TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 12/97 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
294	82039	4.9200	1	2	4	6	9
295	3593	3.9585	1	2	3	5	7
296	235524	5.3934	2	3	4	7	10
297	32715	3.6521	1	2	3	4	7
298	91	3.7253	1	1	2	4	8
299	968	5.3657	1	2	4	7	10
300	16820	6.2855	2	3	5	8	12
301	2395	3.8113	1	2	3	5	7
302	7784	10.1382	5	6	8	12	18
303	19638	9.2247	4	5	7	10	16
304	12813	8.9904	2	4	7	11	18
305	2552	3.8985	1	2	3	5	7
306	10658	5.5019	1	2	3	7	12
307	2355	2.3996	1	1	2	3	4
308	9167	6.0165	1	2	4	8	13
309	3541	2.5945	1	1	2	3	5
310	26694	4.2835	1	2	3	5	9
311	7805	1.9543	1	1	1	2	4
312	1731	4.3437	1	1	3	6	9
313	587	2.3799	1	1	2	3	5
314	1	10.0000	10	10	10	10	10
315	28283	8.0413	1	2	5	10	18
316	93071	6.8024	2	3	5	9	14
317	787	2.8666	1	1	2	3	6
318	6194	6.1022	1	3	5	8	12
319	407	2.9902	1	1	2	4	6
320	177474	5.5698	2	3	4	7	10
321	23679	4.0416	2	2	3	5	7
322	82	4.1098	2	2	3	4	7
323	16931	3.2166	1	1	2	4	6
324	7513	1.9385	1	1	1	2	4
325	7409	3.9591	1	2	3	5	8
326	2192	2.7199	1	1	2	3	5
327	9	2.8889	1	1	2	3	4
328	759	3.7167	1	2	3	5	7
329	87	2.2644	1	1	1	3	4
331	43598	5.5769	1	3	4	7	11
332	4517	3.5603	1	1	3	5	7
333	306	4.9477	1	2	4	6	11
334	18572	4.9690	3	3	4	6	8
335	10338	3.7163	2	3	3	4	5
336	54082	3.6046	1	2	3	4	7
337	31770	2.2858	1	1	2	3	4
338	2767	4.7879	1	2	3	6	10
339	1987	4.1726	1	1	3	5	9
340	2	1.0000	1	1	1	1	1
341	4909	2.9589	1	1	2	3	6
342	1007	3.4518	1	2	2	4	7
344	3882	2.6285	1	1	1	3	5
345	1343	3.6389	1	1	2	4	8
346	4844	5.8179	1	3	4	7	11
347	365	3.1370	1	1	2	4	6
348	3181	4.2521	1	2	3	5	8
349	632	2.7658	1	1	2	4	5
350	6114	4.3999	2	2	4	5	8
352	638	3.6160	1	2	3	4	7
353	2816	6.9457	3	4	5	8	12
354	9926	5.7743	3	3	4	6	10
355	5640	3.4624	2	3	3	4	5
356	28862	2.6478	1	2	2	3	4
357	6330	9.0289	3	5	7	11	17
358	27373	4.3708	2	3	3	5	7
359	27990	2.9775	2	2	3	3	4
360	17843	3.1581	1	2	3	4	5
361	540	3.3259	1	1	2	3	7
363	3943	3.3109	1	2	2	3	6
364	1828	3.5656	1	1	2	5	8
365	2298	6.8903	1	2	5	9	14
366	4368	6.8116	1	3	5	8	14
367	506	2.8893	1	1	2	3	6

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 12/97 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
368	2895	6.3530	2	3	5	8	12
369	2588	3.0622	1	1	2	4	6
370	1154	5.4610	2	3	4	5	9
371	1157	3.4754	2	3	3	4	5
372	975	3.1549	1	2	2	3	5
373	3868	2.1171	1	1	2	2	3
374	147	3.0340	1	2	2	3	3
375	9	5.1111	2	2	3	9	10
376	214	2.9252	1	2	2	3	6
377	52	4.4808	1	2	3	6	9
378	168	2.5952	1	1	2	3	4
379	334	3.5868	1	1	2	3	7
380	87	2.0345	1	1	2	2	3
381	187	2.1283	1	1	1	2	4
382	40	1.2750	1	1	1	1	2
383	1460	3.7301	1	2	3	4	8
384	123	2.6585	1	1	2	3	6
385	1	2.0000	2	2	2	2	2
389	9	8.6667	1	3	7	10	15
390	13	6.0000	2	2	4	5	17
392	2513	10.3828	4	5	7	12	21
394	1805	7.0853	1	2	4	8	16
395	70948	4.7241	1	2	3	6	9
396	15	18.4667	1	2	5	11	15
397	18814	5.5200	1	2	4	7	11
398	18127	6.0414	2	3	5	7	11
399	1322	3.7239	1	2	3	5	7
400	7225	9.3664	2	3	6	12	20
401	6653	11.0137	2	4	8	14	23
402	1464	3.8907	1	1	3	5	9
403	38919	8.1409	2	3	6	10	17
404	3797	4.4464	1	2	3	6	9
406	3308	9.5299	2	4	7	12	20
407	634	4.3202	1	2	4	5	8
408	2667	7.5047	1	2	5	9	16
409	4644	5.8404	2	3	4	6	11
410	59252	3.4182	1	2	3	4	6
411	18	2.8889	1	1	2	2	6
412	24	2.3333	1	1	2	3	4
413	7781	7.4429	2	3	6	9	15
414	676	4.2219	1	2	3	5	8
415	45158	14.3432	4	7	11	18	28
416	230365	7.3967	2	4	6	9	14
417	41	5.9024	2	2	5	7	11
418	21184	6.1906	2	3	5	8	11
419	15269	5.0200	2	3	4	6	9
420	2680	3.9474	1	2	3	5	7
421	12113	3.9569	1	2	3	5	7
422	86	3.3372	1	2	2	5	7
423	10723	7.7520	2	3	6	9	15
424	1621	14.2961	2	5	10	18	29
425	15405	4.1352	1	2	3	5	8
426	4449	4.9020	1	2	3	6	10
427	1633	4.8010	1	2	3	6	10
428	940	7.1755	1	2	4	8	14
429	32769	7.1661	2	3	5	8	14
430	56829	8.7198	2	4	7	11	17
431	217	7.3088	1	3	5	9	13
432	409	5.2152	1	2	3	6	12
433	6811	3.2053	1	1	2	4	7
434	21537	5.1804	2	3	4	6	9
435	14552	4.4078	1	2	4	5	8
436	3322	13.9618	4	7	13	21	28
437	12779	9.2061	3	5	8	12	16
439	1138	7.7065	1	3	5	9	16
440	5155	8.9081	2	3	6	10	19
441	570	3.4333	1	1	2	4	7
442	16247	8.1177	1	3	6	10	17
443	3153	3.3321	1	1	2	4	7
444	3425	4.5007	1	2	3	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM; SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY97 MEDPAR Update 12/97 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
445	1243	3.3628	1	2	3	4	6
446	1	2.0000	2	2	2	2	2
447	4257	2.5130	1	1	2	3	5
449	27905	3.7822	1	1	3	5	8
450	6171	2.0826	1	1	1	2	4
451	9	2.7778	1	1	1	4	5
452	22863	5.0341	1	2	4	6	10
453	3796	2.9236	1	1	2	4	6
454	3855	4.6905	1	2	3	6	9
455	758	2.7401	1	1	2	3	5
461	3047	4.4322	1	1	2	4	11
462	10348	12.4504	4	6	10	16	23
463	13983	4.4209	1	2	3	5	8
464	3556	3.3751	1	2	3	4	6
465	210	2.9095	1	1	1	3	5
466	1748	4.0955	1	1	2	4	9
467	1332	4.3949	1	1	2	4	7
468	61704	13.4718	3	6	10	17	27
471	12918	6.0694	3	4	5	7	10
473	8429	12.7713	2	3	7	18	33
475	109339	11.1900	2	5	9	15	22
476	5924	11.9158	3	6	10	15	22
477	28747	8.1623	1	3	6	11	17
478	123286	7.4571	1	3	5	9	15
479	18337	3.8430	1	2	3	5	7
480	400	26.7550	8	11	20	32	53
481	256	27.1133	16	20	24	32	43
482	6596	12.7329	4	7	10	15	23
483	41763	40.0560	14	21	33	50	73
484	391	14.6931	2	6	11	18	27
485	3471	9.5906	4	5	7	11	18
486	2244	12.3382	1	5	10	16	25
487	4210	7.3983	2	3	6	9	14
488	865	17.0532	4	7	12	22	35
489	14894	8.9049	2	4	6	11	19
490	4863	5.4148	1	2	4	7	11
491	11011	3.6593	2	2	3	4	6
492	2334	17.1418	4	5	12	27	36
493	56210	5.6284	1	2	5	7	11
494	25155	2.4285	1	1	2	3	5
495	125	16.9920	7	10	13	19	31
496	895	10.5821	4	6	8	13	20
497	21969	6.2886	2	3	5	7	11
498	12500	3.5058	1	2	3	5	6
499	36205	4.9604	2	2	4	6	9
500	36448	2.8726	1	2	2	4	5
501	1895	10.4391	4	6	8	12	19
502	468	6.5876	3	4	6	8	10
503	6317	4.2169	1	2	3	5	8
504	157	31.5669	8	14	25	39	57
505	171	5.8421	1	1	1	4	11
506	1130	16.7522	4	8	13	21	34
507	391	8.9668	2	4	7	12	17
508	1206	7.7355	2	3	5	9	16
509	462	4.8528	1	2	3	6	10
510	1006	6.8897	2	3	5	8	13
511	311	4.8135	1	2	3	6	9
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TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) MARCH 1998

State	Urban	Rural
ALABAMA	0.373	0.446
ALASKA	0.503	0.731
ARIZONA	0.375	0.540
ARKANSAS	0.515	0.457
CALIFORNIA	0.363	0.481
COLORADO	0.467	0.565
CONNECTICUT	0.546	0.532
DELAWARE	0.506	0.488
DISTRICT OF COLUMBIA	0.521	.....
FLORIDA	0.384	0.389
GEORGIA	0.497	0.497
HAWAII	0.430	0.559
IDAHO	0.564	0.582
ILLINOIS	0.445	0.546
INDIANA	0.559	0.597
IOWA	0.513	0.640
KANSAS	0.429	0.644
KENTUCKY	0.496	0.519
LOUISIANA	0.442	0.496
MAINE	0.620	0.576
MARYLAND	0.765	0.818
MASSACHUSETTS	0.540	0.571
MICHIGAN	0.467	0.580
MINNESOTA	0.532	0.611
MISSISSIPPI	0.478	0.499
MISSOURI	0.441	0.516
MONTANA	0.524	0.569
NEBRASKA	0.482	0.639
NEVADA	0.320	0.584
NEW HAMPSHIRE	0.573	0.586
NEW JERSEY	0.436	.....
NEW MEXICO	0.466	0.510
NEW YORK	0.553	0.633
NORTH CAROLINA	0.523	0.461
NORTH DAKOTA	0.620	0.666
OHIO	0.533	0.576
OKLAHOMA	0.460	0.529
OREGON	0.546	0.624
PENNSYLVANIA	0.407	0.527
PUERTO RICO	0.481	0.569
RHODE ISLAND	0.571	.....
SOUTH CAROLINA	0.472	0.494
SOUTH DAKOTA	0.537	0.620
TENNESSEE	0.481	0.508
TEXAS	0.427	0.536
UTAH	0.538	0.635
VERMONT	0.615	0.577
VIRGINIA	0.476	0.499
WASHINGTON	0.599	0.662
WEST VIRGINIA	0.592	0.573
WISCONSIN	0.568	0.641
WYOMING	0.495	0.694

