

TABLE 11.—PROPOSED LTC-DRGS RELATIVE WEIGHTS AND GEOMETRIC AND FIVE-SIXTHS OF THE AVERAGE LENGTH OF STAY—FY 2004—Continued

LTC-DRG	Description	Relative weight	Geo-metric average length of stay	5/6ths of the average length of stay
540	<sup>1</sup> LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITHOUT CC .....	0.5711	20.8	17.3

<sup>1</sup> Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low volume quintile 1.

<sup>2</sup> Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low volume quintile 2.

<sup>3</sup> Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low volume quintile 3.

<sup>4</sup> Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low volume quintile 4.

<sup>5</sup> Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low volume quintile 5.

<sup>6</sup> Proposed relative weights for these proposed LTC-DRGs were assigned a value of 0.0000.

<sup>7</sup> Proposed relative weights for these proposed LTC-DRGs were determined after adjusting to account for nonmonotonicity (see step 5 above).

<sup>8</sup> Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to the appropriate proposed low volume quintile because they had no LTCH cases in the FY 2002 MedPAR.

## Appendix A—Regulatory Analysis of Impacts

### I. Background and Summary

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year).

We have determined that this proposed rule is a major rule as defined in 5 U.S.C. 804(2). Based on the overall percentage change in payments per case estimated using our payment simulation model (a 2.5 percent increase), we estimate that the total impact of these proposed changes for FY 2004 payments compared to FY 2003 payments to be approximately a \$2.1 billion increase. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$5 million to \$25 million in any 1 year. For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception

of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the acute care hospital inpatient prospective payment systems, we classify these hospitals as urban hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any proposed rule (or a final rule that has been preceded by a proposed rule) that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million. This proposed rule would not mandate any requirements for State, local, or tribal governments.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this proposed rule in light of Executive Order 13132 and have determined that it would 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 proposed rule was reviewed by the Office of Management and Budget.

The following analysis, in conjunction with the remainder of this document, demonstrates that this proposed rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The proposed rule would affect payments to a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some hospitals may be significant.

### II. Objectives

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

We believe the changes in this proposed rule would 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 that these proposed changes would 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 proposed policy changes, as well as statutory changes effective for FY 2004, on various hospital groups. We estimate the effects of individual proposed 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 proposed 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, we are soliciting comments and information about the anticipated effects of these proposed changes on hospitals and our methodology for estimating them.

### IV. Hospitals Included In and Excluded From the IPPS

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 45 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 48 such hospitals in Maryland remain excluded from the IPPS under the waiver at section 1814(b)(3) of the Act.