

A second significant factor that impacts changes in a hospital's payments per case from FY 2002 to FY 2003 is the change in MGCRB status from one year to the next. That is, hospitals reclassified in FY 2002 that are no longer reclassified in FY 2003 may have a negative payment impact going from FY 2002 to FY 2003; conversely, hospitals not reclassified in FY 2002 that are reclassified in FY 2003 may have a positive impact. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage change in payments for the category may be below the national mean. This effect is alleviated, however, by section 304(a) of Public Law 106-554, which provided that reclassifications for purposes of the wage index are for a 3-year period. Because the impact of MGCRB reclassifications are budget neutral overall, the only impacts of these changes are on payments to individual hospitals and hospital groups.

A third significant factor is that we currently estimate that actual outlier payments during FY 2002 will be 6.9 percent of total DRG payments. When the FY 2002 final rule was published, we projected FY 2002 outlier payments would be 5.1 percent of total DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2002 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 2002 payments per case to estimated FY 2003 payments per case. We estimate FY 2002 payments will be approximately \$1.5 billion higher than if outlier payments had been 5.1 percent of total DRG payments.

Fourth, section 213 of Public Law 106-554 provides that all SCHs may receive payment on the basis of their costs per case during their cost reporting period that began during 1996. This option was to be phased in over 4 years. For FY 2003, the proportion of payments based on affected SCHs' FY 1996 hospital-specific amount increases from 50 percent to 75 percent.

Fifth, under section 1886(d)(5)(B)(ii) of the Act, the formula for IME is reduced beginning in FY 2003. The reduction is from approximately a 6.5 percent increase for every 10 percent increase in the resident-to-bed ratio during FY 2002 to approximately a 5.5 percent increase. We estimate the impact of this reduction will be to

decrease aggregate payments by \$1 billion.

Comment: Numerous commenters expressed concern about the statutory reduction to the IME formula multiplier for FY 2003 of 1.35. The commenters stated that this cut in IME reimbursement will have an extremely detrimental impact on the teaching hospital community.

Response: Congress establishes the IME formula multiplier for FY 2003 by law. Any changes to the multiplier must be made through the legislative process.

Comment: One commenter stated that the reduction to the IME formula multiplier was not considered in the impact analysis table (67 FR 31670) in the proposed rule. The commenter requested that the large impact due to reduction in IME payments be acknowledged and weighed against the cost to hospitals that would be incurred by the proposed outlier reduction, transfer payment expansion, and the removal of resident salary costs from the wage index.

Response: In the May 9, 2002 proposed rule at 67 FR 31670 and 31671, we included several footnotes that explain the various calculations in the impact analysis for FY 2003. Footnote number 9 states that the impact of the reduction in IME adjustment payments is reflected in column 8 of the table, which contains all FY 2003 changes. Thus, we have incorporated the reduction to the IME formula multiplier in the impact analysis of total Medicare hospital expenditures for FY 2003, and have similarly done so in this final rule.

Sixth, the disproportionate share hospital (DSH) adjustment increases in FY 2003 compared with FY 2002. In accordance with section 1886(d)(5)(F)(ix) of the Act, during FY 2002, DSH payments that a hospital would otherwise receive were reduced by 3 percent. This reduction is no longer applicable beginning with FY 2003. We estimate the higher DSH payments will increase overall Medicare payments to hospitals by \$200 million.

Table I demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 4,230 hospitals included in the analysis. This number is 555 fewer hospitals than were included in the impact analysis in the FY 2002 final rule (66 FR 40087). Of this number, 437 are now CAHs and are excluded from our analysis.

The next four rows of Table I contain hospitals categorized according to their geographic location: all urban, which is further divided into large urban and other urban; and rural. There are 2,620 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,519 hospitals located in large urban areas (populations over 1 million), and 1,101 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,610 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2003 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations after consideration of geographic reclassifications are 2,650, 1,576, 1,074, and 1,580, respectively.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 3,119 nonteaching hospitals in our analysis, 870 teaching hospitals with fewer than 100 residents, and 241 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural after MGCRB reclassifications. Hospitals in the rural DSH categories, therefore, represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (They may, however, have been reclassified for purposes of the wage index.)

The next category groups hospitals, considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and MDHs), as well as rural hospitals not receiving a special payment designation. The RRCs (160), SCHs (526), MDHs (241), and hospitals that are both SCH and RRC (76) shown