

policy where the cost-to-charge ratio is based on the latest tentatively settled cost report, there is no minimum ratio, and outlier payments may be subject to reconciliation when the cost report is settled. As a result of these changes, the outlier threshold falls from \$50,200 (this represents what the FY 2004 threshold would be absent the policy changes to \$31,000).

The top row in this column indicates these changes have no impact on overall spending. However, the changes among specific categories of hospitals are quite dramatic. Hospital categories negatively impacted in this column are those groups expected to have dramatic reduction in their cost-to-charge ratios as a result of the new policies. On the other hand, hospitals that are not expected to experience dramatic changes in their cost-to-charge ratios benefit from the decline in the threshold.

Rural hospitals overall experience a 0.7 percent increase in their outlier payments as a result of this change. On the other hand, urban hospitals in the Middle Atlantic census division experience a 3.1 percent decrease. The largest negative impacts are among proprietary hospitals, with a 3.7 percent decrease and among urban hospitals that reclassified for the purposes of wage index only, with a decrease of 5.4 percent.

D. Impact of the Changes to the Postacute Care Transfer Policy (Column 3)

In column 3 of Table I, we present the effects of the postacute care transfer policy expansion, as discussed in section IV.A. of the preamble to this final rule. We compared aggregate payments using the FY 2003 DRG relative weights (GROUPE version 21.0) with the expanded postacute care transfer policy to aggregate payments using the expanded postacute care transfer policy (with the additional 21 DRGs). The changes we are making are estimated to result in 0.2 percent lower payments to hospitals overall. We estimate the total savings at approximately \$205 million.

To simulate the impact of this final policy, we calculated hospitals' transfer-adjusted discharges and case-mix index values, including the additional 21 DRGs, minus 2 of the current 10 DRGs. The transfer-adjusted discharge fraction is calculated in one of two ways, depending on the transfer payment methodology. Under our previous 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 21 additional DRGs qualify

to 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 change to the transfer policy.

This 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 original 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 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-1990s 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.

E. Impact of Wage Index Changes (Columns 4, 5, and 6)

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 final 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. 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 the preamble of this final rule, the final FY 2004

wage index is calculated by removing CAHs, shown in column 5, and the removal of nonphysician Part B costs and hours of RHCs and FQHCs, shown in column 6.

Column 4 shows the impacts of updating the wage data using FY 2000 cost reports. Overall, the new wage data would lead to a 0.3 percent reduction, but this reduction is offset by the budget neutrality factor. Urban hospitals' wage indexes would decline by 0.3 percent, and rural hospitals' wage indexes would decline by 0.3 percent. Among regions, the largest impact of updating the wage data is seen in rural Puerto Rico (a 4.2 percent decrease). Rural hospitals in the West South Central and Pacific regions would experience the next largest impact, with a 0.6 percent decrease for each. The rural East North Central region would experience an increase of 0.1.

The national average hourly wage increased 6.79 percent compared to last year. Therefore, the only manner in which to maintain or exceed the previous year's wage index was to match the national 6.79 increase in average hourly wage. Of the 4,018 hospitals with wage index values in both FYs 2003 and 2004, 1,753, or 43.6 percent, also experienced an average hourly wage increase of 6.79 percent or more.

In order to confirm the -0.3 percent, we compared FY 2003 prereclassified wage indexes to those of FY 2004, which yielded a percent change of -0.62 percent per MSA. We weighted this value based on the frequency of hospitals in each MSA, which produced an overall reduction of 0.4 percent. When we multiplied this value by the 71.1 percent labor share representing the proportion of IPPS payments affected by the wage index, we found that the overall wage index values dropped 0.29 percent, essentially equaling the overall change in column 4.

Among urban hospitals, the Middle Atlantic and East North Central regions would experience 0.9 and 0.6 percent decreases, respectively. These impacts result, respectively from a 4.9 percent fall in the FY 2004 final wage index for Pittsburgh, Pennsylvania, and a 5.7 percent decrease in Janesville-Beloit, Wisconsin, as well as a 5.4 percent decrease in the Muncie and Lafayette, Indiana wage indexes. The Mountain and East South Central regions would experience increases of 0.5 percent and 0.1 percent, respectively.

The next column (5) shows the impacts on the calculation of the FY 2004 wage index of removing CAHs. The effects of this change are relatively small with the exception of urban New England, which would experience a 0.6 percent decrease, due primarily to the Pittsfield, Springfield, and rural Massachusetts wage indexes, each falling 7.5 percent. The rural West North Central region would experience an increase of 0.6 percent.

Column 6 shows the impacts of removing nonphysician Part B costs for RHCs and FQHCs. The effects of this change are relatively small.

The following chart compares the shifts in wage index values for labor market areas for FY 2004 relative to FY 2003. This chart demonstrates the impact of the changes for