

2003 to FY 2004. Five factors have significant impacts here. The first is the update to the standardized amounts. In accordance with section 1886(b)(3)(B)(i) of the Act, we are proposing to update the large urban and the other areas average standardized amounts for FY 2004 using the most recently forecasted hospital market basket increase for FY 2004 of 3.5 percent. Under section 1886(b)(3)(B)(iv) 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, or 3.5 percent.

A second significant factor that impacts changes in hospitals' payments per case from FY 2003 to FY 2004 is the change in MGCRB status from one year to the next. That is, hospitals reclassified in FY 2003 that are no longer reclassified in FY 2004 may have a negative payment impact going from FY 2003 to FY 2004; conversely, hospitals not reclassified in FY 2003 that are reclassified in FY 2004 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. However, this effect is alleviated by section 1886(d)(10)(D)(v) of the Act, which provides that reclassifications for purposes of the wage index are for a 3-year period.

A third significant factor is that we currently estimate that actual outlier payments during FY 2003 will be 5.5 percent of total DRG payments. When the FY 2003 final rule was published, we projected FY 2003 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 2003 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2003 payments per case to estimated FY 2004 payments per case.

Fourth, we are proposing to expand the postacute care transfer policy to 19 additional DRGs. This proposed expansion would result in Medicare savings of \$160 million because we would no longer pay a full DRG payment for these cases. As a result, there would be a lower total increase in Medicare spending for FY 2004.

Fifth, section 402(b) of Pub. L. 108-7 provided that the large urban standardized amount of the Federal rate is applicable for all IPPS hospitals for discharges occurring on or after April 1, 2003, and before October 1, 2003. For discharges occurring on or after October 1, 2003, the Federal rate will again be based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas. The effect is to reduce the percent increase in FY 2004 payments compared to those made in FY 2003.

#### B. Analysis of Table I

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 4,087 hospitals included in the analysis. This number is 143 fewer hospitals than were included in the impact analysis in the FY 2003 final rule (67 FR 50279). There are 98 new CAHs that were excluded from last year's 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 2,582 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,493 hospitals located in large urban areas (populations over 1 million), and 1,089 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,505 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 2004 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 2,591, 1,572, 1,019, and 1,496, 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 2,976 nonteaching hospitals in our analysis, 873 teaching hospitals with fewer than 100 residents, and 238 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. Therefore, hospitals in the rural DSH categories represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (However, they may 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 (149), SCHs (494), MDHs (254), and hospitals that are both SCH and RRC (78) shown here were not reclassified for purposes of the standardized amount.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 2000 Medicare cost report files, if available (otherwise FY 1999 data are used). Data needed to determine ownership status were unavailable for 120 hospitals. Similarly, the data needed to determine Medicare utilization were unavailable for 104 hospitals.

The next series of groupings concern the geographic reclassification status of hospitals. The first grouping displays all hospitals that were reclassified by the MGCRB for FY 2004. The next two groupings separate the hospitals in the first group by urban and rural status. The final row in Table I contains hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act.

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM  
[Percent changes in payments per case]

|  | Number of hosps. <sup>1</sup> | Transfer changes 2004 base <sup>2</sup> | DRG changes <sup>3</sup> | New wage data <sup>4</sup> | New wage index without nonphys. part B <sup>5</sup> | DRG & wage index changes <sup>6</sup> | MGCRB reclassification <sup>7</sup> | ALL FY 2004 changes <sup>8</sup> |
|--|-------------------------------|---|--------------------------|----------------------------|---|---------------------------------------|-------------------------------------|----------------------------------|
|  | (1)                           | (2)                                     | (3)                      | (4)                        | (5)   | (6)                                   | (7)                                 | (8)                              |
| By Geographic Location:                              |                               |   |                          |                            |   |                                       |                                     |                                  |
| All hospitals .....                                  | 4,087                         | -0.2                                    | 0.0                      | -0.4                       | 0.1   | 0.0                                   | 0.0                                 | 2.5                              |
| Urban hospitals .....                                | 2,582                         | -0.2                                    | 0.0                      | -0.5                       | 0.1   | 0.0                                   | -0.4                                | 2.5                              |
| Large urban areas (populations over 1 million) ..... | 1,493                         | -0.2                                    | 0.0                      | -0.4                       | 0.0   | -0.1                                  | -0.4                                | 2.6                              |