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 1998

State	Ratio
ALABAMA	0.047
ALASKA	0.066
ARIZONA	0.043
ARKANSAS	0.054
CALIFORNIA	0.038
COLORADO	0.052
CONNECTICUT	0.042
DELAWARE	0.058

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 1998—Continued

State	Ratio
DISTRICT OF COLUMBIA	0.040
FLORIDA	0.046
GEORGIA	0.049
HAWAII	0.045
IDAHO	0.054
ILLINOIS	0.042
INDIANA	0.059
IOWA	0.054
KANSAS	0.052
KENTUCKY	0.051
LOUISIANA	0.067
MAINE	0.040
MARYLAND	0.013
MASSACHUSETTS	0.056
MICHIGAN	0.046
MINNESOTA	0.056
MISSISSIPPI	0.054
MISSOURI	0.049
MONTANA	0.052
NEBRASKA	0.057
NEVADA	0.068
NEW HAMPSHIRE	0.066
NEW JERSEY	0.039
NEW MEXICO	0.047
NEW YORK	0.053
NORTH CAROLINA	0.047
NORTH DAKOTA	0.075
OHIO	0.053
OKLAHOMA	0.054
OREGON	0.055
PENNSYLVANIA	0.043
PUERTO RICO	0.054
RHODE ISLAND	0.033
SOUTH CAROLINA	0.053
SOUTH DAKOTA	0.061
TENNESSEE	0.056
TEXAS	0.052
UTAH	0.056
VERMONT	0.047
VIRGINIA	0.058
WASHINGTON	0.066
WEST VIRGINIA	0.056
WISCONSIN	0.052
WYOMING	0.056

Appendix A—Regulatory Impact Analysis

I. Introduction

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless we certify that a proposed rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the prospective payment system, we classify these hospitals as urban hospitals.

It is clear that the changes being proposed in this document would affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this proposed rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

II. Objectives

The primary objective of the prospective payment system is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of deficit reduction and restraints on government spending in general.

We believe the proposed changes would further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these proposed changes would ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

As has been the case in previously published regulatory impact analyses, the following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 1999, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case mix. As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effects of these changes on hospitals and our methodology for estimating them.

IV. GME Payment to Nonhospital Providers

In the past, Medicare only paid hospitals for GME costs. Therefore, FQHCs, RHCs and Medicare+Choice organizations may have been reluctant to train many residents since they would incur costs in training the residents but would not be reimbursed for those costs by Medicare. Under this proposed regulation, where the non-hospital site incurs all or substantially all of the costs of the training at that site, Medicare will reimburse

the provider for Medicare's share of the reasonable costs of the training. The proposal to allow for payments directly to these non-hospital sites for the costs of training residents in approved programs will facilitate more training of residents in settings that will be similar to the settings that many of those residents will ultimately practice after their training is completed. Additionally, this could result in an increase in the number of physicians practicing in underserved areas.

In addition, hospitals are currently allowed to count residents, working in nonhospital sites in their count of residents and the hospital would be paid GME payments, if it paid for all or substantially all of the costs of the program at the non-hospital site. Previously the regulation defined the statutory requirement of ''all or substantially all'' to mean at least the residents'' salaries and fringe benefits. Under the proposal we would redefine ''all or substantially all'' of the costs of the program at the nonhospital site to also include the GME portion of the teaching physicians' salaries and fringe benefits. This will require hospitals to incur more of the costs of the training at the nonhospital site in order to receive both direct and indirect GME payments for those residents.

Section 4625 of the Balanced Budget Act, which provides for direct graduate medical education payments to nonhospital providers, would have minimal impact in the context of total graduate medical education costs. We believe that the most significant impact resulting from section 4625 will be the movement of resident training from the inpatient setting to the nonhospital setting. We expect that such a shift in the site where resident training occurs will result in little if any additional cost to Medicare. In addition to the expected shift in training from the inpatient setting to the nonhospital setting, in relatively few cases, section 4625 could result in additional resident training being paid by Medicare. However, Medicare's share of costs incurred in those nonhospital sites based on Medicare utilization is often generally low, so we expect the impact of the cost of training of any additional residents to be negligible.

V. Hospitals Included In and Excluded From the Prospective Payment System

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general, short-term, acute care hospitals that participate in the Medicare program. There were 45 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 50 such hospitals in Maryland remain excluded from the prospective payment system under the waiver at section 1814(b)(3) of the Act. Thus, as of March 1998, we have included 4,956 hospitals in our analysis. This represents about 82 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

The remaining 18 percent are specialty hospitals that are excluded from the prospective payment system and continue to be paid on the basis of their reasonable costs (subject to a rate-of-increase ceiling on their inpatient operating costs per discharge). These hospitals include psychiatric, rehabilitation, long-term care, children's, and cancer hospitals. The impacts of our proposed policy changes on these hospitals are discussed below.

VI. Impact on Excluded Hospitals and Units

As of March 1998, there were 1,082 specialty hospitals excluded from the prospective payment system and instead paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. In addition, there were 2,393 psychiatric and rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also paid in accordance with § 413.40.

As required by section 1886(b)(3)(B) of the Act, the update factor applicable to the rate-of-increase limit for excluded hospitals and units for FY 1999 would be between 0 and 2.5 percent, depending on the hospital's costs in relation to its limit.

The impact on excluded hospitals and units of the proposed update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the percentage increases in the rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and units receive. Conversely, for excluded hospitals and units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect will be the amount of excess costs that would not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and 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 units to restrain the growth in their spending for patient services.

VII. Quantitative Impact Analysis of the Proposed Policy Changes Under the Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We estimate the total payment impact of these changes on FY 1999 payments compared to FY 1998 payments, to be approximately a $400 million reduction. We have prepared separate impact analyses of the proposed changes to each system. This section deals with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are taken from the FY 1997 MedPAR file and the most current provider-specific file that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not incorporate cost data, the most recently available hospital cost report data 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 proposed policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each proposed 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. For individual hospitals, however, some miscategorizations are possible.

Using cases in the FY 1997 MedPAR file, we simulated payments under the operating prospective payment system given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the general prospective payment systems (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations. Payments under the capital prospective payment system, or payments for costs other than inpatient operating costs, are not analyzed here. Estimated payment impacts of proposed FY 1999 changes to the capital prospective payment system are discussed below in section VII of this Appendix.

The proposed changes discussed separately below are the following:

- The effects of implementing the expanded transfer definition enacted by section 4407 of the BBA, which counts as a transfer any discharge from one of 10 DRGs if upon discharge the patient is admitted to an excluded hospital or distinct part unit or a skilled nursing facility, or is provided home health care that is related to the hospitalization within 3 days of the date of discharge.
- 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 changes in hospitals' wage index values reflecting the wage index update (FY 1995 data).
- The effects of two proposed changes to the wage index: (1) including the costs associated with Part A physician costs under contract; and (2) removing the overhead costs related to departments excluded from the wage data used to calculate the wage index (for example, skilled nursing facilities and distinct part units).
- The effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) that will be effective in FY 1999.

• The total change in payments based on FY 1999 policies relative to payments based on FY 1998 policies.

To illustrate the impacts of the FY 1999 proposed changes, our analysis begins with a FY 1999 baseline simulation model using: The FY 1998 GROUPER (version 15.0); the FY 1998 wage index; the transfer definition prior to implementation of section 4407 of the BBA; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total DRG payments.

Each proposed and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 1999 model incorporating all of the changes. This allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 1998 to FY 1999. Four factors have significant impacts here. First is the update to the standardized amounts. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are proposing to update the large urban and the other areas average standardized amounts for FY 1999 using the most recently forecasted hospital market basket increase for FY 1999 of 2.6 percent minus 1.9 percentage points. Similarly, section 1886(b)(3)(C)(ii) of the Act provides that the update factor applicable to the hospital-specific rates for sole community hospitals (SCHs), essential access community hospitals (EACHs) (which are treated as SCHs for payment purposes), and Medicare-dependent, small rural hospitals (MDHs) is equal to the market basket increase of 2.6 percent minus 1.9 percentage points (for an update of 0.7 percent).

A second significant factor impacting changes in hospitals' payments per case from FY 1998 to FY 1999 is a change in MGCRB reclassification status from one year to the next. That is, hospitals reclassified in FY 1998 that are no longer reclassified in FY 1999 may have a negative payment impact going from FY 1998 to FY 1999; conversely, hospitals not reclassified in FY 1998 that are reclassified in FY 1999 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 increase in payments for the category may be below the national mean.

A third significant factor is that we currently estimate that actual outlier payments during FY 1998 will be 5.4 percent of actual total DRG payments. When the FY 1998 final rule was published, we projected FY 1998 outlier payments would be 5.1 percent of total DRG payments, and the standardized amounts were reduced correspondingly. The effects of the slightly higher than expected outlier payments during FY 1998 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 1998 payments per case to estimated FY 1999 payments per case.

Fourth, payments per case in FY 1999 are reduced from FY 1998 for hospitals that receive the indirect medical education (IME) or the disproportionate share (DSH) adjustments. Section 1886(d)(5)(B)(ii) of the Act provides that the IME adjustment is reduced from approximately a 7.0 percent increase for every 10 percent increase in a hospital's resident-to-bed ratio in FY 1998, to a 6.5 percent increase in FY 1999. Similarly, in accordance with section 1886(d)(5)(F)(ix) of the Act, the DSH adjustment for FY 1999 is reduced by 2 percent from what would otherwise have been paid, compared to a 1 percent reduction for FY 1998.

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 4,956 hospitals included in the analysis. This is 132 fewer hospitals than were included in the impact analysis in the FY 1998 final rule with comment period (62 FR 46119).

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, or rural). There are 2,792 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,588 hospitals located in large urban areas (populations over 1 million), and 1,204 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,164 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 1999 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show the numbers of hospitals paid based on these categorizations (after consideration of geographic reclassifications) are 2,877, 1,681, 1,196, and 2,079, respectively.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an IME adjustment), receive DSH payments, or some combination of these two adjustments. There are 3,875 nonteaching hospitals in our analysis, 841 teaching hospitals with fewer than 100 residents, and 240 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural after MGCRB reclassifications. Hospitals in the rural DSH categories, therefore, represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (They may, however, have been reclassified for purposes of the wage index.) The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next row separately examines hospitals that available data show may qualify under section 4401(b) of the BBA for the special temporary relief provision, which grants an additional 0.3 percent update to the standardized amounts (in addition to the 0.7 percent update other hospitals would receive during FY 1999), resulting in a 1.0 percent update for this category of hospitals. To be eligible, a hospital must not be an MDH, nor may it receive either IME or DSH payments. It must also experience a negative margin on its operating prospective payments during FY 1999. We estimated eligible hospitals based on whether they had a negative operating margin on their FY 1995 cost report (latest available data). Finally, to qualify, a hospital must be located in a State where the aggregate FY 1995 operating prospective payments were less than the aggregate associated costs for all of the non-IME, non-DSH, non-MDH hospitals in the State. There are 356 hospitals in this row.

