	14	N	$5,179	$8,512	$13,691	$60,060,366	8	$5,299	$12,114	$17,413	$28,243,728	13
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$23,877,759	10	Y	$9,217	$10,077	$19,294	$57,997,132	11	$9,475	$15,346	$24,820	$38,620,688	9
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$27,418,171	6	Y	$8,288	$16,242	$24,530	$42,878,864	23	$8,304	$17,967	$26,272	$40,090,836	7
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$13,315,493	21	N	$4,368	$4,446	$8,814	$46,150,468	21	$4,512	$8,818	$13,330	$20,127,985	24
552	Medical back problems w/o MCC	2,803	51.1	1,433	$20,011,760	13	N	$3,795	$9,310	$13,105	$36,732,721	27	$3,827	$13,965	$17,792	$25,496,472	19
603	Cellulitis w/o MCC	3,814	33.5	1,277	$13,043,269	22	N	$3,759	$5,244	$9,004	$34,340,199	30	$3,905	$10,214	$14,119	$18,029,334	31
291	Heart failure & shock w MCC	2,962	42.3	1,252	$18,569,778	15	N	$5,621	$10,336	$15,958	$47,267,380	20	$5,884	$14,832	$20,716	$25,936,140	18
312	Syncope & collapse	5,218	23.9	1,245	$12,812,282	25	N	$3,352	$4,412	$7,764	$40,513,224	26	$3,595	$10,291	$13,886	$17,288,371	33
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$12,434,088	26	N	$3,498	$3,831	$7,328	$66,738,713	7	$3,849	$10,093	$13,941	$17,175,512	35
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$12,989,352	23	N	$4,978	$6,883	$11,861	$52,969,321	13	$4,987	$10,691	$15,678	$19,048,241	27
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$10,078,213	31	N	$4,134	$4,764	$8,898	$47,862,321	18	$4,288	$9,179	$13,467	$14,786,410	42
683	Renal failure w CC	2,821	38.4	1,082	$15,083,651	16	N	$6,649	$8,236	$14,885	$41,990,505	24	$6,590	$13,941	$20,530	$22,213,882	21
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$14,706,332	17	N	$3,422	$14,093	$17,515	$19,091,674	63	$3,416	$15,916	$19,332	$17,862,379	32

NOTES:
1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235).

Section 1 - Table 10
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition J: 90 Day Fixed: Any Claim Starting Within 90 Days After Hospital Discharge Excluding Acute Hospital Readmissions

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$883,979,995**	-	-	**$8,287**	**$2,936**	**$11,223**	**$3,486,075,950**	-	**$10,297**	**$8,092**	**$18,389**	**$2,008,794,826**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$107,014,709	1	Y	$10,434	$6,568	$17,002	$280,141,843	1	$10,463	$7,407	$17,871	$258,176,880	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$15,873,697	9	N	$5,028	$2,115	$7,143	$55,534,596	6	$5,107	$5,965	$11,072	$29,463,195	9
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$37,877,048	2	Y	$6,291	$11,566	$17,857	$59,517,120	4	$6,307	$16,390	$22,697	$52,452,879	4
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$32,602,086	3	Y	$9,739	$13,804	$23,543	$56,385,055	5	$9,698	$15,270	$24,968	$53,306,383	3
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$15,995,656	8	N	$3,896	$3,041	$6,938	$38,004,019	15	$4,025	$7,527	$11,553	$24,549,401	13
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$20,617,838	5	Y	$6,044	$6,720	$12,763	$39,681,340	13	$5,985	$11,715	$17,700	$31,151,346	7
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$11,781,365	12	N	$3,457	$2,522	$5,979	$29,872,643	21	$3,700	$7,153	$10,853	$17,875,006	19
292	Heart failure & shock w CC	4,387	37.0	1,622	$9,440,683	18	N	$5,179	$2,241	$7,420	$32,552,361	19	$5,299	$5,820	$11,120	$18,036,011	18
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$12,907,539	11	N	$9,217	$4,390	$13,606	$40,900,918	12	$9,475	$8,295	$17,770	$27,650,468	10
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$22,214,893	4	Y	$8,288	$12,880	$21,168	$37,001,550	16	$8,304	$14,558	$22,862	$34,887,558	6
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$7,938,217	22	N	$4,368	$1,611	$5,979	$31,307,321	20	$4,512	$5,257	$9,769	$14,750,710	26
552	Medical back problems w/o MCC	2,803	51.1	1,433	$11,488,455	13	N	$3,795	$4,215	$8,011	$22,453,600	34	$3,827	$8,017	$11,844	$16,973,167	20
603	Cellulitis w/o MCC	3,814	33.5	1,277	$7,076,532	25	N	$3,759	$1,952	$5,711	$21,782,902	36	$3,905	$5,542	$9,446	$12,062,597	37
291	Heart failure & shock w MCC	2,962	42.3	1,252	$8,737,403	19	N	$5,621	$3,054	$8,675	$25,696,654	28	$5,884	$6,979	$12,862	$16,103,765	23
312	Syncope & collapse	5,218	23.9	1,245	$8,017,600	21	N	$3,352	$1,602	$4,954	$25,848,652	27	$3,595	$6,440	$10,035	$12,493,689	36
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$6,545,265	28	N	$3,498	$778	$4,276	$38,939,676	14	$3,849	$5,313	$9,161	$11,286,689	43
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$5,638,879	33	N	$4,978	$1,350	$6,328	$28,261,095	23	$4,987	$4,641	$9,628	$11,697,768	40
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$4,787,175	40	N	$4,134	$968	$5,102	$27,443,143	25	$4,288	$4,360	$8,648	$9,495,372	49
683	Renal failure w CC	2,821	38.4	1,082	$7,657,980	24	N	$6,649	$2,842	$9,491	$26,775,132	26	$6,590	$7,078	$13,667	$14,788,211	25
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$10,541,241	14	N	$3,422	$9,851	$13,274	$14,468,406	64	$3,416	$11,408	$14,824	$13,697,288	31

