

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM—
Continued
[Payments per case]

| | Number of hospitals | Average FY 2003 payment per case ¹ | Average FY 2004 payment per case ¹ | All FY 2004 changes |
|--|------------------------|---|---|------------------------|
| | (1) | (2) | (3) | (4) |
| Wage Index Only | 41 | 6,934 | 7,200 | 3.8 |
| Both | 2,415 | 7,853 | 8,045 | 2.4 |
| All Reclassified Rural Hospitals | 503 | 6,006 | 6,199 | 3.2 |
| Standardized Amount Only | 15 | 4,743 | 4,843 | 2.1 |
| Wage Index Only | 464 | 6,014 | 6,205 | 3.2 |
| Both | 24 | 6,242 | 6,482 | 3.8 |
| Rural Nonreclassified Hospitals | 999 | 4,624 | 4,756 | 2.8 |
| Other Reclassified Hospitals (Section 1886(d)(8)(B)) | 34 | 4,950 | 5,039 | 1.8 |

¹ These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact of the proposed changes for FY 2004 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2003 with the average estimated per case payments for FY 2004, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 8 of Table I.

VII. Impact of Other Policy Changes

In addition to those proposed changes discussed above that we are able to model using our IPPS payment simulation model, we are proposing various other changes in this proposed rule. Generally, we have limited or no specific data available with which to estimate the impacts of these proposed changes. Our estimates of the likely impacts associated with these other proposed changes are discussed below.

A. Changes to Bed and Patient Day Counting Policies

1. Background

Under IPPS, both the IME and the DSH adjustments utilize statistics regarding the number of beds and patient days of a hospital to determine the level of the respective payment adjustment. For IME, hospitals receiving this adjustment want to minimize their numbers of beds in order to maximize their resident-to-bed ratio. For DSH, urban hospitals with 100 or more beds qualify for a higher payment adjustment, so some hospitals have an incentive to maximize their bed count to qualify for higher payments. Existing regulations specify that the number of beds is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period.

2. Unoccupied Beds

Over the years, questions have arisen as to whether beds in rooms or entire units that are unoccupied for extended periods of time should continue to be counted on the basis

that, if there would ever be a need, they could be put into use. In section IV.C. of the preamble of this proposed rule, we are proposing to base the determination of whether a bed is available upon whether the unit where the bed is located is staffed for patient care. If the bed is located in a unit that was staffed by nurses to provide patient care at any time during the 3 preceding months, all of the beds in the unit would be counted for purposes of determining available bed days during the current month. If no patient care were provided in that unit during the 3 preceding months, the beds in the unit would be excluded from the determination of available bed days during the current month.

This proposal is primarily intended to establish clear and consistent guidelines for hospitals and fiscal intermediaries to use when determining whether beds should be counted. We do not anticipate this proposal would have a significant impact on payments. In some cases, previously uncounted beds would now be counted, such as when a hospital is undertaking to remodel a unit and that unit is temporarily unavailable for patient occupancy. Under the proposed policy, if the remodeling is completed in less than 3 months and patients are again being treated in the unit, all of the beds in the unit would be counted as available for the entire year.

3. Nonacute Care Beds and Days

The proposed rule would clarify that days attributable to a nonacute care unit or ward, regardless of whether the unit or ward is separately certified by Medicare or is adjacent to a unit or ward used to provide an acute level of care, would not be included in the count of bed or patient days. In a recent decision by the Ninth Circuit Court of Appeals (*Alhambra Hosp. v. Thompson*, 259 F.3d 1017 (9th Cir. 2001)), the court found that our policy for counting patient days did not preclude a hospital from counting the patient days attributable to a nonacute care unit adjacent to an area of the hospital subject to the IPPS. Under this ruling, hospitals within the jurisdiction of the Ninth Circuit would be able to count those patient days.

Because the *Alhambra* decision was based on a regulatory interpretation, this proposed

rule, when finalized, would supersede the *Alhambra* decision in the Ninth Circuit. We estimate that if all hospitals in the Ninth Circuit that could take advantage of this ruling were currently doing so, the impact of this provision of the proposed rule would be \$184 million in reduced Medicare program payments to the affected hospitals in FY 2004 for DSH. This estimate reflects the impact of adding all days of non-Medicare certified nursing facilities to the count of inpatient days for hospitals in the nine States under the jurisdiction of the Ninth Circuit. For example, in Alaska, nursing facility days constitute 11 percent of total Medicaid inpatient days. If all of these nursing facility days are currently included in the Medicaid inpatient days count, we estimate this proposed provision would reduce Medicare DSH payments to Alaska's hospitals by \$662,097.

We are unable to estimate the effect of this proposed provision on specific hospitals because we are not aware of specific hospitals that are presently including those inpatient days in their calculation of Medicaid days for purposes of determining their Medicare DSH percentage. However, we expect the impact on any particular hospital would be minimal (with no impact on the level of beneficiary services), because the days attributable to patients receiving these limited benefit programs should be only a small portion of the overall Medicaid days at any particular hospital. No other provider types would be affected. However, because our policy is to count patient days and beds consistently, inclusion of the days of postacute care units in the DSH calculation would lead to an offsetting negative payment impact for teaching hospitals. The inclusion of additional beds decreases the resident-to-bed ratios used to calculate the IME adjustments. Therefore, the actual potential impact on hospitals of this policy clarification is likely to be significantly less than \$184 million.

4. Observation and Swing-Beds

We are proposing to revise our regulations to clarify that swing-bed and observation bed days are to be excluded from the count of bed and patient days. Because this certification reflects our current policy, despite the fact