

reclassification decisions for FY 2004. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, we applied an adjustment of 0.992026 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this final rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments would rise 2.2 percent in column 9. Payments to urban hospitals would decline 0.3 percent. Hospitals in other urban areas would experience an overall decrease in payments of 0.3 percent, while large urban hospitals would lose 0.4 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally would decline.

A positive impact is evident among most of the rural hospital groups. The smallest increases among the rural census divisions are 0.4 for Puerto Rico and 1.3 percent for the West North Central region. The largest increases are in the rural Middle Atlantic, New England, and East South Central with increases of 2.6 percent and in the West South Central region which would experience an increase of 3.6 percent.

Among all the hospitals that were reclassified for FY 2004 (including hospitals that received wage index reclassifications in FY 2002 or FY 2003 that extend for 3 years), the MGCRB changes are estimated to provide a 4.3 percent increase in payments. Urban hospitals reclassified for FY 2004 are expected to receive an increase of 4.6 percent, while rural reclassified hospitals are expected to benefit from the MGCRB changes with a 4.0 percent increase in payments. Overall, among hospitals that were reclassified for purposes of the standardized amount only, a payment increase of 3.4 percent is expected, while those reclassified for purposes of the wage index only show a 4.2 percent increase in payments. Payments to urban and rural hospitals that did not reclassify are expected to decrease slightly due to the MGCRB changes, decreasing by 0.6 percent for urban hospitals and 0.4 percent for rural hospitals.

I. All Changes (Columns 10 and 11)

Column 10 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2004 (including statutory changes), to our estimate of payments per case in FY 2003. This column includes all of the final policy changes. Because the reclassifications shown in column 9 do not reflect FY 2003 reclassifications, the impacts of FY 2004 reclassifications only affect the impacts from FY 2003 to FY 2004 if the reclassification impacts for any group of hospitals are different in FY 2004 compared to FY 2003.

Column 10 includes the effects of the 3.4 percent update to the standardized amounts

and the hospital-specific rates for MDHs and SCHs. It also reflects the 1.4 percentage point difference between the projected outlier payments in FY 2003 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2003 (6.5 percent), as described in the introduction to this Appendix and the Addendum to this final rule. As a result, payments are projected to be 1.4 percent higher in FY 2003 than originally estimated, resulting in a 1.4 percent smaller increase than would otherwise occur. (Column 11, as discussed below, displays the changes from FY 2003 to 2004 after adjusting for the higher than expected FY 2003 outlier payments.)

Section 213 of Pub. L. 106-554 provides that all SCHs may receive payment on the basis of their costs per case during their cost reporting period that began during 1996. For FY 2004, eligible SCHs receive 100 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 10 as well.

The expansion of the postacute care transfer policy also reduces payments by paying for discharges to postacute care in 21 additional DRGs as transfers and dropping 2 DRGs from the original list of affected DRGs. Because FY 2003 payments reflect full DRG payments for all cases in these 29 DRGs, there is a negative impact due to the expansion of this policy compared to FY 2003. The net effect of this expanded policy, as displayed in column 3, is also seen in the lower overall percent change shown in column 10 comparing FY 2004 simulated payments per case to FY 2003 payments.

Another influence on the overall change reflected in this column is the requirement of section 402(b) of Pub. L. 108-7 that all hospitals receive the large urban standardized amount for all 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 calculated 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 reflected in the "all changes" column.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 10 may not equal the sum of the changes described above.

The overall change in payments per case for hospitals in FY 2004 would increase by 1.8 percent. Hospitals in urban areas would experience a 1.2 percent increase in payments per case compared to FY 2003. Hospitals in rural areas, meanwhile, would experience a 5.8 percent payment increase. Hospitals in large urban areas would experience a 1.1 percent increase in payments.

Among urban census divisions, the largest payment increase was 4.4 percent in the Mountain region. Hospitals in the urban East South Central region and in Puerto Rico

would experience an overall increase of 2.9 percent and 2.8 percent, respectively. The smallest increase would occur in the West South Central region, with an increase of 1.6 percent. These below average increases are primarily due to the inflated outlier payments for some of these hospitals during FY 2003 compared to FY 2004.

The effect of outlier payments is illustrated in column 11, which sets each hospital's outlier percentage equal to their projected percentage for FY 2004. In this way, we are able to model FY 2003 payments as if outlier payments were on a par with projected FY 2004 outlier payments. The results illustrate the dampening effect the high FY 2003 outliers have on column 10. After removing this effect, the impact for all hospitals in FY 2004 is a 3.2 percent increase, equal to the 3.4 percent update minus 0.2 percent for the impact of the expanded postacute transfer policy. For the most part (except for the 0.5 percent decrease in the rural Puerto Rico category), this reverses any negative overall impacts observed in column 10.

Among rural regions in column 10, the only hospital category that would experience overall payment decreases is Puerto Rico, where payments would decrease by 0.3 percent, largely due to the updated wage data. The West North Central and Pacific regions would benefit the most, with 7.9 and 8.7 percent increases, respectively.

Among special categories of rural hospitals in column 10, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) would experience payment increases of 10.8 percent, 3.3 percent, and 7.4 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there are no outlier payments. Therefore, these hospitals would not experience negative payment impacts from the decline in outlier payments from FY 2003 to FY 2004 as would hospitals paid based on the national standardized amounts. The 10.8 percent increase for SCHs is due to the increase in percentage of the 1996 hospital-specific rate percentage from 75 percent in FY 2003 to 100 percent in FY 2004.

Hospitals that were reclassified for FY 2004 are estimated to receive a 2.6 percent increase in payments. Urban hospitals reclassified for FY 2004 are anticipated to receive a decrease of 1.8 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 5.5 percent increase in payments. Overall, among hospitals reclassified for purposes of the standardized amount, a payment increase of 5.4 percent is expected, while those hospitals reclassified for purposes of the wage index only would show an expected 1.9 percent increase in payments. Those hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive an increase in payments of 3.0 percent.