

costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this final rule in light of Executive Order 13132 and have determined that it will not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

II. Objectives

The primary objective of the acute care hospital inpatient prospective payment system is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to compensate hospitals adequately for their legitimate costs. In addition, we share the national goal of preserving the Medicare Trust Fund.

We believe the changes in this final rule will further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect these changes will ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our policy changes, as well as statutory changes effective for FY 2003, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. As we have done in previous proposed rules, in the May 9, 2002 proposed rule, we solicited comments and information about the anticipated effects of these changes on hospitals and our methodology for estimating payments.

We received several comments on the impact analysis for our May 9, 2002 proposed rule.

Comment: Several commenters noted that the effects of the proposed expansion to the postacute transfer policy were not included in the May 9, 2002 proposed rule impact tables. These commenters were concerned that the effect of implementing either of the two

proposed expansions of this policy would result in an overall decrease in per case payments in FY 2003.

Response: We did not analyze the postacute care transfer policy in the impact tables in the proposed rule because we did not propose a specific policy expansion. We did consider overall savings estimates attributable to the provision in the preamble discussion. Furthermore, we have not provided such an analysis in the impact tables in this final rule because we have decided not to make revisions to the postacute care transfer policy at this time. As stated elsewhere in the preamble, we will continue to assess whether further expansions or refinements of the transfer policy may be warranted for FY 2004 or subsequent years, and, if so, how to design such refinements and assess their impact.

Comment: Several commenters noted the impact that the large, legislated decreases in IME payments and the update factor (market basket increase minus 0.55 percentage point) will have on many hospitals. They argued that these decreases in payments, in combination with our proposals and an update factor of less than inflation, will have an even larger overall impact than indicated in our impact tables. The commenters indicated that, in a time when other health care costs are escalating due to nursing shortages, rising drug and technology costs, and “skyrocketing” professional and general insurance premiums, hospitals cannot absorb a reduction in inpatient Medicare payments. They argued that decreasing payments and increasing costs will make hospitals less able to make decisions based solely on the needs of the beneficiary and force them to make more decisions based on solvency.

Response: As the commenters pointed out, these reductions are legislated by Congress. However, as discussed further below, one of the biggest impacts on the changes in payments from FY 2002 to FY 2003 is the high total of outlier payments hospitals are receiving in FY 2002 (approximately 6.9 percent of total DRG payments) compared to the FY 2003 estimate of 5.1 percent. The net effect of this difference is to reduce the rate of change by 2.1 percentage points.

IV. Hospitals Included In and Excluded From the Acute Care Hospital Inpatient Prospective Payment System

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general short-term, acute care hospitals that participate in the Medicare program. There were 44 Indian Health

Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment methodology for these hospitals. Among other short-term, acute care hospitals, only the 67 such hospitals in Maryland remain excluded from the acute care hospital inpatient prospective payment system under the waiver at section 1814(b)(3) of the Act.

There are approximately 631 critical access hospitals (CAHs). These small, limited service hospitals are paid on the basis of reasonable costs rather than under the acute care hospital inpatient prospective payment system. The remaining 20 percent are specialty hospitals that are excluded from the acute care hospital inpatient prospective payment system. These hospitals include psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals. The impacts of our final policy changes on these hospitals are discussed below.

Thus, as of July 2002, we have included 4,230 hospitals in our analysis. This represents about 80 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

V. Impact on Excluded Hospitals and Hospital Units

As of July 2002, there were 1,076 specialty hospitals excluded from the acute care hospital inpatient prospective payment system. Broken down by specialty, there were 486 psychiatric, 220 rehabilitation, 279 long-term care, 80 children's, and 11 cancer hospitals. In addition, there were 1,427 psychiatric units and 962 rehabilitation units in hospitals otherwise subject to the acute care hospital inpatient prospective payment system. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 67 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

In the past, hospitals and units excluded from the acute care hospital inpatient prospective payment system have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid based on their reasonable costs are subject to TEFRA limits for FY 2003. For these hospitals, the proposed update is the percentage increase in the excluded hospital market basket (currently estimated at 3.5 percent).