

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM (PAYMENTS PER CASE)—Continued

	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)
Medicare-dependent hospitals (MDH)	250	4,162	4,301	3.3
SCH and RRC	75	6,805	7,312	7.4
Type of Ownership:				
Voluntary	2,411	7,617	7,784	2.2
Proprietary	698	7,189	7,035	-2.1
Government	818	7,264	7,557	4.0
Unknown	122	7,528	7,794	3.5
Medicare Utilization as a Percent of Inpatient Days:				
0-25	303	10,131	10,383	2.5
25-50	1,533	8,568	8,669	1.2
50-65	1,651	6,505	6,686	2.8
Over 65	456	5,824	5,891	1.1
Unknown	106	6,766	6,884	1.7
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2004 Reclassifications:				
All Reclassified Hospitals	616	6,892	7,071	2.6
Standardized Amount Only	22	5,672	5,980	5.4
Wage Index Only	554	6,952	7,082	1.9
Both	33	6,146	6,398	4.1
All Nonreclassified Hospitals	3,407	7,639	7,777	1.8
All Urban Reclassified Hospitals	125	8,779	8,619	-1.8
Urban Nonreclassified Hospitals	15	6,352	6,646	4.6
Standardized Amount Only	71	9,881	9,471	-4.1
Wage Index Only	39	7,018	7,304	4.1
Both	2,408	7,946	8,059	1.4
All Reclassified Rural Hospitals	491	6,040	6,372	5.5
Standardized Amount Only	27	6,218	6,363	2.3
Wage Index Only	451	6,047	6,393	5.7
Both	13	5,345	5,632	5.4
Rural Nonreclassified Hospitals	992	4,863	5,166	6.2
Other Reclassified Hospitals (Section 1886(d)(8)(B))	33	5,087	5,241	3.0

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

Table II presents the projected impact of the final 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 10 of Table I.

VII. Impact of Other Policy Changes

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

The rule clarifies 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 final rule 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 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 provision would reduce Medicare DSH payments to Alaska's hospitals by \$662,097.

We are unable to estimate the effect of this 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