The next four rows examine the impacts of the proposed changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), MDHs, and EACHs), as well as rural hospitals not receiving a special payment designation. The RRCs (137), SCH/EACHs (633), MDHs (351), and SCH/EACH and RRCs (54) shown here were not reclassified for purposes of the standardized amount. There is one SCH that will be reclassified for the standardized amount in FY 1999 that, therefore, is not included in these rows. There are six EACHs included in our analysis and three EACH/RRCs.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 1995 Medicare cost report files, if available (otherwise FY 1994 data are used). Data needed to determine ownership status or Medicare utilization percentages were unavailable for 95 hospitals. For the most part, these are new hospitals.

The next series of groupings concern the geographic reclassification status of hospitals. The first three groupings display hospitals that were reclassified by the MGCRB for both FY 1998 and FY 1999, or for either of those 2 years, by urban/rural status. The next rows illustrate the overall number of FY 1999 reclassifications, as well as the numbers of reclassified hospitals grouped by urban and rural location. The final row in Table I contains hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act.

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1999 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent changes in payments per case]

	Number of hosps.[1]	PAC tran. provision[2]	DRG recalib.[3]	New wage data[4]	Contract phys. pt a costs[5]	Allocated overhead costs[6]	DRG & WI changes[7]	MGCRB recl- assification[8]	All FY 99 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
(BY GEOGRAPHIC LOCATION):									
ALL HOSPITALS	4,956	−0.6	0.1	0.1	0.0	−0.1	0.0	0.0	−0.7
URBAN HOSPITALS	2,792	−0.7	0.1	0.0	0.0	−0.2	−0.2	−0.4	−1.1
LARGE URBAN	1,588	−0.7	0.1	−0.3	0.0	−0.2	−0.5	−0.4	−1.4
OTHER URBAN	1,204	−0.6	0.1	0.4	0.0	−0.2	0.2	−0.3	−0.5
RURAL HOSPITALS	2,164	−0.4	0.1	0.9	−0.1	0.3	1.3	2.4	1.5
BED SIZE (URBAN):									
0–99 BEDS	690	−0.8	0.2	−0.3	0.0	−0.1	−0.3	−0.5	−0.7
100–199 BEDS	936	−0.8	0.2	−0.2	0.0	−0.1	−0.3	−0.4	−1.0
200–299 BEDS	566	−0.7	0.1	−0.1	0.0	−0.1	−0.3	−0.3	−0.9
300–499 BEDS	448	−0.6	0.1	0.0	0.0	−0.2	−0.3	−0.5	−1.2
500 OR MORE BEDS	152	−0.5	0.1	0.3	0.0	−0.3	0.1	−0.2	−1.2
BED SIZE (RURAL):									
0–49 BEDS	1,135	−0.3	0.1	0.9	−0.1	0.5	1.3	−0.1	1.3
50–99 BEDS	635	−0.4	0.1	0.8	−0.1	0.3	1.1	0.9	1.1
100–149 BEDS	229	−0.5	0.1	0.8	−0.1	0.4	1.3	3.3	1.3
150–199 BEDS	91	−0.5	0.1	1.0	−0.1	0.3	1.5	3.9	2.7
200 OR MORE BEDS	74	−0.4	0.1	1.0	0.0	0.2	1.4	4.6	1.6
URBAN BY CENSUS DIVISION:									
NEW ENGLAND	152	−0.7	0.1	−2.4	−0.1	0.1	−2.7	0.1	−3.5
MIDDLE ATLANTIC	425	−0.4	0.2	0.4	0.3	−0.2	0.6	−0.5	−0.5
SOUTH ATLANTIC	413	−0.6	0.1	0.8	−0.1	−0.2	0.6	−0.6	−0.3
EAST NORTH CENTRAL	475	−0.8	0.1	0.0	−0.1	−0.4	−0.6	−0.3	−1.5
EAST SOUTH CENTRAL	159	−0.6	0.1	0.5	−0.1	−0.4	0.0	−0.5	−0.7
WEST NORTH CENTRAL	186	−0.7	0.0	0.9	0.0	0.1	1.0	−0.6	0.1
WEST SOUTH CENTRAL	350	−0.9	0.1	−1.1	0.1	−0.2	−1.4	−0.1	−2.0
MOUNTAIN	126	−0.8	0.1	0.4	0.2	−0.2	0.5	−0.6	−0.3
PACIFIC	458	−0.8	0.1	−0.5	−0.1	0.0	−0.7	−0.3	−1.4
PUERTO RICO	48	−0.2	0.3	0.8	−0.3	−0.3	0.3	−0.5	0.3
RURAL BY CENSUS DIVISION:									
NEW ENGLAND	53	−0.4	0.0	1.3	0.1	0.0	1.4	0.6	−0.4
MIDDLE ATLANTIC	80	−0.3	0.1	0.9	0.1	0.0	1.2	1.2	1.1
SOUTH ATLANTIC	286	−0.4	0.2	0.8	−0.1	0.3	1.1	3.3	2.0
EAST NORTH CENTRAL	284	−0.5	0.1	1.0	−0.3	0.3	1.2	1.9	1.5
EAST SOUTH CENTRAL	269	−0.4	0.1	1.5	−0.1	0.3	1.9	2.5	2.0

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1999 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Number of hosps.[1]	PAC tran. provision[2]	DRG recalib.[3]	New wage data[4]	Contract phys. pt a costs[5]	Allocated overhead costs[6]	DRG & WI changes[7]	MGCRB recl- assification[8]	All FY 99 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
WEST NORTH CENTRAL ..	499	−0.4	0.0	1.1	0.0	0.7	1.9	2.1	1.8
WEST SOUTH CENTRAL ..	341	−0.5	0.1	0.3	−0.1	0.5	0.8	3.1	0.7
MOUNTAIN ...	206	−0.3	0.0	0.3	−0.1	0.5	0.8	1.6	1.2
PACIFIC	141	−0.6	0.1	0.4	−0.1	0.4	1.0	2.3	1.1
PUERTO RICO	5	−0.4	0.1	2.3	0.1	−0.3	2.2	1.9	0.8
(BY PAYMENT CATEGORIES):									
URBAN HOSPITALS	2,877	−0.7	0.1	0.0	0.0	−0.2	−0.2	−0.3	−1.0
LARGE URBAN	1,681	−0.7	0.1	−0.3	0.0	−0.2	−0.4	−0.3	−1.3
OTHER URBAN	1,196	−0.6	0.1	0.4	0.0	−0.2	0.2	−0.4	−0.5
RURAL HOSPITALS	2,079	−0.4	0.1	0.9	−0.1	0.4	1.3	2.0	1.4
TEACHING STATUS:									
NON-TEACHING	3,875	−0.7	0.1	0.2	−0.1	0.0	0.2	0.3	−0.1
LESS THAN 100 RES. ...	841	−0.7	0.1	0.0	0.0	−0.2	−0.2	−0.3	−0.9
100+ RESIDENTS	240	−0.6	0.1	0.0	0.1	−0.2	−0.1	−0.3	−1.7
DISPROPORTIONATE SHARE HOSPITALS (DSH):									
NON-DSH	3,074	−0.6	0.1	0.1	0.0	−0.1	0.1	0.3	−0.4
URBAN DSH:									
100 BEDS OR MORE	1,402	−0.7	0.1	0.0	0.0	−0.2	−0.2	−0.3	−1.1
FEWER THAN 100 BEDS ..	93	−0.7	0.2	−0.2	−0.1	−0.1	−0.3	−0.5	−0.7
RURAL DSH:									
SOLE COMMUNITY (SCH) ..	156	−0.2	0.1	0.8	−0.1	0.2	1.1	−0.1	1.3
REFERRAL CENTERS (RRC) ..	47	−0.5	0.2	1.3	−0.1	0.3	1.9	4.8	2.9
OTHER RURAL DSH HOSP.:									
100 BEDS OR MORE	64	−0.6	0.2	1.2	−0.1	0.4	1.8	1.3	0.8
FEWER THAN 100 BEDS ..	120	−0.3	0.1	1.4	−0.1	0.4	1.8	0.0	1.7
URBAN TEACHING AND DSH:									

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1999 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Number of hosps.[1]	PAC tran. provision[2]	DRG recalib.[3]	New wage data[4]	Contract phys. pt a costs[5]	Allocated overhead costs[6]	DRG & WI changes[7]	MGCRB recl- assification[8]	All FY 99 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
BOTH TEACHING AND DSH	700	−0.7	0.1	0.0	0.0	−0.2	−0.2	−0.4	−1.4
TEACHING AND NO DSH	328	−0.6	0.0	0.0	0.0	−0.3	−0.2	−0.1	−1.0
NO TEACHING AND DSH	795	−0.8	0.2	0.0	−0.1	−0.1	−0.1	−0.2	−0.6
NO TEACHING AND NO DSH	1,054	−0.7	0.1	−0.2	0.0	−0.1	−0.3	−0.3	−0.6
SPECIAL UPDATE HOSPITALS (UNDER SEC. 4401(b) OF PUBLIC LAW 105–33)	356	−0.6	0.2	0.1	−0.1	−0.1	0.1	0.3	−0.3
RURAL HOSPITAL TYPES:									
NONSPECIAL STATUS HOSPITALS	904	−0.5	0.2	1.1	−0.1	0.5	1.6	1.1	1.0
RRC	137	−0.6	0.1	1.2	0.0	0.4	1.8	5.6	2.5
SCH/EACH	633	−0.2	0.0	0.4	0.0	0.2	0.6	0.1	0.8
MDH	351	−0.3	0.1	1.1	−0.1	0.5	1.5	0.4	1.3
SCH/EACH AND RRC	54	−0.2	0.0	0.3	0.0	0.1	0.4	1.5	1.3
TYPE OF OWNERSHIP:									
VOLUNTARY	2,859	−0.6	0.1	0.1	0.0	−0.1	−0.1	−0.1	−0.8
PROPRIETARY	671	−0.9	0.2	0.1	−0.1	−0.1	−0.1	0.1	−0.9
GOVERNMENT	1,331	−0.5	0.1	0.3	−0.1	0.0	0.3	0.3	−0.3
UNKNOWN	95	−0.7	0.2	0.3	−0.1	−0.1	0.2	−0.2	−0.7
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:									
0–25	249	−0.7	0.2	−0.7	−0.1	−0.1	−1.0	0.1	−1.6
25–50	1,267	−0.7	0.1	0.0	0.0	−0.1	−0.2	−0.2	−1.2
50–65	1,975	−0.6	0.1	0.2	0.0	−0.1	0.1	0.1	−0.4
OVER 65	1,370	−0.6	0.1	0.3	0.0	0.0	0.4	0.0	0.0
UNKNOWN	95	−0.7	0.2	0.3	−0.1	−0.1	0.2	−0.2	−0.7
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:									
RECLASSIFICATION STATUS DURING FY 98 AND FY 99:									
RECLASSIFIED DURING BOTH FY98 AND FY99	311	−0.5	0.1	0.6	−0.1	0.1	0.8	6.6	−0.1
URBAN	70	−0.5	0.1	0.2	−0.1	−0.3	−0.1	5.4	−0.5
RURAL	241	−0.5	0.1	1.0	−0.1	0.4	1.5	7.5	0.2
RECLASSIFIED DURING FY99 ONLY	178	−0.5	0.1	0.8	−0.1	0.2	1.0	4.0	4.7

