

hospitals overall. We estimate the total savings at approximately \$160 million.

To simulate the impact of this proposed policy, we calculated hospitals' transfer-adjusted discharges and case-mix index values, including the proposed additional 19 DRGs. The transfer-adjusted discharge fraction is calculated in one of two ways, depending on the transfer payment methodology. Under our current transfer payment methodology, for all but the three DRGs receiving special payment consideration (DRGs 209, 210, and 211), this adjustment is made by adding 1 to the length of stay and dividing that amount by the geometric mean length of stay for the DRG (with the resulting fraction not to exceed 1.0). For example, a transfer after 3 days from a DRG with a geometric mean length of stay of 6 days would have a transfer-adjusted discharge fraction of 0.667 ((3+1)/6).

For transfers from any one of the three DRGs receiving the alternative payment methodology, the transfer-adjusted discharge fraction is 0.5 (to reflect that these cases receive half the full DRG amount the first day), plus one half of the result of dividing 1 plus the length of stay prior to transfer by the geometric mean length of stay for the DRG. None of the proposed 19 additional DRGs would receive the alternative payment methodology. As with the above adjustment, the result is equal to the lesser of the transfer-adjusted discharge fraction or 1.

The transfer-adjusted case-mix index values are calculated by summing the transfer-adjusted DRG weights and dividing by the transfer-adjusted discharges. The transfer-adjusted DRG weights are calculated by multiplying the DRG weight by the lesser of 1 or the transfer-adjusted discharge fraction for the case, divided by the geometric mean length of stay for the DRG. In this way, simulated payments per case can be compared before and after the proposed change to the transfer policy.

This proposed expansion of the policy has a negative 0.2 percent payment impact overall among both urban and rural hospitals. There is very small variation among all of the hospital categories from this negative 0.2 percent impact. This outcome is different than the impacts exhibited when we implemented the postacute care transfer policy for the current 10 DRGs in the July 31, 1998 **Federal Register** (63 FR 41108). At that time, the impact of going from no postacute transfer policy to a postacute care transfer policy applicable to 10 DRGs was a 0.6 percent decrease in payments per case. In addition, at that time, the impact was greatest among urban hospitals (0.7 percent payment decrease, compared to 0.4 percent among rural hospitals).

The less dramatic impact observed for this proposed expansion to additional DRGs is not surprising. The movement to transfer more and more patients for postacute care sooner appears to have abated in recent years. While it does appear that many patients continue to be transferred for postacute care early in the course of their acute care treatment, the rapid expansion of this trend that was apparent during the mid-90s appears to have subsided. To a large extent, this decline probably stems from the

decreased payment incentives to transfer patients to postacute care settings as a result of the implementation of prospective payment systems for IRFs, SNFs, LTCHs, and HHAs.

D. Impact of the Proposed Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 3)

In column 3 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II. of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us annually to make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 2003 DRG relative weights (GROUPE version 20.0) to aggregate payments using the proposed FY 2004 DRG relative weights (GROUPE version 21.0). Both simulations reflected the proposed expansion of the postacute care transfer policy. We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we have applied a budget neutrality factor to ensure that the overall payment impact of the DRG changes (combined with the wage index changes) is budget neutral. This proposed budget neutrality factor of 1.003133 is applied to payments in Column 6. Because this is a combined DRG reclassification and recalibration and wage index budget neutrality factor, it is not applied to payments in this column.

The major DRG classification changes we are proposing are: Creating additional DRGs that are split based on the presence or absence of CCs; creating a new DRG for cases with ruptured brain aneurysms; and creating a new DRG for cases involving the implantation of a cardiac defibrillator where the patient experiences acute myocardial infarction, heart failure, or shock. In the aggregate, these proposed changes would result in 0.0 percent change in overall payments to hospitals.

The overall level of the DRG weights are determined by the normalization factor intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS. Because we count transfer cases as a fraction of a case in the recalibration process, expanding the postacute care transfer policy to 19 additional DRGs would affect the proposed relative weights for those DRGs. Therefore, we calculated the proposed FY 2004 normalization factor comparing the case-mix using the proposed FY 2004 DRG relative weights in which we treated postacute care transfer cases in the 19 additional DRGs being proposed for FY 2004 as a fraction of a case with the case-mix using the FY 2003 DRG relative weights without treating cases in these 19 additional DRGs as transfer cases. As noted above, the proposed expansion of the postacute care transfer policy impacts the overall level of the DRG weights, contributing to the impacts seen in this column.

Rural hospitals with fewer than 50 beds would experience a 0.2 percent increase due to these changes, while rural hospitals with

more than 150 beds will experience a 0.1 percent decrease. Also, RRCs and hospitals classified with both SCH and RRC would experience a 0.1 percent decrease. MDHs would experience a 0.2 percent increase. Hospitals in the urban Mountain census division would experience the largest change, with a 0.2 percent decrease. Again, these impacts are ultimately offset by the budget neutrality factor of 1.003133.

E. Impact of Proposed Wage Index Changes (Columns 4 and 5)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for FY 2004 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000. As with column 3, the impact of the new data on hospital payments is isolated in column 4 by holding the other payment parameters constant in this simulation. That is, column 4 shows the percentage changes in payments when going from a model using the FY 2003 wage index (based on FY 1999 wage data to a model using the FY 2004 pre-reclassification wage index based on FY 2000 wage data).

The wage data collected on the FY 2000 cost reports are similar to the data used in the calculation of the FY 2003 wage index. Also, as described in section III.B of this preamble, the proposed FY 2004 wage index is calculated by removing the nonphysician Part B costs and hours of RHCs and FQHCs, shown in column 5.

Column 4 shows the impacts of updating the wage data using FY 2000 cost reports. Overall, the new wage data would lead to a 0.4 percent reduction, but this reduction is offset by the budget neutrality factor. Urban hospitals' wage indexes would decline by 0.5 percent, and rural hospitals' wage indexes would decline by 0.2 percent. Among regions, the largest impact of updating the wage data is seen in rural Puerto Rico (a 4.1 percent decrease). Rural hospitals in the Pacific and West South Central regions would experience the next largest impact, a 0.5 percent and 0.4 percent decrease, respectively. Rural New England and East North Central regions would experience an increase of 0.3 percent and 0.2 percent, respectively.

Among urban hospitals, New England and the Middle Atlantic regions would experience 1.0 percent decreases, respectively. These impacts result, respectively, from a 9.0 percent decrease in the proposed FY 2004 wage index for Springfield, Massachusetts, and a 6.1 percent decrease in the Pittsburgh, Pennsylvania wage index. The East South Central, West North Central, and Mountain regions would experience increases of 0.3 percent, 0.1 percent, and 0.5 percent, respectively.

The next column shows the impacts on the calculation of the proposed FY 2004 wage index of removing nonphysician Part B data for RHCs and FQHCs. Column 5 shows the impacts of removing nonphysician Part B costs for RHCs and FQHCs. The effects of this proposed change are relatively small with the