NOTES:
1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235).

Section 1 - Table 11
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition K: 90 Day Fixed Following Hospital Discharge (pro rated)

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$1,383,076,435**	-	-	**$8,287**	**$16,133**	**$15,015**	**$4,664,223,595**	-	**$10,297**	**$12,661**	**$22,958**	**$2,507,891,265**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$131,784,402	1	Y	$10,434	$20,211	$18,693	$308,003,639	1	$10,463	$9,122	$19,585	$282,946,573	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$26,886,741	5	Y	$5,028	$11,330	$10,716	$83,316,582	4	$5,107	$10,104	$15,211	$40,476,239	6
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$48,237,180	2	Y	$6,291	$22,806	$21,864	$72,871,404	5	$6,307	$20,873	$27,180	$62,813,011	3
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$40,981,122	3	Y	$9,739	$29,166	$27,453	$65,749,076	6	$9,698	$19,195	$28,892	$61,685,419	4
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$25,158,085	8	Y	$3,896	$10,924	$10,432	$57,144,368	10	$4,025	$11,839	$15,864	$33,711,830	11
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$27,274,170	4	Y	$6,044	$16,892	$16,135	$50,162,423	15	$5,985	$15,497	$21,482	$37,807,678	8
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$19,294,108	12	N	$3,457	$10,198	$9,704	$48,482,564	17	$3,700	$11,715	$15,415	$25,387,749	17
292	Heart failure & shock w CC	4,387	37.0	1,622	$18,577,297	14	N	$5,179	$13,950	$13,245	$58,106,554	9	$5,299	$11,453	$16,753	$27,172,625	14
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$22,205,452	10	Y	$9,217	$19,880	$18,632	$56,008,648	12	$9,475	$14,271	$23,746	$36,948,381	9
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$26,525,610	6	Y	$8,288	$25,523	$24,001	$41,953,375	23	$8,304	$17,382	$25,687	$39,198,275	7
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$12,714,790	21	N	$4,368	$9,063	$8,616	$45,114,956	21	$4,512	$8,420	$12,932	$19,527,283	24
552	Medical back problems w/o MCC	2,803	51.1	1,433	$18,881,368	13	N	$3,795	$13,217	$12,611	$35,347,869	27	$3,827	$13,176	$17,004	$24,366,080	19
603	Cellulitis w/o MCC	3,814	33.5	1,277	$12,203,667	24	N	$3,759	$9,190	$8,693	$33,153,299	31	$3,905	$9,557	$13,461	$17,189,732	33
291	Heart failure & shock w MCC	2,962	42.3	1,252	$17,653,724	15	N	$5,621	$16,466	$15,440	$45,734,331	20	$5,884	$14,100	$19,984	$25,020,086	18
312	Syncope & collapse	5,218	23.9	1,245	$12,171,619	25	N	$3,352	$8,100	$7,486	$39,062,614	26	$3,595	$9,776	$13,372	$16,647,708	34
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$11,629,756	27	N	$3,498	$7,668	$7,121	$64,850,472	7	$3,849	$9,440	$13,288	$16,371,180	35
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$12,225,205	23	N	$4,978	$12,071	$11,546	$51,566,554	14	$4,987	$10,062	$15,049	$18,284,094	27
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$9,449,477	31	N	$4,134	$9,074	$8,613	$46,331,118	19	$4,288	$8,606	$12,894	$14,157,674	44
683	Renal failure w CC	2,821	38.4	1,082	$14,170,616	16	N	$6,649	$15,231	$14,347	$40,472,012	25	$6,590	$13,097	$19,687	$21,300,847	21
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$14,131,290	17	N	$3,422	$17,551	$16,944	$18,469,115	64	$3,416	$15,294	$18,709	$17,287,337	31