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1999 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Number of hosps.[1]	PAC tran. provision[2]	DRG recalib.[3]	New wage data[4]	Contract phys. pt a costs[5]	Allocated overhead costs[6]	DRG & WI changes[7]	MGCRB recl- assification[8]	All FY 99 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
URBAN	25	−0.5	0.1	0.4	−0.1	0.0	0.4	3.1	1.9
RURAL	153	−0.5	0.1	1.0	−0.1	0.3	1.3	4.4	6.1
RECLASSIFIED DURING FY98 ONLY	111	−0.7	0.1	0.6	0.0	−0.2	0.5	−0.5	−3.1
URBAN	38	−0.7	0.1	0.5	0.1	−0.3	0.2	−0.6	−2.2
RURAL	73	−0.4	0.1	0.9	−0.1	0.4	1.3	−0.5	−6.1
FY 99 RECLASSIFICATIONS:									
ALL RECLASSIFIED HOSP.	489	−0.5	0.1	0.7	−0.1	0.1	0.9	5.7	1.6
STAND. AMOUNT ONLY	94	−0.6	0.1	0.6	0.1	−0.3	0.5	1.0	−0.3
WAGE INDEX ONLY	281	−0.5	0.1	0.5	−0.1	0.3	0.8	6.6	−0.9
BOTH	47	−0.6	0.2	0.9	−0.1	−0.4	0.6	3.8	−1.6
NON-RECLASSIFIED	4,507	−0.7	0.1	0.1	0.0	−0.1	−0.1	−0.4	−0.7
ALL URBAN RECLASS.	95	−0.5	0.1	0.3	−0.1	−0.2	0.0	4.7	0.2
STAND. AMOUNT ONLY	25	−0.4	0.2	0.9	0.1	−0.4	0.7	0.7	0.0
WAGE INDEX ONLY	45	−0.5	0.1	0.0	−0.1	0.1	−0.1	6.5	0.6
BOTH	25	−0.5	0.1	0.6	−0.2	−0.6	−0.1	2.9	−0.5
NON-RECLASSIFIED	2,670	−0.7	0.1	0.0	0.0	−0.2	−0.2	−0.6	−1.1
ALL RURAL RECLASS.	394	−0.5	0.1	1.0	−0.1	0.4	1.4	6.3	2.5
STAND. AMOUNT ONLY	57	−0.5	0.1	1.1	−0.2	0.3	1.5	5.1	2.4
WAGE INDEX ONLY	309	−0.5	0.1	0.9	−0.1	0.4	1.4	6.1	2.3
BOTH	28	−0.6	0.1	1.1	−0.1	0.3	1.6	9.2	3.8
NON-RECLASSIFIED	1,770	−0.3	0.1	0.9	−0.1	0.3	1.2	−0.5	0.8
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	27	−0.5	0.1	−0.9	0.2	−0.3	−0.9	0.7	−0.6

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 1997, and hospital cost report data are from reporting periods beginning in FY 1994 and FY 1995.

[2] This column displays the impact of the change enacted by section 4407 of the BBA, which defines discharges from 1 of 10 DRGs to postacute care as transfers. Under our proposed policy, 3 of the 10 DRGs would be paid under an alternative methodology where they would receive 50 percent of the full DRG amount on the first day and 50 percent of the current per diem transfer payment amount for each remaining day of the stay. The remaining seven DRGs would be paid using our current transfer payment methodology.

[3] This column displays the payment impact of the recalibration of the DRG weights based on FY 1997 MedPAR data and the DRG classification changes, in accordance with section 1886(d)(4)(C) of the Act.

[4] This column shows the payment effects of updating the data used to calculate the wage index with data from the FY 1995 cost reports.

[5] This column displays the impact of adding contract Part A physician costs to the wage data.

[6] This column illustrates the payment impact of removing the overhead costs allocated to departments where the directly assigned costs are already excluded from the wage index calculation (for example, SNFs and distinct part units).

[7] This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated and revised wage data used to calculate the wage index, and the budget neutrality adjustment factor for these two changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 2, 3, 4, and 5, and the FY 1999 budget neutrality factor of 0.999227.

[8] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects shown here demonstrate the FY 1999 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 1999. Reclassification for prior years has no bearing on the payment impacts shown here.

[9] This column shows changes in payments from FY 1998 to FY 1999. It incorporates all of the changes displayed in columns 1, 6, and 7 (the changes displayed in columns 2, 3, 4 and 5 are included in column 6). It also displays the impact of the FY 1999 update, changes in hospitals' reclassification status in FY 1999 compared to FY 1998, the difference in outlier payments from FY 1998 to FY 1999, and the reductions to payments through the IME and DSH adjustments taking effect during FY 1999. The sum of these columns may be different from the percentage changes shown here due to rounding and interactive effects.

B. Impact of the Proposed Implementation of the Expanded Transfer Definition (Column 1)

Section 1886(d)(5)(J) of the Act (added by section 4407 of the BBA) requires the Secretary to select 10 DRGs for which discharges (from any one of these DRGs) to a postacute care provider will be treated as a transfer beginning with discharges on or after October 1, 1998. Column 1 shows the impact of this provision.

Although the expanded definition encompasses only 10 DRGs, they were selected, in accordance with the statute, based upon their large and disproportionate volume of cases receiving postacute care. We estimate that approximately 25 percent of all cases receiving follow-up postacute care come from these 10 DRGs. Therefore, the overall payment impact of this change is significant (a 0.6 percent decrease in payments per case).

The 10 DRGs that we are proposing to include under this provision are identified in section V.A. of the preamble to this proposed rule. In addition to selecting 10 DRGs, the statute authorizes the Secretary to develop an alternative transfer payment methodology for DRGs where a substantial portion of the costs of the cases occur very early in the stay. This is particularly likely to happen in some surgical DRGs because of the high cost of the surgical procedure. Based on our analysis comparing the costs per case for these cases with payments under our current transfer payment methodology, we are proposing to pay the current transfer per diem for all DRGs except DRGs 209, 210, and 211. For those three DRGs, the alternative payment methodology we are proposing is 50 percent of the full DRG payment amount for the first day of the stay, plus 50 percent of the current per diem transfer payment for each remaining day, up to the full DRG payment.

To simulate the impact of these proposed policies, we adjusted hospitals' transfer-adjusted discharges and case-mix index values (using version 15 of the GROUPER) to reflect the impact of this expansion in the transfer definition. The transfer-adjusted discharge amount is calculated one of two ways, depending on the transfer payment methodology. Under our current transfer payment methodology, and for all but the three DRGs receiving special payment consideration, this adjustment is made simply by adding one to the length of stay and dividing that amount by the geometric mean length of stay for the DRG (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 weight of 0.667 ((3+1)/6).

For transfers from any one of the three DRGs receiving the alternative payment methodology, the transfer-adjusted discharge amount 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 one plus the length of stay prior to transfer by the geometric mean length of stay for the DRG. As with the above adjustment, the result is equal to the lesser of the transfer-adjusted DRG 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 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 change has the greatest impact among urban hospitals (0.7 percent decrease). Among urban hospitals, smaller hospitals (under 200 beds) are most affected, with a 0.8 percent reduction in payments. For urban hospitals grouped by census division, Puerto Rico and the Middle Atlantic division have the smallest negative impacts, 0.2 and 0.4 percent decreases, respectively. The Middle Atlantic division has traditionally had the longest average lengths of stay, therefore, it is not surprising that the impact is smallest here. Transfer cases with a length of stay more than the (geometric) mean length of stay minus one day do not experience any payment impact under this provision. (Full payment is reached one day prior to the mean length of stay due to the double per diem paid for the first day under our current transfer payment methodology.) The small impact in Puerto Rico would indicate that these hospitals also are not discharging patients to postacute care early in the stay.

Rural hospitals experience a smaller payment impact overall, especially the smallest rural hospitals: Those with fewer than 50 beds (a 0.3 percent decrease). The smallest impacts among rural census divisions are in the Middle Atlantic and the Mountain. The largest rural impact is in the Pacific division, with a 0.6 percent decrease. This change is consistent with the shorter lengths of stay in this geographic region.

The largest negative impact is a 0.9 percent decrease in payments, observed among urban West South Central hospitals, and proprietary hospitals. The smallest negative impact besides urban Puerto Rico hospitals occurs in SCHs (0.2 percent decrease). Those SCHs paid based on their hospital-specific amount would see no impact related to this change, since there is no transfer adjustment made to the hospital-specific amount.

C. Impact of the Proposed Changes to the DRG Classifications and Relative Weights (Column 2)

In column 2 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II of the preamble to this proposed rule. Section 1886(d)(4)(C)(I) of the Act requires us to annually make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 1998 DRG relative weights (GROUPER version 15) to aggregate payments using the proposed FY 1999 DRG relative weights (GROUPER version 16). Overall, payments increase by 0.1 percent due to the DRG changes, although this is prior to applying the budget neutrality factor for DRG and wage index changes (see column 6). Consistent with the minor changes we are proposing for the FY 1999 GROUPER, the redistributional impacts of DRG reclassifications and recalibration across hospital groups are very small (a 0.1 percent increase for large and other urban hospitals, as well as for rural hospitals). Within hospital categories, the net effects for urban hospitals are small positive changes for all hospitals (a 0.2 percent increase for hospitals with fewer than 200 beds and a 0.1 percent increase for larger hospitals). Among rural hospitals, all hospital categories experience an increase of 0.1 percent.

The breakdowns by urban census division show that the increase among urban hospitals is spread across all census categories, with the largest increase (0.3 percent) for hospitals in Puerto Rico. For rural hospitals, there is no impact (that is, a 0.0 percent change) for hospitals in the New England, West North Central, and Mountain census divisions. All other divisions experience a 0.1 percent increase.

This pattern of small increases or no change applies to all other hospital categories. Overall, we attribute this change to the increasing severity of illness of

hospital inpatients. That is, as greater numbers of less acutely ill patients are treated outside the inpatient setting, the acuity of the remaining hospital inpatients increases. Although, in the past, this effect was seen more clearly in large urban and very large rural hospitals, which often had more outpatient settings available for patient treatment, hospitals in all areas now appear to be able to take advantage of this practice. Of course, in general, these positive impacts are very minor, with virtually no hospital group experiencing more than a 0.2 percent increase.

D. Impact of Updating the Wage Data (Column 3)

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 proposed wage index for FY 1999 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1994 and before October 1, 1995. As with the previous column, the impact of the new data on hospital payments is isolated by holding the other payment parameters constant in the two simulations. That is, column 3 shows the percentage changes in payments when going from a model using the FY 1998 wage index based on FY 1994 wage data before geographic reclassifications to a model using the FY 1999 prereclassification wage index based on FY 1995 wage data.

The wage data collected on the FY 1995 cost reports includes, for the first time, contract labor costs and hours for top management positions as allowable in the wage index calculation. In addition, the changes to wage-related costs associated with hospital and home office salaries that were discussed in the September 1, 1994 final rule (59 FR 45355) are reflected in the FY 1995 data. These changes are reflected in column 3, as well as other year-to-year changes in hospitals' labor costs.

The results indicate that the new wage data have an overall impact of a 0.1 percent increase in hospital payments (prior to applying the budget neutrality factor, see column 6). Rural hospitals especially appear to benefit from the update. Their payments increase by 0.9 percent. These increases are attributable to relatively large increases in the wage index values for the rural areas of particular States; South Dakota, Hawaii, Mississippi, Wyoming, New Hampshire, and Iowa all had increases greater than 6 percent in their prereclassification wage index values.

