

individual hospitals, some miscategorizations are possible.

Using cases from the December 2002 update of the FY 2002 MedPAR file, we simulated payments under the capital prospective payment system for FY 2003 and FY 2004 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general hospital inpatient prospective payment systems (Indian Health Service Hospitals and hospitals in Maryland) are excluded from the simulations.

As we explain in section III.A.4. of the Addendum of this proposed rule, payments will no longer be made under the regular exceptions provision under §§ 412.348(b) through (e). Therefore, we are no longer using the actuarial capital cost model (described in Appendix B of August 1, 2001 final rule (66 FR 40099)). We modeled payments for each hospital by multiplying the Federal rate by the GAF and the hospital's case-mix. We then added estimated payments for indirect medical education, disproportionate share, large urban add-on, and outliers, if applicable. For purposes of this impact analysis, the model includes the following assumptions:

- We estimate that the Medicare case-mix index would increase by 1.01505 percent in FY 2003 and would increase by 1.02010 percent in FY 2004.

- We estimate that the Medicare discharges will be 14,288,000 in FY 2003 and 14,507,000 in FY 2004 for a 1.5 percent increase from FY 2003 to FY 2004.

- The Federal capital rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The proposed FY 2004 update is 0.7 percent (see section III.A.1.a. of the Addendum to this proposed rule).

- In addition to the proposed FY 2004 update factor, the proposed FY 2004 Federal rate was calculated based on a GAF/DRG budget neutrality factor of 1.0038, an outlier adjustment factor of 0.9455, and a (special) exceptions adjustment factor of 0.9995.

2. Results

In the past, in this impact section we presented the redistributive effects that were expected to occur between "hold-harmless"

hospitals and "fully prospective" hospitals and a cross-sectional summary of hospital groupings by the capital prospective payment system transition period payment methodology. We are no longer including this information since all hospitals (except new hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid 100 percent of the Federal rate in FY 2004.

We used the actuarial model described above to estimate the potential impact of our proposed changes for FY 2004 on total capital payments per case, using a universe of 3,922 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the December 2002 update of the FY 2002 MedPAR file, the December 2002 update to the Provider-Specific File, and the most recent cost report data from the December 2002 update of HCRIS. In Table III, we present a comparison of total payments per case for FY 2003 compared to FY 2004 based on the proposed FY 2004 payment policies. Column 2 shows estimates of payments per case under our model for FY 2003. Column 3 shows estimates of payments per case under our model for FY 2004. Column 4 shows the total percentage change in payments from FY 2003 to FY 2004. The change represented in Column 4 includes the 0.7 percent update to the Federal rate, a 1.02010 percent increase in case-mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB, as well as changes in special exception payments. The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 1.0 percent in FY 2004. Our comparison by geographic location shows an overall increase in payments to hospitals in all areas. This comparison also shows that urban and rural hospitals will experience different rates of increase in capital payments per case (0.9 percent and 1.5 percent, respectively). This difference is due to a projection that rural hospitals will experience a larger increase in the GAF due to reclassifications from rural to urban and a slightly larger increase in DSH and IME payments from FY 2003 to FY 2004 compared to urban hospitals.

All regions are estimated to receive an increase in total capital payments per case. Changes by region vary from a minimum increase of 0.4 percent (Middle Atlantic urban region) to a maximum increase of 2.1 percent (New England rural region). Hospitals located in Puerto Rico are expected to experience an increase in total capital payments per case of 1.3 percent.

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (1.2 percent). Similarly, payments to voluntary hospitals will increase 1.0 percent, while payments to proprietary hospitals will increase 0.9 percent.

Section 1886(d)(10) of the Act established the MGCRB. Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both. Although the Federal capital rate is not affected, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. Reclassification for wage index purposes also affects the geographic adjustment factor, since that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2004 compared to the effects of reclassification for FY 2003, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 2004 as a whole are projected to experience a 1.7 percent increase in payments. Payments to nonreclassified hospitals would increase almost half as much (0.9 percent) as reclassified hospitals, overall. Hospitals reclassified during both FY 2003 and FY 2004 are projected to receive an increase in payments of 1.4 percent. Hospitals reclassified during FY 2004 only are projected to receive an increase in payments of 4.9 percent. This increase is primarily due to changes in the GAF (wage index).

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE
[FY 2003 payments compared to proposed FY 2004 payments]

	Number of hospitals	Average FY 2003 payments/case	Average FY 2004 payments/case	Change
By Geographic Location:				
All hospitals	3,922	706	713	1.0
Large urban areas (populations over 1 million)	1,420	808	815	0.9
Other urban areas (populations of 1 million or fewer)	1,041	693	700	1.0
Rural areas	1,461	476	483	1.5
Urban hospitals	2,461	758	765	0.9
0–99 beds	549	529	535	1.0
100–199 beds	884	643	649	1.0
200–299 beds	501	728	735	0.9
300–499 beds	373	809	817	1.1
500 or more beds	154	959	967	0.8
Rural hospitals	1,461	476	483	1.5