NOTES:
1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235)

Section 1 - Table 12
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition L: 90 Day Fixed Following Hospital Discharge (pro rated) Excluding Acute Hospital Readmissions

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$849,232,843**	-	-	**$8,287**	**$2,812**	**$11,099**	**$3,447,636,891**	-	**$10,297**	**$7,774**	**$18,071**	**$1,974,047,674**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$105,226,571	1	Y	$10,434	$6,455	$16,889	$278,282,120	1	$10,463	$7,284	$17,747	$256,388,742	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$15,198,560	9	N	$5,028	$2,019	$7,047	$54,787,034	6	$5,107	$5,712	$10,819	$28,788,058	9
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$36,437,546	2	Y	$6,291	$11,116	$17,407	$58,018,238	4	$6,307	$15,767	$22,074	$51,013,377	4
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$31,547,704	3	Y	$9,739	$13,353	$23,092	$55,305,808	5	$9,698	$14,776	$24,474	$52,252,001	3
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$15,420,126	8	N	$3,896	$2,920	$6,817	$37,341,381	15	$4,025	$7,257	$11,282	$23,973,871	13
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$19,924,485	5	Y	$6,044	$6,486	$12,530	$38,955,144	13	$5,985	$11,321	$17,306	$30,457,993	8
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$11,335,335	12	N	$3,457	$2,411	$5,868	$29,315,296	21	$3,700	$6,882	$10,582	$17,428,976	19
292	Heart failure & shock w CC	4,387	37.0	1,622	$8,901,778	18	N	$5,179	$2,103	$7,282	$31,946,178	19	$5,299	$5,488	$10,787	$17,497,106	18
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$12,368,097	11	N	$9,217	$4,198	$13,415	$40,324,685	12	$9,475	$7,949	$17,424	$27,111,026	10
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$21,568,963	4	Y	$8,288	$12,498	$20,786	$36,334,553	16	$8,304	$14,134	$22,439	$34,241,628	6
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$7,658,150	22	N	$4,368	$1,549	$5,917	$30,981,715	20	$4,512	$5,072	$9,583	$14,470,643	25
552	Medical back problems w/o MCC	2,803	51.1	1,433	$11,145,232	13	N	$3,795	$4,081	$7,877	$22,078,406	34	$3,827	$7,778	$11,605	$16,629,944	20
603	Cellulitis w/o MCC	3,814	33.5	1,277	$6,733,382	26	N	$3,759	$1,850	$5,610	$21,395,121	36	$3,905	$5,273	$9,177	$11,719,447	38
291	Heart failure & shock w MCC	2,962	42.3	1,252	$8,326,038	19	N	$5,621	$2,897	$8,518	$25,230,422	28	$5,884	$6,650	$12,534	$15,692,400	23
312	Syncope & collapse	5,218	23.9	1,245	$7,708,532	21	N	$3,352	$1,532	$4,884	$25,482,146	27	$3,595	$6,192	$9,787	$12,184,621	36
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$6,254,485	28	N	$3,498	$736	$4,233	$38,552,209	14	$3,849	$5,077	$8,925	$10,995,909	43
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$5,232,779	35	N	$4,978	$1,244	$6,222	$27,788,581	24	$4,987	$4,307	$9,294	$11,291,668	40
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$4,515,299	41	N	$4,134	$905	$5,039	$27,103,877	25	$4,288	$4,112	$8,400	$9,223,496	50
683	Renal failure w CC	2,821	38.4	1,082	$7,326,031	24	N	$6,649	$2,705	$9,354	$26,387,266	26	$6,590	$6,771	$13,361	$14,456,262	26
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$10,288,513	14	N	$3,422	$9,600	$13,023	$14,194,894	64	$3,416	$11,135	$14,550	$13,444,560	30

NOTES:
1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235)

Section 1 - Table 13
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition M: 30 Day Variable Length