Urban hospitals as a group are not significantly affected by the updated wage data. The gains of hospitals in other urban areas (0.4 percent increase) are offset by decreases among hospitals in large urban areas (0.3 percent decrease). The negative impact among large urban areas appears to be largely due to a 5.8 percent decrease in the wage index values for the Boston MSA. This impact is especially evident in the 2.4 percent decrease for urban New England hospitals. Urban West South Central hospitals experience a 1.1 percent decrease, largely due to 11 Texas MSAs with FY 1999 wage indexes that fall by more than 7 percent. These appear to be primarily related to large changes in the average hourly wages of individual hospitals in MSAs with only a few hospitals. We would point out that the wage data used for the proposed wage index is not final, and we understand that many hospitals have submitted revision requests. To the extent these requests are granted by hospitals' fiscal intermediaries, these revisions are likely to affect the impacts shown in the final rule. In addition, we continue to verify the accuracy of the data for hospitals with extraordinary changes in their data from the prior year. We anticipate that all these verifications will be completed when we calculate the final FY 1999 wage index.

The largest increases are seen in the rural census divisions. Rural Puerto Rico experiences the greatest positive impact, 2.3 percent. Hospitals in three other census divisions receive positive impacts over 1.0 percent; East South Central at 1.5 percent, New England at 1.3 percent, and West North Central at 1.1 percent. We believe these positive impacts of the new wage data for rural hospitals stem from the expansion of the contract labor definition, specifically to include certain management categories. On average, the hourly cost of contract labor increased for rural hospitals by 5.9 percent. Among urban hospitals, the increase was 4.2 percent.

E. Impact of Including Contract Physician Part A Costs (Column 4)

As discussed in section III.C.1 of the preamble, we began collecting separate wage data for both direct and contract physician Part A services on the FY 1995 cost report. This change was made in order to address any potential inequity of including only salaried Part A physician costs in the wage index while some States had laws prohibiting their hospitals from employing physicians directly (forcing hospitals to contract with physicians for administrative services). Based on our analysis, we are proposing to include contract physician Part A costs in the wage index calculation.

Column 4 shows the payment impacts of including these data. Although only two States currently maintain the prohibition against hospitals directly employing physicians (Texas and California), many hospitals in other States reported these costs as well. Thus, the impacts of this proposed change extend well beyond Texas and California. In fact, the urban Middle Atlantic census division shows the largest positive impact from this change (0.3 percent).

In general, hospitals in other areas experience either no changes due to this proposed policy, or small (0.1 percent) increases or decreases. However, urban hospitals in Puerto Rico and rural hospitals in the East North Central census division experience 0.3 percent decreases. The negative rural East North Central impact is largely due to a negative impact of this change on the rural Wisconsin wage index.

As noted above, the data used to prepare the proposed FY 1999 wage index are subject to revision, and we understand that many hospitals requested changes to their contract physician Part A costs prior to the March 9 deadline for all requests for wage data changes to be submitted to the fiscal intermediaries. The extent of these requests and the number which are approved by the fiscal intermediaries may change the impacts in the final rule.

F. Impact of Removing Overhead Costs of Excluded Areas (Column 5)

Prior years' wage index calculations have removed the direct wages and hours associated with certain subprovider components excluded from the prospective payment system; however, the overhead costs associated with these excluded components have not been removed. We revised the FY 1995 cost report to allow hospitals to report separately overhead salaries and hours, and we are proposing to remove the overhead costs and hours allocated to areas of the hospital excluded from the wage index calculation.

Column 5 displays the impacts on FY 1999 payments per case of implementing this change. The overall impact is a 0.1 percent decline in payments; however, once again (as with the impacts of the FY 1995 data), the impact diverges along urban and rural lines. Urban hospitals lose 0.2 percent as a result of removing these overhead costs, while rural hospitals gain 0.3 percent. Among rural hospitals by bed size, the smallest rural hospitals benefit the most, with a 0.5 percent increase for rural hospitals with fewer than 50 beds.

Hospitals in the rural West North Central census division experience the largest percentage increase (0.7 percent). The largest negative impacts are in Puerto Rico (urban and rural), and urban East North Central and urban East South Central.

The combined wage index changes in Table I are determined by summing the individual impacts in columns 3, 4, and 5. For example, the rural West North Central census division gains 1.1 percent from the new wage data, and 0.7 percent from removing the overhead costs allocated to excluded areas. Therefore, the combined impact of the FY 1999 wage index for these hospitals is a 1.8 percent increase.

The following chart compares the shifts in wage index values for labor market areas for FY 1999 relative to FY 1998. This chart demonstrates the impact of the proposed changes for the FY 1999 wage index relative to the FY 1998 wage index. The majority of labor market areas (282) experience less than a 5 percent change. A total of 54 labor market areas experience an increase of more than 5 percent with 13 having an increase greater than 10 percent. A total of 34 areas experience decreases of more than 5 percent (all urban). Of those, 6 decline by 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 1998	FY 1999
Increase more than 10 percent	2	13
Increase more than 5 percent and less than 10 percent	24	41
Increase or decrease less than 5 percent	334	282

Percentage change in area wage index values	Number of labor market areas	
	FY 1998	FY 1999
Decrease more than 5 percent and less than 10 percent	9	28
Decrease more than 10 percent	1	6

Among urban hospitals, 164 would experience an increase of more than 5 percent and 29 more than 10 percent. More rural hospitals have increases greater than 5 percent (360), but none greater than 10 percent. On the negative side, 268 urban hospitals but no rural hospitals have decreases in their wage index values of at least 5 percent (30 of the urban hospitals have decreases greater than 10 percent). The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	29	0
Increase more than 5 percent and less than 10 percent	164	360
Increase or decrease less than 5 percent	2440	1924
Decrease more than 5 percent and less than 10 percent	238	0
Decrease more than 10 percent	30	0

G. Combined Impact of DRG and Wage Index Changes—Including Budget Neutrality Adjustment (Column 6)

The impact of DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this proposed rule, we compared aggregate payments using the FY 1998 DRG relative weights and wage index to aggregate payments using the FY 1999 DRG relative weights and wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.999227. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 6. The 0.0 percent impact for All Hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral.

For the most part, the changes in this column are the sum of the changes in columns 2, 3, 4, and 5, minus approximately 0.1 percent attributable to the budget neutrality factor. There may, of course, be some variation of plus or minus 0.1 percent due to rounding.

H. Impact of MGCRB Reclassifications (Column 7)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 7 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 1999. As noted below, these decisions affect hospitals' standardized amount and wage index area assignments. In addition, rural hospitals reclassified for purposes of the standardized amount qualify to be treated as urban for purposes of the DSH adjustment.

Beginning in 1998, by February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. (In previous years, these determinations were made by March 30.) The MGCRB may approve a hospital's reclassification request for the purpose of using the other area's standardized amount, wage index value, or both or for FYS 1999–2001 for purposes of qualifying for a DSH adjustment or to receive a higher DSH payment.

The proposed FY 1999 wage index values incorporate all of the MGCRB's reclassification decisions for FY 1999. The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and review process for MGCRB decisions as of February 27, 1998. Additional changes that result from the Administrator's review of MGCRB decisions or a request by a hospital to withdraw its application will be reflected in the final rule for FY 1999.

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 0.994019 to ensure that the effects of reclassification are budget neutral. (See section II.A.4 of the Addendum to this proposed rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.4 percent, while payments to urban hospitals decline 0.4 percent. Hospitals in other urban areas see a decrease in payments of 0.3 percent, while large urban hospitals lose 0.4 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally decline.

A positive impact is evident among all rural hospital groups except the smallest hospitals (under 50 beds), which experience a slight decrease of 0.1 percent. The smallest increase among the rural census divisions is 0.6 percent for New England. The largest increase is in rural South Atlantic, with an increase of 3.3 percent.

Among rural hospitals designated as RRCs, 108 hospitals are reclassified for purposes of the wage index only, leading to the 5.6 percent increase in payments among RRCs overall. This positive impact on RRCs is also reflected in the category of rural hospitals with 200 or more beds, which has a 4.6 percent increase in payments.

Rural hospitals reclassified for FY 1998 and FY 1999 experience a 6.6 percent increase in payments. This may be due to the fact that these hospitals have the most to gain from reclassification and have been reclassified for a period of years. Rural hospitals reclassified for FY 1999 only experience a 4.4 percent increase in payments, while rural hospitals reclassified for FY 1998 only experience a 0.5 percent decrease in payments. Urban hospitals reclassified for FY 1998 but not FY 1999 experience a 0.6 percent decline in payments overall. Urban hospitals reclassified for FY 1999 but not for FY 1998 experience a 3.1 percent increase in payments.

The FY 1999 Reclassification rows of Table I show the changes in payments per case for all FY 1999 reclassified and nonreclassified hospitals in urban and rural locations for each of the three reclassification categories (standardized amount only, wage index only, or both). The table illustrates that the largest impact for reclassified rural hospitals is for those hospitals reclassified for both the standardized amount and the wage index. These hospitals receive a 9.2 percent increase in payments. In addition, rural hospitals reclassified just for the wage index receive a 6.1 percent payment increase. The overall impact on reclassified hospitals is to increase their payments per case by an average of 5.7 percent for FY 1999.

Among the 27 rural hospitals deemed to be urban under section 1886(d)(8)(B) of the Act, payments increase 0.7 percent due to MGCRB reclassification. This is because, although these hospitals are treated as being attached to an urban area in our baseline (their redesignation is ongoing, rather than annual like the MGCRB reclassifications), they are eligible for MGCRB reclassification. For FY 1999, one hospital in this category reclassified to a large urban area.

The reclassification of hospitals primarily affects payment to nonreclassified hospitals through changes in the wage index and the geographic reclassification budget neutrality adjustment required by section 1886(d)(8)(D) of the Act. Among hospitals that are not reclassified, the overall impact of hospital reclassifications is an average decrease in payments per case of about 0.4 percent. Rural nonreclassified hospitals decrease slightly more, experiencing a 0.5 percent decrease, and urban nonreclassified hospitals lose 0.6 percent (the amount of the budget neutrality offset).

The number of reclassifications for purposes of the standardized amount, or for both the standardized amount and the wage index, has increased from 149 in FY 1998 to 162 in FY 1999. The number of wage index only reclassifications increased from 284 in FY 1998 to 358 in FY 1999. These increases are mainly attributable to two changes made by the BBA. Section 4202 of the BBA amended section 1886(d)(10)(D) of the Act to allow RRCs to reclassify for wage index purposes based only on comparison of the RRC's average hourly wage to the average hourly wage of the area to which it applies to be reclassified. In addition, section 4203 provides that for FYs 1999–2001, a rural

hospital may be reclassified to an other urban area for the sole purpose of receiving a higher DSH payment.

The foregoing analysis was based on MGCRB and HCFA Administrator decisions made by February 27 of this year. As previously noted, there may be changes to some MGCRB decisions through the appeals, review, and applicant withdrawal process. The outcome of these cases will be reflected in the analysis presented in the final rule.

I. All Changes (Column 8)

Column 8 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 1999 (including statutory changes), to our estimate of payments per case in FY 1998. It includes the effects of the 0.7 percent update to the standardized amounts and the hospital-specific rates for SCHs, EACHs, and MDHs. It also reflects the 0.3 percentage point difference between the projected outlier payments in FY 1999 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 1998 (5.4 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule.

