

of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

As we explained in the August 1, 2001 IPPS final rule (66 FR 39912 through 39914), in order to determine the estimated proportion of special exceptions payments to total capital payments, we attempted to identify the universe of eligible hospitals that may potentially qualify for special exceptions payments. First, we identified hospitals that met the eligibility requirements at § 412.348(g)(1). Then we determined each hospital's average fixed asset age in the earliest available cost report starting in FY 1992 and subsequent fiscal years. For each of those hospitals, we calculated the average fixed asset age by dividing the accumulated depreciation by the current year's depreciation. In accordance with § 412.348(g)(3), a hospital must have an average age of buildings and fixed assets above the 75th percentile of all hospitals in the first year of the capital PPS. In the September 1, 1994 final rule (59 FR 45385), we stated that, based on the June 1994 update of the cost report files in HCRIS, the 75th percentile for buildings and fixed assets for FY 1992 was 16.4 years. However, we noted that we would make a final determination of that value on the basis of more complete cost report information at a later date. In the August 29, 1997 final rule (62 FR 46012), based on the December 1996 update of HCRIS and the removal of outliers, we finalized the 75th percentile for buildings and fixed assets for FY 1992 as 15.4 years. Thus, we eliminated any hospitals from the potential universe of hospitals that may qualify for special exception payments if its average age of fixed assets did not exceed 15.4 years.

For the hospitals remaining in the potential universe, we estimated project-size by using the fixed capital acquisitions shown on Worksheet A7 from the following HCRIS cost reports updated through December 2002.

PPS year	Cost reporting periods beginning in . . .
IX .....	FY 1992.
X .....	FY 1993.
XI .....	FY 1994.
XII .....	FY 1995.
XIII .....	FY 1996.
XIV .....	FY 1997.
XV .....	FY 1998.
XVI .....	FY 1999.
XVII .....	FY 2000.
XVIII .....	FY 2001.

Because the project phase-in may overlap 2 cost reporting years, we added together the fixed acquisitions from sequential pairs of cost reports to determine project size. Under § 412.348(g)(5), the hospital's project cost must be at least \$200 million or 100 percent of its operating cost during the first 12-month cost reporting period beginning on or after October 1, 1991. We calculated the operating costs from the earliest available cost report starting in FY 1992 and later by subtracting inpatient capital costs from inpatient costs

(for all payers). We did not subtract the direct medical education costs as those costs are not available on every update of the HCRIS minimum data set. If the hospital met the project size requirement, we assumed that it also met the project need requirements at § 412.348(g)(2) and the excess capacity test for urban hospitals at § 412.348(g)(4).

Because we estimate that so few hospitals will qualify for special exceptions, projecting costs, payments, and margins would result in high statistical variance. Consequently, we decided to model the effects of special exceptions using historical data based on hospitals' actual cost experiences. If we determined that a hospital may qualify for special exceptions, we modeled special exceptions payments from the project start date through the last available cost report (FY 2000). (Although some FY 2001 cost reports are available in HCRIS, only a few hospitals have submitted FY 2001 costs. Consequently, too few cost reports are available to reliably model FY 2001 special exceptions payments.) For purposes of modeling, we used the cost and payment data on the cost reports from HCRIS assuming that special exceptions would begin at the start of the qualifying project. In other words, when modeling costs and payment data, we ignored any regular exception payments that these hospitals may otherwise have received as if there had not been regular exception provision during the transition period. In projecting an eligible hospital's special exception payment, we applied the 70-percent minimum payment level, the cumulative comparison of current year capital PPS payments and costs, and the cumulative operating margin offset (excluding 75 percent of operating DSH payments).

Our modeling of special exception payments for FY 2004 produced the following results:

Cost report	Number of hospitals eligible for special exceptions	Special exceptions as a fraction of capital payments to all hospitals
PPS IX .....	.....	.....
PPS X .....	.....	.....
PPS XI .....	1	.....
PPS XII .....	4	.....
PPS XIII .....	5	.....
PPS XIV .....	11	.....
PPS XV .....	15	.....
PPS XVI .....	24	0.0002
PPS XVII .....	27	0.0005
PPS XVIII .....	N/A	N/A

We note that hospitals still have one more cost reporting period (PPS XVIII) to complete their projects in order to be eligible for special exceptions payments, and, therefore, we estimate that about 30 hospitals could qualify for special exceptions payments. Thus, we project that special exception payments as a fraction of capital payments to all hospitals to be approximately 0.0005.

Because special exceptions are budget neutral, we are proposing to offset the Federal capital rate by 0.05 percent for special exceptions payments for FY 2004.

Therefore, the proposed exceptions adjustment factor would equal 0.9995 ( $1 - 0.0005$ ) to account for special exceptions payments in FY 2004. Furthermore, we are proposing to estimate the exceptions payment adjustment factor for special exceptions payments in FY 2004 in the final rule based on updated data.

In the August 1, 2002 IPPS final rule (67 FR 50131) for FY 2003, we estimated that total (special) exceptions payments would equal 0.30 percent of aggregate payments based on the Federal rate. Therefore, we applied an exceptions reduction factor of 0.9970 ( $1 - 0.0030$ ) in determining the FY 2003 Federal rate. As we stated, we estimate that exceptions payments in FY 2004 would equal 0.05 percent of aggregate payments based on the proposed FY 2004 Federal rate. Therefore, we are proposing to apply an exceptions payment adjustment factor of 0.9995 ( $1 - 0.0005$ ) to the proposed Federal rate for FY 2004. The proposed exceptions adjustment factor for FY 2004 is 0.25 percent higher than the factor for FY 2003 published in the August 1, 2002 IPPS final rule (67 FR 50131). This increase is primarily due to a refined analysis of more recent data.

The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. Therefore, the proposed net change in the exceptions adjustment factor used in determining the proposed FY 2004 Federal rate is 0.9995/0.9970, or 1.0025.

#### 5. Proposed Standard Capital Federal Rate for FY 2004

In the August 1, 2002 IPPS final rule (67 FR 50131) we established a capital Federal rate of \$407.01 for FY 2003. As we noted above, as a result of the revisions to the GAF effective for discharges occurring on or after April 1, 2003 through September 30, 2003, we have established a capital Federal rate of \$406.93 for discharges occurring on or after April 1, 2003 through September 30, 2003. The rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003, were used in determining the proposed FY 2004 rates. In this proposed rule, we are proposing a capital Federal rate of \$411.72 for FY 2004. The proposed Federal rate for FY 2004 was calculated as follows:

- The proposed FY 2004 update factor is 1.0070; that is, the update is 0.70 percent.
- The proposed FY 2004 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the GAF is 1.0038.
- The proposed FY 2004 outlier adjustment factor is 0.9455.
- The proposed FY 2004 (special) exceptions payment adjustment factor is 0.9995.

Since the proposed Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are proposing to make no additional adjustments in the standard Federal rate for these factors, other than the