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$1,567,270,349**	-	-	**$8,287**	**$6,522**	**$14,809**	**$4,600,058,189**	-	**$10,297**	**$14,348**	**$24,645**	**$2,692,085,180**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$139,007,609	1	Y	$10,434	$8,639	$19,073	$314,265,364	1	$10,463	$9,622	$16,603	$239,862,011	2
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$29,651,046	5	Y	$5,028	$5,241	$10,269	$79,839,223	4	$5,107	$11,143	$17,312	$46,066,446	8
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$55,839,503	2	Y	$6,291	$17,545	$23,836	$79,443,738	5	$6,307	$24,162	$29,777	$68,815,316	5
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$45,783,399	3	Y	$9,739	$19,612	$29,351	$70,296,372	6	$9,698	$21,444	$26,072	$55,662,706	6
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$28,233,296	8	Y	$3,896	$6,415	$10,311	$56,481,178	9	$4,025	$13,286	$37,143	$78,928,666	4
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$30,327,355	4	Y	$6,044	$10,659	$16,703	$51,928,920	14	$5,985	$17,231	$176,170	$310,059,550	1
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$23,012,539	11	Y	$3,457	$6,137	$9,594	$47,930,742	16	$3,700	$13,972	$20,153	$33,191,535	14
292	Heart failure & shock w CC	4,387	37.0	1,622	$22,754,573	12	Y	$5,179	$7,690	$12,869	$56,457,064	10	$5,299	$14,029	$24,435	$39,633,796	11
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$25,734,301	10	Y	$9,217	$9,993	$19,210	$57,744,494	7	$9,475	$16,539	$122,706	$190,931,168	3
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$28,775,518	7	Y	$8,288	$16,894	$25,182	$44,018,977	20	$8,304	$18,857	$16,618	$25,358,852	19
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$13,730,985	24	N	$4,368	$3,809	$8,177	$42,813,605	22	$4,512	$9,093	$22,638	$34,183,339	13
552	Medical back problems w/o MCC	2,803	51.1	1,433	$21,343,491	14	N	$3,795	$9,012	$12,807	$35,899,027	27	$3,827	$14,894	$33,264	$47,667,037	7
603	Cellulitis w/o MCC	3,814	33.5	1,277	$14,820,574	21	N	$3,759	$4,877	$8,636	$32,937,270	28	$3,905	$11,606	$23,356	$29,826,118	17
291	Heart failure & shock w MCC	2,962	42.3	1,252	$20,349,996	15	N	$5,621	$9,460	$15,081	$44,669,932	19	$5,884	$16,254	$21,075	$26,385,911	18
312	Syncope & collapse	5,218	23.9	1,245	$13,702,802	26	N	$3,352	$3,633	$6,985	$36,445,158	26	$3,595	$11,006	$29,332	$36,518,615	12
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$13,702,830	25	N	$3,498	$2,827	$6,325	$57,604,071	8	$3,849	$11,122	$11,570	$14,253,640	46
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$14,894,038	20	N	$4,978	$5,598	$10,576	$47,231,441	17	$4,987	$12,258	$33,347	$40,516,209	10
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$10,759,221	32	N	$4,134	$3,671	$7,805	$41,984,174	24	$4,288	$9,799	$11,752	$12,903,482	56
683	Renal failure w CC	2,821	38.4	1,082	$16,669,729	16	N	$6,649	$7,684	$14,333	$40,434,785	25	$6,590	$15,406	$20,050	$21,694,462	23
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$15,347,595	19	N	$3,422	$14,517	$17,939	$19,553,324	62	$3,416	$16,610	$17,771	$16,420,103	36

NOTES:
1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235).

Section 1 - Table 14
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition N: 30 Day Variable Length Excluding Acute Hospital Readmission

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$901,881,258**	-	-	**$8,287**	**$2,958**	**$11,246**	**$3,493,184,738**	-	**$10,297**	**$8,256**	**$18,553**	**$2,026,696,089**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$108,053,895	1	Y	$10,434	$6,617	$17,051	$280,954,991	1	$10,463	$7,479	$17,943	$259,216,066	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$16,069,756	9	N	$5,028	$2,116	$7,144	$55,547,344	6	$5,107	$6,039	$11,146	$29,659,254	9
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$38,952,615	2	Y	$6,291	$11,838	$18,129	$60,424,913	4	$6,307	$16,855	$23,162	$53,528,446	4
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$33,144,707	3	Y	$9,739	$13,991	$23,730	$56,834,123	5	$9,698	$15,524	$25,222	$53,849,004	3
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$16,373,216	8	N	$3,896	$3,064	$6,960	$38,126,961	15	$4,025	$7,705	$11,730	$24,926,961	13
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$21,082,546	5	Y	$6,044	$6,841	$12,885	$40,058,215	13	$5,985	$11,979	$17,964	$31,616,054	7
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$12,103,071	12	N	$3,457	$2,526	$5,983	$29,891,667	21	$3,700	$7,349	$11,048	$18,196,712	19
292	Heart failure & shock w CC	4,387	37.0	1,622	$9,727,201	18	N	$5,179	$2,264	$7,443	$32,654,487	19	$5,299	$5,997	$11,296	$18,322,529	18
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$13,196,035	11	N	$9,217	$4,454	$13,671	$41,094,444	12	$9,475	$8,481	$17,956	$27,938,964	10
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$22,442,779	4	Y	$8,288	$12,969	$21,257	$37,156,407	16	$8,304	$14,707	$23,011	$35,115,444	6
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$8,054,422	22	N	$4,368	$1,598	$5,966	$31,235,707	20	$4,512	$5,334	$9,846	$14,866,915	26
552	Medical back problems w/o MCC	2,803	51.1	1,433	$11,663,636	13	N	$3,795	$4,246	$8,041	$22,538,072	34	$3,827	$8,139	$11,967	$17,148,348	20
603	Cellulitis w/o MCC	3,814	33.5	1,277	$7,319,730	25	N	$3,759	$1,979	$5,738	$21,885,232	36	$3,905	$5,732	$9,636	$12,305,795	37
291	Heart failure & shock w MCC	2,962	42.3	1,252	$8,881,187	19	N	$5,621	$3,059	$8,680	$25,710,575	28	$5,884	$7,094	$12,977	$16,247,549	23
312	Syncope & collapse	5,218	23.9	1,245	$8,286,952	21	N	$3,352	$1,616	$4,968	$25,921,771	27	$3,595	$6,656	$10,251	$12,763,041	36
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$6,694,074	28	N	$3,498	$768	$4,266	$38,849,563	14	$3,849	$5,434	$9,282	$11,435,498	41
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$5,933,519	33	N	$4,978	$1,380	$6,358	$28,396,869	23	$4,987	$4,884	$9,870	$11,992,408	39
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$4,998,676	40	N	$4,134	$972	$5,106	$27,463,453	25	$4,288	$4,553	$8,841	$9,706,873	49
683	Renal failure w CC	2,821	38.4	1,082	$7,841,062	24	N	$6,649	$2,842	$9,491	$26,773,728	26	$6,590	$7,247	$13,837	$14,971,293	25
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$10,732,970	14	N	$3,422	$9,970	$13,392	$14,596,943	64	$3,416	$11,616	$15,031	$13,889,017	29

