

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 Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this final 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 1.8 percent increase), we estimate the total impact of these changes for FY 2004 payments compared to FY 2003 payments to be approximately a \$1.8 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 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 making in this final rule. However, there are other changes we have made, but for which we do not have data available that would allow us to estimate the payment impacts using this model. For those changes, we have attempted to predict the payment impacts of those 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 final 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 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 final FY 2004 changes to the capital IPPS are discussed in section VIII of this Appendix.

The final changes discussed separately below are the following:

- The effects of expanding the postacute care transfer policy to 21 additional DRGs.
- The effects of the 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 final 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 effects on FY 2004 outlier payments of the policy changes implemented in the June 9, 2003 final rule on high-cost outlier payments.
- The total change in payments based on final FY 2004 policies relative to payments based on FY 2003 policies.

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

Our final comparison illustrates the percent change in payments per case from FY 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 have updated 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 3.4 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 3.4 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 6.5 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 final 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 have expanded the postacute care transfer policy to 21 additional DRGs and dropped 2 DRGs from the original policy. This makes a total of 29 DRGs that will be subject to the postacute care transfer policy. This expansion is estimated to result in Medicare savings of \$205 million because we will no longer pay a full DRG payment for these cases. As a result, there will 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 4,049 hospitals included in the analysis. This number is 181 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 2,564 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,488 hospitals located in large urban areas (populations over 1 million), and 1,076 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,485 hospitals in rural areas. The next two groupings are by bed-size categories, shown