

As we explain in section III.A.4. of the Addendum of this final 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 capital 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 1.01 percent in both FY 2003 and FY 2004.

- We estimate that the Medicare discharges will be 14.3 million in FY 2003 and 14.5 million in FY 2004 for a 1.5 percent increase from FY 2003 to FY 2004.

- The capital Federal 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 FY 2004 update is 0.7 percent (see section III.A.1.a. of the Addendum to this final rule).

- In addition to the FY 2004 update factor, the FY 2004 capital Federal rate was calculated based on a GAF/DRG budget neutrality factor of 1.0059, an outlier adjustment factor of 0.9522, 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 capital Federal rate in FY 2004.

We used the actuarial model described above to estimate the potential impact of our changes for FY 2004 on total capital payments per case, using a universe of 3,929

hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the March 2003 update of the FY 2002 MedPAR file, the March 2003 update to the Provider-Specific File, and the most recent cost report data from the March 2003 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 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 capital Federal rate, a 1.01 percent increase in case-mix, changes in the adjustments to the capital 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 decrease slightly – 0.2 percent) in FY 2004. This projected decrease in capital payments per case is mostly due to the estimated decrease in outlier payments in FY 2004 as a result of the changes to the outlier policy established in the June 9, 2003 high-cost outlier final rule (68 FR 34494). Our comparison by geographic location shows that urban hospitals are expected to experience a slight decrease in capital payments per case (– 0.6 percent), while rural hospitals are expected to experience an increase in capital payments per case (2.5 percent). This difference is mostly due to a projection that urban hospitals will experience a larger decrease in outlier payments from FY 2003 to FY 2004 due to the changes in the outlier policy established in the June 9, 2003 high-cost outlier final rule compared to rural hospitals.

Most regions are estimated to receive an increase in total capital payments per case. Changes by region vary from a maximum decrease of 4.1 percent (Middle Atlantic urban region) to a maximum increase of 3.3 percent (West North Central rural region). Hospitals located in Puerto Rico are expected

to experience an increase in total capital payments per case of 0.4 percent.

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (2.0 percent). Similarly, payments to voluntary hospitals are expected to increase 0.7 percent, while payments to proprietary hospitals are expected to decrease 6.9 percent. As noted above, this projected decrease in capital payments per case for proprietary hospitals is mostly due to the estimated decrease in outlier payments in FY 2004 as a result of the changes to the outlier policy established in the June 9, 2003 high-cost outlier final rule.

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 capital Federal 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 0.3 percent increase in payments. Payments to nonreclassified hospitals in FY 2004 are expected to decrease 0.3 percent. Hospitals reclassified during both FY 2003 and FY 2004 are projected to experience a slight decrease in payments of 0.2 percent. Hospitals reclassified during FY 2004 only are projected to receive an increase in payments of 5.7 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 FY 2004 PAYMENTS)

	Number of hospitals	Average FY 2003 payments/case	Average FY 2004 payments/case	Change
By Geographic Location:				
All hospitals .....	3,929	715	714	–0.2
Large urban areas (populations over 1 million) .....	1,436	820	813	–0.8
Other urban areas (populations of 1 million or fewer) .....	1,035	703	701	–0.3
Rural areas .....	1,458	479	491	2.5
Urban hospitals .....	2,471	770	765	–0.6
0–99 beds .....	549	545	545	–0.1
100–199 beds .....	895	647	646	–0.1
200–299 beds .....	503	738	734	–0.6
300–499 beds .....	369	823	814	–1.0
500 or more beds .....	155	980	976	–0.5
Rural hospitals .....	1,458	479	491	2.5
0–49 beds .....	650	391	402	2.9
50–99 beds .....	468	442	453	2.5