NOTES:
1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235).

Section 1 - Table 15
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition O: 45 Day Variable Length

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment [5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$1,667,919,577**	-	-	**$8,287**	**$7,267**	**$15,554**	**$4,831,667,306**	-	**$10,297**	**$15,269**	**$25,566**	**$2,792,734,409**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$143,865,858	1	Y	$10,434	$8,972	$19,406	$319,758,173	1	$10,463	$9,958	$20,421	$295,028,029	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$31,959,382	4	Y	$5,028	$5,922	$10,950	$85,132,769	4	$5,107	$12,010	$17,117	$45,548,880	6
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$57,614,324	2	Y	$6,291	$18,258	$24,549	$81,821,577	5	$6,307	$24,930	$31,238	$72,190,155	3
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$46,963,936	3	Y	$9,739	$20,198	$29,937	$71,699,502	6	$9,698	$21,997	$31,695	$67,668,233	4
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$30,076,689	6	Y	$3,896	$7,107	$11,003	$60,276,845	10	$4,025	$14,154	$18,179	$38,630,434	10
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$31,500,954	5	Y	$6,044	$11,269	$17,313	$53,827,456	14	$5,985	$17,898	$23,883	$42,034,462	9
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$24,159,091	12	Y	$3,457	$6,815	$10,272	$51,320,541	17	$3,700	$14,669	$18,368	$30,252,732	14
292	Heart failure & shock w CC	4,387	37.0	1,622	$25,354,273	11	Y	$5,179	$8,977	$14,156	$62,102,651	8	$5,299	$15,631	$20,931	$33,949,601	13
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$27,683,670	9	Y	$9,217	$11,046	$20,263	$60,911,096	9	$9,475	$17,792	$27,266	$42,426,599	7
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$29,458,399	7	Y	$8,288	$17,340	$25,628	$44,797,896	22	$8,304	$19,304	$27,609	$42,131,064	8
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$14,880,836	23	N	$4,368	$4,368	$8,736	$45,740,689	21	$4,512	$9,855	$14,366	$21,693,329	25
552	Medical back problems w/o MCC	2,803	51.1	1,433	$23,084,993	14	N	$3,795	$9,963	$13,758	$38,564,925	27	$3,827	$16,110	$19,937	$28,569,705	17
603	Cellulitis w/o MCC	3,814	33.5	1,277	$16,033,347	19	N	$3,759	$5,584	$9,343	$35,632,728	28	$3,905	$12,555	$16,460	$21,019,412	28
291	Heart failure & shock w MCC	2,962	42.3	1,252	$22,307,851	15	N	$5,621	$10,800	$16,421	$48,639,371	18	$5,884	$17,818	$23,701	$29,674,213	16
312	Syncope & collapse	5,218	23.9	1,245	$14,821,210	25	N	$3,352	$4,226	$7,578	$39,541,405	26	$3,595	$11,905	$15,500	$19,297,299	33
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$14,726,483	26	N	$3,498	$3,477	$6,975	$63,517,946	7	$3,849	$11,953	$15,802	$19,467,907	32
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$16,764,773	17	N	$4,978	$6,763	$11,741	$52,435,342	16	$4,987	$13,798	$18,785	$22,823,662	23
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$12,659,468	29	N	$4,134	$4,541	$8,675	$46,660,838	20	$4,288	$11,530	$15,818	$17,367,665	38
683	Renal failure w CC	2,821	38.4	1,082	$17,817,792	16	N	$6,649	$8,506	$15,155	$42,752,169	25	$6,590	$16,467	$23,057	$24,948,023	21
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$15,830,606	21	N	$3,422	$15,042	$18,464	$20,125,596	62	$3,416	$17,133	$20,548	$18,986,653	34

NOTES:
1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235).