Additional changes affecting the difference between FY 1998 and FY 1999 payments are the reductions to the IME and DSH adjustments enacted by the BBA. These changes initially went into effect during FY 1998 and include additional decreases in payment for each of several succeeding years. As noted in the introduction to this impact analysis, for FY 1999, IME is reduced to approximately a 6.5 percent rate of increase, and DSH is reduced by 2 percent from what hospitals otherwise would receive. We estimate the overall effect of these statutory changes to be a 0.4 percent reduction in FY 1999 payments. For hospitals receiving both IME and DSH, the impact is estimated to be a 0.9 percent reduction in payments per case.

We also note that column 8 includes the impacts of FY 1999 MGCRB reclassifications compared to the payment impacts of FY 1998 reclassifications. Therefore, when comparing FY 1999 payments to FY 1998, the percent changes due to FY 1999 reclassifications shown in column 7 need to be offset by the effects of reclassification on hospitals' FY 1998 payments (column 7 of Table 1, August 29, 1997 final rule with comment period; 62 FR 46119). For example, the impact of MGCRB reclassifications on rural hospitals' FY 1998 payments was approximately a 2.2 percent increase, offsetting much of the 2.4 percent increase in column 7 for FY 1999. Therefore, the net change in FY 1999 payments due to reclassification for rural hospitals is actually closer to an increase of 0.2 percent relative to FY 1998. However, last year's analysis contained a somewhat different set of hospitals, so this might affect the numbers slightly.

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 8 may not equal the sum of the changes in columns 1, 6, and 7, plus the other impacts that we are able to identify.

The overall payment change from FY 1998 to FY 1999 for all hospitals is a 0.7 percent decrease. This reflects the 0.6 percent net change in total payments due to the postacute transfer change for FY 1999 shown in column 1; the 0.7 percent update for FY 1999, the 0.3 percent lower outlier payments in FY 1999 compared to FY 1998 (5.1 percent compared to 5.4 percent); and the 0.4 percent reduction due to lower IME and DSH payments.

Hospitals in urban areas experience a 1.1 percent drop in payments per case compared to FY 1998. Urban hospitals lose 0.9 percent due to the expanded transfer definition and the DRG and wage index changes combined. The 0.4 percent negative impact due to reclassification is offset by an identical negative impact for FY 1998. The impact of reducing IME and DSH is a 0.6 percent reduction in FY 1999 payments per case. Most of this negative impact is incurred by hospitals in large urban areas, where payments are expected to fall 1.4 percent per case compared to 0.5 percent per case for hospitals in other urban areas.

Hospitals in rural areas, meanwhile, experience a 1.5 percent payment increase. As discussed previously, this is primarily due to a smaller negative impact due to the expanded transfer definition (0.4 percent decrease compared to 0.6 percent nationally) and the positive effect due to the wage index and DRG changes (1.3 percent increase).

Among census divisions, urban New England displays the largest negative impact, 3.5 percent. This outcome is primarily related to the 2.4 percent decrease due to the new wage data. Similarly, urban West South Central experiences a 2.0 percent drop in payments per case, due to a 1.1 percent drop due to the new wage data. The urban East North Central and the urban Pacific also experience overall payment declines of more than 1.0 percent, with 1.5 and 1.4 percent decreases, respectively. The West North Central is the only urban census category to experience a rise in payments, stemming primarily from a 0.9 percent increase due to the new wage data. Hospitals in this census division also are less reliant on IME and DSH funding, and are therefore, impacted less by these reductions.

The only rural census division to experience a negative payment impact is New England (0.4 percent fall). This appears to result from a much smaller reclassification effect for rural New England hospitals in FY 1999. For FY 1998, the impact of MGCRB reclassification for these hospitals was a 2.1 percent increase (see 62 FR 46119). For FY 1999, the increase is only 0.6 percent. The largest increases by rural census division are in the South Atlantic and the East South Central, both with 2.0 percent increases in their FY 1999 payments per case. In the South Atlantic, this is primarily due to a larger FY 1999 benefit from MGCRB reclassifications. For the East South Central, it is largely due to a 1.5 percent increase from the FY 1995 wage data.

Among special categories of rural hospitals, RRCs have the largest increase, 2.5 percent. This carries over to other categories as well: rural hospitals with between 150 and 200 beds have a 2.7 percent rise in payments (there are 37 RRCs in this category); and RRCs receiving DSH see a 2.9 percent increase.

The largest negative payment impacts from FY 1998 to FY 1999 are among hospitals that were reclassified for FY 1998 and are not reclassified for FY 1999. Overall, these hospitals lose 3.1 percent. The urban hospitals in this category lose 2.2 percent, while the rural hospitals lose 6.1 percent. On the other hand, hospitals reclassified for FY 1999 that were not reclassified for FY 1998 would experience the greatest payment increases: 4.7 percent overall; 6.1 percent for 153 rural hospitals in this category and 1.9 percent for 25 urban hospitals.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1999 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	Number of hospitals (1)	Average FY 1998 payment per case (2) [1]	Average FY 1999 payment per case (3) [1]	All changes (4)
(BY GEOGRAPHIC LOCATION):				
ALL HOSPITALS	4,956	6,764	6,715	−0.7
URBAN HOSPITALS	2,792	7,332	7,255	−1.1
LARGE URBAN AREAS	1,588	7,891	7,782	−1.4

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1999 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals (1)	Average FY 1998 payment per case (2) [1]	Average FY 1999 payment per case (3) [1]	All changes (4)
OTHER URBAN AREAS	1,204	6,584	6,549	−0.5
RURAL AREAS	2,164	4,461	4,528	1.5
BED SIZE (URBAN):				
0–99 BEDS	690	4,922	4,890	−0.7
100–199 BEDS	936	6,127	6,069	−1.0
200–299 BEDS	566	6,921	6,860	−0.9
300–499 BEDS	448	7,839	7,744	−1.2
500 OR MORE BEDS	152	9,724	9,607	−1.2
BED SIZE (RURAL):				
0–49 BEDS	1,135	3,663	3,712	1.3
50–99 BEDS	635	4,173	4,218	1.1
100–149 BEDS	229	4,609	4,669	1.3
150–199 BEDS	91	4,799	4,927	2.7
200 OR MORE BEDS	74	5,603	5,692	1.6
URBAN BY CENSUS DIV.:				
NEW ENGLAND	152	7,873	7,597	−3.5
MIDDLE ATLANTIC	425	8,168	8,123	−0.5
SOUTH ATLANTIC	413	6,973	6,955	−0.3
EAST NORTH CENTRAL	475	7,016	6,909	−1.5
EAST SOUTH CENTRAL	159	6,558	6,511	−0.7
WEST NORTH CENTRAL	186	7,001	7,011	0.1
WEST SOUTH CENTRAL	350	6,807	6,672	−2.0
MOUNTAIN	126	7,065	7,045	−0.3
PACIFIC	458	8,403	8,289	−1.4
PUERTO RICO	48	3,049	3,057	0.3
RURAL BY CENSUS DIV.:				
NEW ENGLAND	53	5,308	5,285	−0.4
MIDDLE ATLANTIC	80	4,802	4,857	1.1
SOUTH ATLANTIC	286	4,606	4,697	2.0
EAST NORTH CENTRAL	284	4,492	4,559	1.5
EAST SOUTH CENTRAL	269	4,160	4,242	2.0
WEST NORTH CENTRAL	499	4,174	4,250	1.8
WEST SOUTH CENTRAL	341	3,989	4,019	0.7
MOUNTAIN	206	4,815	4,871	1.2
PACIFIC	141	5,603	5,664	1.1
PUERTO RICO	5	2,369	2,389	0.8
(BY PAYMENT CATEGORIES):				
URBAN HOSPITALS	2,877	7,289	7,215	−1.0
LARGE URBAN AREAS	1,681	7,795	7,691	−1.3
OTHER URBAN AREAS	1,196	6,564	6,533	−0.5
RURAL AREAS	2,079	4,440	4,501	1.4
TEACHING STATUS:				
NON-TEACHING	3,875	5,478	5,472	−0.1
FEWER THAN 100 RESIDENTS	841	7,219	7,155	−0.9
100 OR MORE RESIDENTS	240	10,987	10,796	−1.7
DISPROPORTIONATE SHARE HOSPITALS (DSH):				
NON–DSH	3,074	5,830	5,809	−0.4
URBAN DSH:				
100 BEDS OR MORE	1,402	7,941	7,850	−1.1
FEWER THAN 100 BEDS	93	5,024	4,990	−0.7
RURAL DSH:				
SOLE COMMUNITY (SCH)	156	4,255	4,310	1.3
REFERRAL CENTERS (RRC)	47	5,293	5,446	2.9
OTHER RURAL DSH HOSP.:				
100 BEDS OR MORE	64	4,196	4,229	0.8
FEWER THAN 100 BEDS	120	3,572	3,633	1.7
URBAN TEACHING AND DSH:				
BOTH TEACHING AND DSH	700	8,961	8,837	−1.4
TEACHING AND NO DSH	328	7,390	7,318	−1.0
NO TEACHING AND DSH	795	6,342	6,303	−0.6
NO TEACHING AND NO DSH	1,054	5,661	5,626	−0.6
SPECIAL UPDATE HOSPITALS (UNDER SEC. 4401(b) OF PUBLIC LAW 105–33	356	5,322	5,305	−0.3
RURAL HOSPITAL TYPES:				
NONSPECIAL STATUS HOSPITALS	904	3,948	3,986	1.0

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1999 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals (1)	Average FY 1998 payment per case (2) [1]	Average FY 1999 payment per case (3) [1]	All changes (4)
RRC	137	5,182	5,309	2.5
SCH/EACH	633	4,490	4,525	0.8
MDH	351	3,701	3,747	1.3
SCH/EACH AND RRC	54	5,363	5,433	1.3
TYPE OF OWNERSHIP:				
VOLUNTARY	2,859	6,949	6,894	−0.8
PROPRIETARY	671	6,148	6,092	−0.9
GOVERNMENT	1,331	6,233	6,215	−0.3
UNKNOWN	95	7,984	7,928	−0.7
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:				
0–25	249	8,884	8,740	−1.6
25–50	1,267	8,243	8,142	−1.2
50–65	1,975	6,168	6,143	−0.4
OVER 65	1,370	5,250	5,247	0.0
UNKNOWN	95	7,984	7,928	−0.7
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:				
RECLASSIFICATION STATUS DURING FY98 AND FY99:				
RECLASSIFIED DURING BOTH FY98 AND FY99	311	5,995	5,989	−0.1
URBAN	70	7,505	7,468	−0.5
RURAL	241	5,250	5,258	0.2
RECLASSIFIED DURING FY99 ONLY	178	5,512	5,773	4.7
URBAN	25	8,442	8,605	1.9
RURAL	153	4,705	4,993	6.1
RECLASSIFIED DURING FY98 ONLY	111	6,192	6,000	−3.1
URBAN	38	7,018	6,865	−2.2
RURAL	73	4,458	4,185	−6.1
FY 99 RECLASSIFICATIONS:				
ALL RECLASSIFIED HOSP.	489	5,815	5,908	1.6
STAND. AMT. ONLY	94	5,938	5,920	−0.3
WAGE INDEX ONLY	281	5,994	5,940	−0.9
BOTH	47	6,390	6,290	−1.6
NONRECLASS.	4,507	6,844	6,795	−0.7
ALL URBAN RECLASS.	95	7,767	7,786	0.2
STAND. AMT. ONLY	25	5,922	5,924	0.0
WAGE INDEX ONLY	45	9,138	9,194	0.6
BOTH	25	6,679	6,647	−0.5
NONRECLASS.	2,670	7,327	7,245	−1.1
ALL RURAL RECLASS.	394	5,026	5,149	2.5
STAND. AMT. ONLY	57	4,516	4,626	2.4
WAGE INDEX ONLY	309	5,086	5,204	2.3
BOTH	28	5,038	5,230	3.8
NONRECLASS.	1,770	4,106	4,137	0.8
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	27	4,725	4,695	−0.6

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

Table II presents the projected impact of the proposed changes for FY 1999 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the projected payments per case for FY 1999 with the average estimated per case payments for FY 1998, 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 8 of Table I.

