

Inpatient rehabilitation facilities (IRFs) are paid under the IRF prospective payment system for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2003, the IRF prospective payment is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually (see the August 7, 2001 final rule (66 FR 41316 through 41430)). Therefore, these hospitals are not impacted by this final rule.

Effective for cost reporting periods beginning during FY 2003, we have proposed that long-term care hospitals would be paid under a long-term care hospital prospective payment system, where long-term care hospitals receive payment based on a 5-year transition period (see the March 22, 2002 proposed rule (67 FR 13416 through 13494)). However, under this proposed payment system, a long-term care hospital may also elect to be paid at 100 percent of the Federal prospective rate at the beginning of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor, the portion of the proposed prospective payment system transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the long-term care hospital's TEFRA limit by the estimate of the excluded hospital market basket (or 3.5 percent).

The impact on excluded hospitals and hospital units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and hospital units receive. Conversely, for excluded hospitals and hospital units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect will be the amount of excess costs that would not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and hospital units can obtain payment adjustments for justifiable

increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and hospital units to restrain the growth in their spending for patient services.

## **VI. Quantitative Impact Analysis of the Policy Changes Under the Hospital Inpatient Prospective Payment System for Operating Costs**

### *A. Basis and Methodology of Estimates*

In this final rule, we are announcing policy changes and payment rate updates for the hospital inpatient prospective payment systems for operating and capital-related costs. We estimate the total impact of these changes for FY 2003 payments compared to FY 2002 payments to be approximately a \$300 million increase. We have prepared separate impact analyses of the changes to each system. This section deals with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are taken from the FY 2001 MedPAR file and the most current provider-specific file that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not incorporate cost data, the most recently available hospital cost report data were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these policy changes. Second, due to the interdependent nature of the hospital inpatient prospective payment system, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available data overall. For individual hospitals, however, some miscategorizations are possible.

Using cases in the FY 2001 MedPAR file, we simulated payments under the operating prospective payment system given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the acute care hospital inpatient prospective payment systems (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations. The impact of payments under the capital prospective payment system, or the impact of payments for costs other than inpatient

operating costs, are not analyzed in this section. Estimated payment impacts of FY 2003 changes to the capital prospective payment system are discussed in section IX. of this Appendix.

The changes discussed separately below are the following:

- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of the changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 1999, compared to the FY 1998 wage data, and the effects of removing from the wage data the costs and hours associated with GME and CRNAs.

- The effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRRB) that will be effective in FY 2003.

- The total change in payments based on FY 2003 policies relative to payments based on FY 2002 policies.

To illustrate the impacts of the FY 2003 changes, our analysis begins with a FY 2003 baseline simulation model using: the FY 2002 DRG GROUPE (version 19.0); the FY 2002 wage index; and no MGCRRB reclassifications. Outlier payments are set at 5.1 percent of total DRG plus outlier payments.

Each final and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2003 model incorporating all of the changes. This methodology allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 2002 to FY 2003. Six factors have significant impacts here. The first is the update to the standardized amounts. In accordance with section 1886(d)(3)(A)(iv) of the Act, as amended by section 301 of Public Law 106-554, we are updating the large urban and the other areas average standardized amounts for FY 2003 using the most recently forecasted hospital market basket increase for FY 2003 of 3.5 percent minus 0.55 percentage points (for an update of 2.95 percent). Under section 1886(b)(3) of the Act, the updates to the hospital-specific amounts for sole community hospitals (SCHs) and for Medicare-dependent small rural hospitals (MDHs) are also equal to the market basket increase of 3.5 percent minus 0.55 percentage points (for an update of 2.95 percent). We estimate the aggregate impact of this update will be to increase hospital payments by \$500 million.