Section 1 - Table 16
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition P: 45 Day Variable Length Excluding Acute Hospital Readmission

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$906,780,684**	-	-	**$8,287**	**$2,990**	**$11,277**	**$3,503,051,778**	-	**$10,297**	**$8,301**	**$18,598**	**$2,031,595,515**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$108,342,895	1	Y	$10,434	$6,645	$17,079	$281,406,494	1	$10,463	$7,499	$17,963	$259,505,066	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$16,216,923	9	N	$5,028	$2,146	$7,174	$55,775,699	6	$5,107	$6,094	$11,201	$29,806,421	9
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$39,138,152	2	Y	$6,291	$11,929	$18,220	$60,728,047	4	$6,307	$16,936	$23,243	$53,713,983	4
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$33,293,844	3	Y	$9,739	$14,074	$23,813	$57,033,207	5	$9,698	$15,594	$25,292	$53,998,141	3
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$16,506,396	8	Y	$3,896	$3,110	$7,006	$38,378,731	15	$4,025	$7,768	$11,793	$25,060,141	12
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$21,142,989	5	Y	$6,044	$6,876	$12,920	$40,168,962	13	$5,985	$12,013	$17,998	$31,676,497	7
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$12,186,199	12	N	$3,457	$2,569	$6,026	$30,105,015	21	$3,700	$7,399	$11,099	$18,279,840	19
292	Heart failure & shock w CC	4,387	37.0	1,622	$9,788,202	17	N	$5,179	$2,300	$7,479	$32,809,698	19	$5,299	$6,035	$11,334	$18,383,530	18
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$13,328,121	11	N	$9,217	$4,512	$13,729	$41,269,001	11	$9,475	$8,566	$18,041	$28,071,050	10
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$22,529,540	4	Y	$8,288	$13,039	$21,327	$37,279,361	16	$8,304	$14,764	$23,068	$35,202,205	6
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$8,122,439	22	N	$4,368	$1,623	$5,991	$31,366,431	20	$4,512	$5,379	$9,891	$14,934,932	26
552	Medical back problems w/o MCC	2,803	51.1	1,433	$11,763,404	13	N	$3,795	$4,299	$8,094	$22,686,831	33	$3,827	$8,209	$12,036	$17,248,116	20
603	Cellulitis w/o MCC	3,814	33.5	1,277	$7,381,358	25	N	$3,759	$2,009	$5,768	$21,997,341	36	$3,905	$5,780	$9,685	$12,367,423	37
291	Heart failure & shock w MCC	2,962	42.3	1,252	$8,916,177	19	N	$5,621	$3,093	$8,714	$25,811,224	28	$5,884	$7,122	$13,005	$16,282,539	22
312	Syncope & collapse	5,218	23.9	1,245	$8,351,528	21	N	$3,352	$1,645	$4,997	$26,075,478	27	$3,595	$6,708	$10,303	$12,827,617	36
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$6,777,561	28	N	$3,498	$788	$4,286	$39,035,894	14	$3,849	$5,501	$9,350	$11,518,985	41
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$5,980,043	33	N	$4,978	$1,408	$6,386	$28,517,886	23	$4,987	$4,922	$9,909	$12,038,932	39
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$5,027,553	40	N	$4,134	$987	$5,121	$27,546,730	25	$4,288	$4,579	$8,867	$9,735,750	49
683	Renal failure w CC	2,821	38.4	1,082	$7,895,986	23	N	$6,649	$2,901	$9,550	$26,940,334	26	$6,590	$7,298	$13,887	$15,026,217	25
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$10,785,857	14	N	$3,422	$10,054	$13,476	$14,688,592	64	$3,416	$11,673	$15,089	$13,941,904	29

NOTES:
1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235).

Section 1 - Table 17
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition Q: 60 Day Variable Length

MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Per Index Acute Hospital Discharge					Per PAC User				
								Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$1,754,142,903**	-	-	**$8,287**	**$7,844**	**$16,131**	**$5,010,719,782**	-	**$10,297**	**$16,058**	**$26,355**	**$2,878,957,734**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$148,678,506	1	Y	$10,434	$9,282	$19,716	$324,867,330	1	$10,463	$10,291	$20,755	$299,840,677	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$34,309,011	4	Y	$5,028	$6,563	$11,591	$90,116,366	3	$5,107	$12,893	$18,000	$47,898,509	6
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$58,748,154	2	Y	$6,291	$18,692	$24,983	$83,266,745	5	$6,307	$25,421	$31,728	$73,323,985	3
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$48,125,110	3	Y	$9,739	$20,771	$30,510	$73,072,473	6	$9,698	$22,541	$32,239	$68,829,407	4
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$31,703,148	6	Y	$3,896	$7,650	$11,546	$63,246,251	9	$4,025	$14,919	$18,944	$40,256,893	10
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$32,702,634	5	Y	$6,044	$11,873	$17,917	$55,704,194	14	$5,985	$18,581	$24,566	$43,236,142	8
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$25,239,599	12	Y	$3,457	$7,344	$10,801	$53,963,370	16	$3,700	$15,325	$19,024	$31,333,240	15
292	Heart failure & shock w CC	4,387	37.0	1,622	$27,754,154	11	Y	$5,179	$10,068	$15,247	$66,888,934	8	$5,299	$17,111	$22,410	$36,349,482	11
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$29,015,203	9	Y	$9,217	$11,758	$20,975	$63,050,812	10	$9,475	$18,647	$28,122	$43,758,132	7
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$29,974,013	7	Y	$8,288	$17,684	$25,972	$45,398,698	22	$8,304	$19,642	$27,947	$42,646,678	9
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$15,611,329	25	N	$4,368	$4,734	$9,102	$47,659,896	21	$4,512	$10,339	$14,850	$22,423,822	25
552	Medical back problems w/o MCC	2,803	51.1	1,433	$24,527,652	13	N	$3,795	$10,782	$14,577	$40,860,636	27	$3,827	$17,116	$20,944	$30,012,364	17
603	Cellulitis w/o MCC	3,814	33.5	1,277	$17,195,464	18	N	$3,759	$6,123	$9,882	$37,690,582	28	$3,905	$13,466	$17,370	$22,181,529	27
291	Heart failure & shock w MCC	2,962	42.3	1,252	$24,359,620	14	N	$5,621	$12,128	$17,749	$52,574,002	18	$5,884	$19,457	$25,340	$31,725,982	14
312	Syncope & collapse	5,218	23.9	1,245	$16,295,293	22	N	$3,352	$4,769	$8,121	$42,376,054	26	$3,595	$13,089	$16,684	$20,771,382	29
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$15,723,320	24	N	$3,498	$3,891	$7,389	$67,293,747	7	$3,849	$12,762	$16,611	$20,464,744	30
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$18,356,392	17	N	$4,978	$7,628	$12,606	$56,297,143	13	$4,987	$15,108	$20,095	$24,415,281	22
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$13,495,564	29	N	$4,134	$5,142	$9,276	$49,897,672	19	$4,288	$12,291	$16,579	$18,203,761	37
683	Renal failure w CC	2,821	38.4	1,082	$18,947,656	16	N	$6,649	$9,351	$16,000	$45,135,162	23	$6,590	$17,512	$24,102	$26,077,887	20
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$16,529,518	20	N	$3,422	$15,708	$19,130	$20,852,233	62	$3,416	$17,889	$21,305	$19,685,565	34

NOTES:

1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235)

Section 1 - Table 18
Medicare Post-Acute Care Episode Payments, By MS-DRG, 2006, Top 20 MS-DRGs by Volume of Discharges to PAC
Episode Definition R: 60 Day Variable Length Excluding Acute Hospital Readmission