VIII. Impact of Proposed Changes in the Capital Prospective Payment System

A. General Considerations

We now have data that were unavailable in previous impact analyses for the capital prospective payment system. Specifically, we have cost report data available for the fourth year of the capital prospective payment system (cost reports beginning in FY 1995) available through the December 1997 update of the Health Care Provider Cost Report Information System (HCRIS). We also have updated information on the projected aggregate amount of obligated capital approved by the fiscal intermediaries. However, our impact analysis of payment changes for capital-related costs is still limited by the lack of hospital-specific data on several items. These are the hospital's projected new capital costs for each year, its projected old capital costs for each year, and the actual amounts of obligated capital that will be put in use for patient care and recognized as Medicare old capital costs in each year. The lack of this information affects our impact analysis in the following ways:

- Major investment in hospital capital assets (for example in building and major fixed equipment) occurs at irregular intervals. As a result, there can be significant variation in the growth rates of Medicare capital-related costs per case among hospitals. We do not have the necessary hospital-specific budget data to project the hospital capital growth rate for individual hospitals.

• Moreover, our policy of recognizing certain obligated capital as old capital makes it difficult to project future capital-related costs for individual hospitals. Under § 412.302(c), a hospital is required to notify its intermediary that it has obligated capital by the later of October 1, 1992, or 90 days after the beginning of the hospital's first cost reporting period under the capital prospective payment system. The intermediary must then notify the hospital of its determination whether the criteria for recognition of obligated capital have been met by the later of the end of the hospital's first cost reporting period subject to the capital prospective payment system or 9 months after the receipt of the hospital's notification. The amount that is recognized as old capital is limited to the lesser of the actual allowable costs when the asset is put in use for patient care or the estimated costs of the capital expenditure at the time it was obligated. We have substantial information regarding intermediary determinations of projected aggregate obligated capital amounts. However, we still do not know when these projects will actually be put into use for patient care, the actual amount that will be recognized as obligated capital when the project is put into use, or the Medicare share of the recognized costs. Therefore, we do not know actual obligated capital commitments for purposes of the FY 1999 capital cost projections. In Appendix B of this proposed rule, we discuss the assumptions and computations that we employ to generate the amount of obligated capital commitments for use in the FY 1999 capital cost projections.

In Table III of this section, we present the redistributive effects that are expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals in FY 1999. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the proposed FY 1999 capital payment policies by the standard prospective payment system hospital groupings. While we now have actual information on the effects of the transition payment methodology and interim payments under the capital prospective payment system and cost report data for most hospitals, we still need to randomly generate numbers for the change in old capital costs, new capital costs for each year, and obligated amounts that will be put in use for patient care services and recognized as old capital each year. We continue to be unable to predict accurately FY 1999 capital costs for individual hospitals, but with the most recent data hospitals' experience under the capital prospective payment system, there is adequate information to estimate the aggregate impact on most hospital groupings.

B. Projected Impact Based on the Proposed FY 1999 Actuarial Model

1. Assumptions. In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 1998 to FY 1999 using a capital cost model. The FY 1999 model, as described in Appendix B of this proposed rule, integrates actual data from individual hospitals with randomly generated capital cost amounts. We have capital cost data from cost reports beginning in FY 1989 through FY 1995 as reported on the December 1997 update of HCRIS, interim payment data for hospitals already receiving capital prospective payments through PRICER, and data reported by the intermediaries that include the hospital-specific rate determinations that have been made through January 1, 1998 in the provider-specific file. We used these data to determine the proposed FY 1999 capital rates. However, we do not have individual hospital data on old capital changes, new capital formation, and actual obligated capital costs. We have data on costs for capital in use in FY 1995, and we age that capital by a formula described in Appendix B. Therefore, we need to randomly generate only new capital acquisitions for any year after FY 1995. All Federal rate payment parameters are assigned to the applicable hospital.

For purposes of this impact analysis, the FY 1999 actuarial model includes the following assumptions:

• Medicare inpatient capital costs per discharge will change at the following rates during these periods:

AVERAGE PERCENTAGE CHANGE IN CAPITAL COSTS PER DISCHARGE

Fiscal Year	Percentage Change
1997	−2.20
1998	−0.44
1999	0.61

We have reduced our estimate of the growth in Medicare costs per discharge from the August 29, 1997 final rule with comment period to this proposed rule based on later cost data. We are now estimating a much smaller increase in costs per discharge.

• The Medicare case-mix index will increase by 1.0 percent in FY 1998 and FY 1999.

• The Federal capital rate and hospital-specific rate were updated 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 proposed FY 1999 update for inflation is 0.20 percent (see section III of the Addendum).

2. Results. We have used the actuarial model to estimate the change in payment for capital-related costs from FY 1998 to FY 1999. Table III shows the effect of the capital prospective payment system on low capital cost hospitals and high capital cost hospitals. We consider a hospital to be a low capital cost hospital if, based on a comparison of its initial hospital-specific rate and the applicable Federal rate, it will be paid under the fully prospective payment methodology. A high capital cost hospital is a hospital that, based on its initial hospital-specific rate and the applicable Federal rate, will be paid under the hold-harmless payment methodology. Based on our actuarial model, the breakdown of hospitals is as follows:

CAPITAL TRANSITION PAYMENT METHODOLOGY FOR FY 1999

Type of hospital	Percent of hospitals	Percent of discharges	Percent of capital costs	Percent of capital payments
Low Cost Hospital	67	62	53	58
High Cost Hospital	33	38	47	42

A low capital cost hospital may request to have its hospital-specific rate redetermined based on old capital costs in the current year, through the later of the hospital's cost reporting period beginning in FY 1994 or the first cost reporting period beginning after obligated capital comes into use (within the limits established in § 412.302(e) for putting obligated capital in to use for patient care). If the redetermined hospital-specific rate is greater than the adjusted Federal rate, these hospitals will be paid under the hold-harmless payment methodology. Regardless of whether the hospital became a hold-harmless payment hospital as a result of a redetermination, we continue to show these hospitals as low capital cost hospitals in Table III.

Assuming no behavioral changes in capital expenditures, Table III displays the percentage change in payments from FY 1998 to FY 1999 using the above described actuarial model. With the proposed Federal rate, we estimate aggregate Medicare capital payments will increase by 2.60 percent in FY 1999.

TABLE III.—IMPACT OF PROPOSED CHANGES FOR FY 1999 ON PAYMENTS PER DISCHARGE

	Number of hospitals	Discharges	Adjusted federal payment	Average federal percent	Hospital specific payment	Hold harmless payment	Exceptions payment	Total payment	Percent change over FY 1998
FY 1998 Payments per Discharge:									
Low Cost Hospitals	3,260	6,746,172	$458.89	72.51	$86.07	$4.04	$8.87	$557.88	.....
Fully Prospective	3,021	6,102,199	440.78	70.00	95.16	.....	8.21	544.15	.....
100% Federal Rate	208	567,402	661.26	100.00	.....	.....	11.10	672.36	.....
Hold Harmless	31	76,570	402.65	59.69	.....	355.79	45.50	803.94	.....
High Cost Hospitals	1,637	4,163,057	636.32	95.82	.....	36.64	16.72	689.68	.....
100% Federal Rate	1,398	3,701,256	667.50	100.00	.....	.....	11.65	679.14	.....
Hold Harmless	239	461,801	386.44	60.70	.....	330.33	57.34	774.12	.....
Total Hospitals	4,897	10,909,229	526.60	81.67	53.23	16.48	11.87	608.18	.....
FY 1999 Payments per Discharge:									
Low Cost Hospitals	3,260	6,596,003	$529.51	81.61	$58.10	$3.38	$9.53	$597.52	7.11
Fully Prospective	3,021	5,966,449	513.52	80.00	64.23	.....	8.47	586.21	7.73
100% Federal Rate	211	561,909	674.19	100.00	.....	.....	10.98	685.17	1.91
Hold Harmless	28	67,646	445.71	64.76	.....	329.56	91.77	867.04	7.85
High Cost Hospitals	1,637	4,068,306	655.17	97.22	.....	25.50	23.85	704.52	2.15
100% Federal Rate	1,417	3,678,286	681.02	100.00	.....	.....	16.94	697.97	2.77
Hold Harmless	220	390,020	411.40	67.81	.....	265.94	88.99	766.33	−1.01
Total Hospitals	4,897	10,664,309	575.59	87.73	35.93	11.82	15.00	638.34	4.96

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 7.73 percent, and high capital cost hospitals will experience an average increase of 2.15 percent.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 70 percent to 80 percent and the hospital-specific rate payment percentage will decrease from 30 to 20 percent in FY 1999. The Federal rate payment percentage for hospitals paid under the hold-harmless payment methodology is based on the hospital's ratio of new capital costs to total capital costs. The average Federal rate payment percentage for high cost hospitals receiving a hold-harmless payment for old capital will increase from 60.70 percent to 67.81 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 85.6 percent to 86.8 percent. We estimate that high cost hold-harmless hospitals will experience a decrease in payments of 1.01 percent from FY 1998 to FY 1999. The apparent decrease occurs because we estimate that there will be 19 fewer high-cost hold-harmless hospitals in FY 1999. These 19 hospitals may have higher payments than the remaining hospitals, hence the apparent decrease when they are removed from the group. This decrease is partially offset by an increase in the Federal portion of the hospital's payments and a projected increase in exceptions payments.

We expect that the average hospital-specific rate payment per discharge will decrease from $95.16 in FY 1998 to $64.23 in FY 1999. This is partly due to the decrease in the hospital-specific rate payment percentage from 30 percent in FY 1998 to 20 percent in FY 1999.

We are proposing no changes in our exceptions policies for FY 1999. As a result, the minimum payment levels would be:

- 90 percent for sole community hospitals;
- 80 percent for urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or more; or
- 70 percent for all other hospitals.

We estimate that exceptions payments will increase from 1.95 percent of total capital payments in FY 1998 to 2.35 percent of payments in FY 1999. Since the August 29, 1997 final rule with comment period, we have reduced our estimates of capital cost per case based on more recent data. Although we still estimate that more hospitals will receive exceptions payment in FY 1999 than in FY 1998 fewer hospitals will have costs over the exceptions threshold then we previously estimated. The projected distribution of the exception payments is shown in the table below:

Estimated FY 1999 Exceptions Payments

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	178	39
High Capital Cost	200	61
Total	378	100

C. Cross-Sectional Comparison of Capital Prospective Payment Methodologies

Table IV presents a cross-sectional summary of hospital groupings by capital prospective payment methodology. This distribution is generated by our actuarial model.

