

There are approximately 729 critical access hospitals (CAHs). These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. The remaining 20 percent are specialty hospitals that are excluded from the IPPS. These specialty hospitals include psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals. The impacts of our proposed policy changes on these hospitals are discussed below.

Thus, as of April 2003, we have included 4,087 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 April 2003, there were 1,085 specialty hospitals excluded from the IPPS that were paid instead on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. Broken down by specialty, there were 484 psychiatric, 214 rehabilitation, 296 long-term care, 80 children's, and 11 cancer hospitals. In addition, there were 1,410 psychiatric units and 979 rehabilitation units in hospitals otherwise subject to the IPPS. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 48 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 IPPS 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 2004. For these hospitals, the proposed update is the percentage increase in the excluded hospital market basket (currently estimated at 3.5 percent).

Inpatient rehabilitation facilities (IRFs) are paid under a prospective payment system (IRF PPS) for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2004, the IRF PPS is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually. Therefore, these hospitals would not be impacted by this proposed rule.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs are paid under a LTCH PPS, based on the adjusted Federal prospective payment amount, updated annually. LTCHs will receive a blended payment (Federal prospective payment and a reasonable cost-based payment) over a 5-year transition period. However, under the LTCH PPS, a LTCH 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 LTCH PPS transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the LTCH'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 would 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 would 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 Proposed Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for the IPPS for operating and capital-related costs. Based on the overall percentage change in payments per case estimated using our payment simulation model (a 2.5 percent increase), we estimate the total impact of these 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.

We have prepared separate impact analyses of the proposed changes to each system. This section deals with changes to the operating prospective payment system. Our payment simulation model relies on available data to enable us to estimate the impacts on payments per case of certain changes we are proposing in this proposed rule. However, there are other changes we are proposing for which we do not have data available that would allow us to estimate the payment impacts using this model. For those proposals, we have attempted to predict the payment impacts of those proposed changes based upon our experience and other more limited data.

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 2002 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of

the changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report 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 proposed policy changes, and we do not adjust for future changes in such variables as admissions, lengths of stay, or case-mix. Second, due to the interdependent nature of the IPPS payment components, it is very difficult to precisely quantify the impact associated with each proposed 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 source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases in the FY 2002 MedPAR file, we simulated payments under the operating IPPS given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the IPPSs (Indian Health Service hospitals and hospitals in Maryland) were excluded from the simulations. The impact of payments under the capital IPPS, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of proposed FY 2004 changes to the capital IPPS are discussed in section IX. of this Appendix.

The proposed changes discussed separately below are the following:

- The effects of expanding the postacute care transfer policy to 19 additional DRGs.
- The effects of the proposed 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 proposed changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2000, compared to the FY 1999 wage data, including the effects of removing wage data for Part B costs of RCHs and FQHCs.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2004.
- The total change in payments based on proposed FY 2004 policies relative to payments based on FY 2003 policies.

To illustrate the impacts of the proposed FY 2004 changes, our analysis begins with a FY 2004 baseline simulation model using: the FY 2003 DRG GROUPER (version 20.0); the current postacute care transfer policy for 10 DRGs; the FY 2003 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total operating DRG and outlier payments.

Each proposed and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2004 model incorporating all of the proposed changes. This allows us to isolate the effects of each proposed change.

Our final comparison illustrates the percent change in payments per case from FY