								Per Index Acute Hospital Discharge					Per PAC User				
MS-DRG	Descriptor	Total Live Index Acute Hospital Discharges[1]	Percent of Beneficiaries Discharged to PAC (PAC Users)[2]	Number of PAC Users	Total Medicare Spending on PAC[3]	Rank By Total PAC Spending	MS-DRG in top 30% of PAC Spending[4] (Y/N)	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[6]	Rank By Total Medicare Acute + PAC Spending	Mean Index Acute Hospital Payment	Mean PAC Payment[5]	Mean Medicare Spending (Acute+PAC Episodes)	Total Medicare Spending (Acute+PAC Episodes)[7]	Rank By Total Medicare Acute + PAC Spending
	All MS-DRGs	**310,629**	**35.2**	**109,236**	**$910,746,335**	-	-	**$8,287**	**$3,013**	**$11,300**	**$3,510,097,167**	-	**$10,297**	**$8,337**	**$18,635**	**$2,035,561,166**	-
470	Major joint replacement or reattachment of lower extremity w/o MCC	16,477	87.7	14,447	$108,564,855	1	Y	$10,434	$6,661	$17,095	$281,668,591	1	$10,463	$7,515	$17,978	$259,727,026	1
194	Simple pneumonia & pleurisy w CC	7,775	34.2	2,661	$16,341,786	9	N	$5,028	$2,168	$7,196	$55,945,348	6	$5,107	$6,141	$11,248	$29,931,284	9
65	Intracranial hemorrhage or cerebral infarction w CC	3,333	69.3	2,311	$39,233,071	2	Y	$6,291	$11,966	$18,257	$60,850,472	4	$6,307	$16,977	$23,284	$53,808,902	4
481	Hip & femur procedures except major joint w CC	2,395	89.1	2,135	$33,435,302	3	Y	$9,739	$14,139	$23,878	$57,188,888	5	$9,698	$15,661	$25,358	$54,139,599	3
690	Kidney & urinary tract infections w/o MCC	5,478	38.8	2,125	$16,565,641	8	Y	$3,896	$3,131	$7,027	$38,492,879	15	$4,025	$7,796	$11,821	$25,119,386	12
66	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	3,109	56.6	1,760	$21,225,282	5	Y	$6,044	$6,910	$12,954	$40,273,897	13	$5,985	$12,060	$18,045	$31,758,790	7
641	Nutritional & misc metabolic disorders w/o MCC	4,996	33.0	1,647	$12,235,980	12	N	$3,457	$2,601	$6,058	$30,267,294	21	$3,700	$7,429	$11,129	$18,329,621	19
292	Heart failure & shock w CC	4,387	37.0	1,622	$9,916,901	16	N	$5,179	$2,337	$7,516	$32,971,439	19	$5,299	$6,114	$11,413	$18,512,229	18
871	Septicemia w/o MV 96+ hours w MCC	3,006	51.8	1,556	$13,369,582	11	N	$9,217	$4,537	$13,754	$41,344,975	11	$9,475	$8,592	$18,067	$28,112,511	10
482	Hip & femur procedures except major joint w/o CC/MCC	1,748	87.3	1,526	$22,590,496	4	Y	$8,288	$13,091	$21,379	$37,371,137	16	$8,304	$14,804	$23,108	$35,263,161	6
195	Simple pneumonia & pleurisy w/o CC/MCC	5,236	28.8	1,510	$8,156,222	22	N	$4,368	$1,640	$6,008	$31,457,382	20	$4,512	$5,401	$9,913	$14,968,715	26
552	Medical back problems w/o MCC	2,803	51.1	1,433	$11,817,487	13	N	$3,795	$4,324	$8,119	$22,756,712	33	$3,827	$8,247	$12,074	$17,302,199	20
603	Cellulitis w/o MCC	3,814	33.5	1,277	$7,432,816	25	N	$3,759	$2,037	$5,796	$22,106,366	36	$3,905	$5,821	$9,725	$12,418,881	37
291	Heart failure & shock w MCC	2,962	42.3	1,252	$8,961,075	19	N	$5,621	$3,118	$8,739	$25,885,523	28	$5,884	$7,157	$13,041	$16,327,437	22
312	Syncope & collapse	5,218	23.9	1,245	$8,395,419	21	N	$3,352	$1,662	$5,014	$26,163,639	27	$3,595	$6,743	$10,339	$12,871,508	35
392	Esophagitis, gastroent & misc digest disorders w/o MCC	9,107	13.5	1,232	$6,841,631	28	N	$3,498	$804	$4,302	$39,180,865	14	$3,849	$5,553	$9,402	$11,583,055	41
293	Heart failure & shock w/o CC/MCC	4,466	27.2	1,215	$6,024,476	32	N	$4,978	$1,430	$6,408	$28,618,300	23	$4,987	$4,958	$9,945	$12,083,365	39
192	Chronic obstructive pulmonary disease w/o CC/MCC	5,379	20.4	1,098	$5,049,613	40	N	$4,134	$1,006	$5,140	$27,648,772	25	$4,288	$4,599	$8,887	$9,757,810	48
683	Renal failure w CC	2,821	38.4	1,082	$7,950,818	23	N	$6,649	$2,938	$9,587	$27,045,691	26	$6,590	$7,348	$13,938	$15,081,049	25
536	Fractures of hip & pelvis w/o MCC	1,090	84.8	924	$10,807,521	14	N	$3,422	$10,091	$13,513	$14,729,037	64	$3,416	$11,696	$15,112	$13,963,568	29

NOTES:

1. Index acute hospitalizations are defined as hospital admissions following a 60-day period without acute, LTCH, SNF, IRF, or HHA service use. The study sample is limited to live discharges from index acute hospitalizations.
2. PAC users are defined as beneficiaries discharged to SNF, IRF, or LTCH within 5 days of discharge from the index acute hospitalization, or discharged to HHA or hospital outpatient therapy within 14 days of discharge from the index acute hospitalization.
3. Total Medicare Spending on PAC is equal to Mean PAC Payment Per PAC User * Number of PAC Users.
4. This flag was assigned after sorting data descending by Total Medicare Spending on PAC and identifying the MS-DRGs accounting for the top 30% of PAC spending.
5. Mean PAC payment includes Medicare payments for SNF, IRF, LTCH, HHA, and hospital outpatient therapy.
6. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of Live Index Acute Hospital Discharges.
7. Total Medicare Spending is equal to (Mean Index Acute Hospital Payment + Mean PAC Payment) * Number of PAC Users.

SOURCE: RTI Analysis of 2006 5% Medicare claims data (MM2Y235).