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS

	(1) Total No. of Hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
By Geographic Location:				
All hospitals	4,897	5.1	33.2	61.7
Large urban areas (populations over 1 million)	1,558	5.7	40.7	53.6

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS—Continued

	(1) Total No. of Hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
Other urban areas (populations of 1 million or fewer)	1,188	6.2	40.8	52.9
Rural areas	2,151	4.0	23.7	72.4
Urban hospitals	2,746	5.9	40.8	53.3
0–99 beds	653	5.8	33.8	60.3
100–199 beds	928	8.5	45.9	45.6
200–299 beds	565	5.8	40.9	53.3
300–499 beds	448	2.2	40.8	56.9
500 or more beds	152	2.0	38.2	59.9
Rural hospitals	2,151	4.0	23.7	72.4
0–49 beds	1,124	3.5	16.1	80.4
50–99 beds	633	4.3	28.8	67.0
100–149 beds	229	4.8	38.0	57.2
150–199 beds	91	7.7	25.3	67.0
200 or more beds	74	1.4	48.6	50.0
By Region				
Urban by Region	2,746	5.9	40.8	53.3
New England	151	0.0	27.8	72.2
Middle Atlantic	421	4.5	34.0	61.5
South Atlantic	409	5.4	53.5	41.1
East North Central	472	5.5	30.5	64.0
East South Central	157	10.8	48.4	40.8
West North Central	183	6.0	36.6	57.4
West South Central	332	13.3	55.7	31.0
Mountain	122	4.9	50.8	44.3
Pacific	451	3.3	37.7	59.0
Puerto Rico	48	6.3	22.9	70.8
Rural by Region	2,151	4.0	23.7	72.4
New England	53	0.0	22.6	77.4
Middle Atlantic	79	5.1	25.3	69.6
South Atlantic	282	2.5	33.0	64.5
East North Central	283	3.2	19.1	77.7
East South Central	267	1.9	34.1	64.0
West North Central	498	3.6	16.1	80.3
West South Central	339	3.8	27.4	68.7
Mountain	205	10.7	15.6	73.7
Pacific	140	5.0	23.6	71.4
Large urban areas (populations over 1 million)	1,651	5.9	40.5	53.7
Other urban areas (populations of 1 million or fewer)	1,180	5.8	41.1	53.1
Rural areas	2,066	4.0	23.0	73.0
Teaching Status:				
Non-teaching	3,818	5.1	32.8	62.0
Fewer than 100 Residents	840	5.7	35.1	59.2
100 or more Residents	239	1.7	33.5	64.9
Disproportionate share hospitals (DSH):				
Non-DSH	3,029	5.3	28.9	65.8
Urban DSH:				
100 or more beds	1,397	5.2	43.7	51.0
Less than 100 beds	87	1.1	29.9	69.0
Rural DSH:				
Sole Community (SCH/EACH)	156	5.1	22.4	72.4
Referral Center (RRC/EACH)	47	2.1	53.2	44.7
Other Rural:				
100 or more beds	64	4.7	37.5	57.8
Less than 100 beds	117	0.9	28.2	70.9
Urban teaching and DSH:				
Both teaching and DSH	699	4.0	36.6	59.4
Teaching and no DSH	327	6.7	31.5	61.8
No teaching and DSH	785	5.9	48.5	45.6
No teaching and no DSH	1,020	6.8	40.5	52.7
Rural Hospital Types:				
Non special status hospitals	894	2.0	24.0	73.9
RRC/EACH	137	2.2	40.1	57.7
SCH/EACH	632	8.2	19.9	71.8
Medicare-dependent hospitals (MDH)	349	1.1	17.5	81.4
SCH, RRC and EACH	54	11.1	33.3	55.6

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS—Continued

	(1) Total No. of Hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
Type of Ownership:				
Voluntary	2,847	4.9	33.0	62.1
Proprietary	656	10.1	58.2	31.7
Government	1,329	3.2	21.1	75.7
Medicare Utilization as a Percent of Inpatient Days:				
0–25	238	4.2	30.7	65.1
25–50	1,260	5.9	41.0	53.2
50–65	1,970	5.6	33.0	61.4
Over 65	1,364	3.8	26.6	69.6

As we explain in Appendix B, we were not able to determine a hospital-specific rate for 59 of the 4,956 hospitals in our database. Consequently, the payment methodology distribution is based on 4,897 hospitals. These data should be fully representative of the payment methodologies that will be applicable to hospitals.

The cross-sectional distribution of hospital by payment methodology is presented by: (1) Geographic location, (2) region, and (3) payment classification. This provides an indication of the percentage of hospitals within a particular hospital grouping that will be paid under the fully prospective payment methodology and the hold-harmless payment methodology.

The percentage of hospitals paid fully Federal (100 percent of the Federal rate) as hold-harmless hospitals is expected to increase to 33.2 percent in FY 1999. We note that the number of hospitals paid fully Federal as hold-harmless hospitals has not increased as quickly as we predicted in the August 29, 1997 final rule with comment period because of revised estimates.

Table IV indicates that 61.7 percent of hospitals will be paid under the fully prospective payment methodology. (This figure, unlike the figure of 67 percent for low cost capital hospitals in the previous section, takes account of the effects of redeterminations. In other words, this figure does not include low cost hospitals that, following a hospital-specific rate redetermination, are now paid under the hold-harmless methodology.) As expected, a relatively higher percentage of rural and governmental hospitals (73.0 percent and 75.7 percent, respectively by payment classification) are being paid under the fully prospective methodology. This is a reflection of their lower than average capital costs per case. In contrast, only 31.7 percent of proprietary hospitals are being paid under the fully prospective methodology. This is a reflection of their higher than average capital costs per case. (We found at the time of the August 30, 1991 final rule (56 FR 43430) that 62.7 percent of proprietary hospitals had a capital cost per case above the national average cost per case.)

D. Cross-Sectional Analysis of Changes in Aggregate Payments

We used our FY 1999 actuarial model to estimate the potential impact of our proposed changes for FY 1999 on total capital payments per case, using a universe of 4,897 hospitals. The individual hospital payment parameters are taken from the best available data, including: The January 1, 1998 update to the provider-specific file, cost report data, and audit information supplied by intermediaries. In Table V we present the results of the cross-sectional analysis using the results of our actuarial model and the aggregate impact of the FY 1999 payment policies. Columns 3 and 4 show estimates of payments per case under our model for FY 1998 and FY 1999. Column 5 shows the total percentage change in payments from FY 1998 to FY 1999. Column 6 presents the percentage change in payments that can be attributed to Federal rate changes alone.

Federal rate changes represented in Column 6 include the 1.5 percent increase in the Federal rate, a 1.0 percent increase in case mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB. Column 5 includes the effects of the Federal rate changes represented in Column 6. Column 5 also reflects the effects of all other changes, including: the change from 70 percent to 80 percent in the portion of the Federal rate for fully prospective hospitals, the hospital-specific rate update, changes in the proportion of new to total capital for hold-harmless hospitals, changes in old capital (for example, obligated capital put in use), hospital-specific rate redeterminations, and exceptions. 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 increase 5.0 percent in FY 1999. The results show that the effect of the Federal rate changes alone is to increase payments by 1.5 percent. In addition to the increase attributable to the Federal rate changes, a 3.5 percent increase is attributable to the effects of all other changes.

Our comparison by geographic location shows that urban and rural hospitals will experience slightly different rates of increase in capital payments per case (4.8 percent and 6.3 percent, respectively). This difference is due to the lower rate of increase for urban hospitals relative to rural hospitals (1.3 percent and 3.2 percent, respectively) from the Federal rate changes alone. Urban hospitals will gain approximately the same as rural hospitals (3.5 percent versus 3.1 percent) from the effects of all other changes.

All regions are estimated to receive increases in total capital payments per case, partly due to the increased share of payments that are based on the Federal rate (from 70 to 80 percent). Changes by region vary from a low of 3.6 percent increase (West South Central urban region) to a high of 7.8 percent increase (Pacific rural region).

By type of ownership, government hospitals are projected to have the largest rate of increase (6.2 percent, 1.9 percent due to Federal rate changes and 4.3 percent from the effects of all other changes). Payments to voluntary hospitals will increase 5.1 percent (a 1.5 percent increase due to Federal rate changes and a 3.6 percent increase from the effects of all other changes) and payments to proprietary hospitals will increase 2.8 percent (a 1.1 percent increase due to Federal rate changes and a 1.7 percent increase from the effects of all other changes).

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 and for purposes of DSH, for FY 1999–2001. Although the Federal capital 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 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 1999 compared to the effects of reclassification for FY 1998, we show the average payment percentage increase for hospitals reclassified in each

fiscal year and in total. For FY 1999 reclassifications, we indicate those hospitals reclassified for standardized amount purposes only, for wage index purposes only, and for both purposes. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 1999 as a whole are projected to experience a 6.8 percent increase in payments (a 3.5 percent increase attributable to Federal rate changes and a 3.3 percent increase attributable to the effects of all other changes). Payments to nonreclassified hospitals will increase slightly less (5.1 percent) than reclassified hospitals (6.8 percent) overall. Payments to nonreclassified hospitals will increase less than reclassified hospitals from the Federal rate changes (1.5 percent compared to 3.5 percent), but they will gain about the same from the effects of all other changes (3.6 percent compared to 3.3 percent).

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE (FY 1998 COMPARED TO FY 1999)

	Number of hospitals	Average FY 1998 payments/case	Average FY 1999 payments/case	All changes	Portion attributable to federal rate change
By Geographic Location:					
All hospitals	4,897	608	638	5.0	1.5
Large urban areas (populations over 1 million)	1,558	700	732	4.5	1.1
Other urban areas (populations of 1 million of fewer)	1,188	601	633	5.2	1.5
Rural areas	2,151	405	431	6.3	3.2
Urban hospitals	2,746	658	689	4.8	1.3
0–99 beds	653	482	502	4.1	1.2
100–199 beds	928	584	605	3.6	1.1
200–299 beds	565	628	661	5.4	1.3
300–499 beds	448	686	720	4.9	1.2
500 or more beds	152	824	866	5.1	1.4
Rural hospitals	2,151	405	431	6.3	3.2
0–49 beds	1,124	325	348	6.9	2.9
50–99 beds	633	382	407	6.6	2.8
100–149 beds	229	421	446	5.9	3.0
150–199 beds	91	442	469	6.0	3.8
200 or more beds	74	500	531	6.2	3.7
By Region:					
Urban by Region	2,746	658	689	4.8	1.3
New England	151	659	685	4.0	−0.4
Middle Atlantic	421	708	743	5.0	1.8
South Atlantic	409	649	678	4.4	1.8
East North Central	472	616	650	5.5	1.0
East South Central	157	611	633	3.6	0.8
West North Central	183	638	673	5.6	2.3
West South Central	332	664	688	3.6	0.5
Mountain	122	691	728	5.4	1.6
Pacific	451	719	755	5.1	1.0
Puerto Rico	48	277	288	4.1	1.9
Rural by Region	2,151	405	431	6.3	3.2
New England	53	475	497	4.5	1.9
Middle Atlantic	79	413	443	7.4	3.4
South Atlantic	282	430	455	5.9	3.5
East North Central	283	401	431	7.4	3.4
East South Central	267	376	400	6.6	3.4
West North Central	498	390	411	5.6	3.4
West South Central	339	370	390	5.5	2.5
Mountain	205	434	461	6.4	2.4
Pacific	140	478	515	7.8	2.8
By Payment Classification:					
All hospitals	4,897	608	638	5.0	1.5
Large urban areas (populations over 1 million)	1,651	692	724	4.5	1.1
Other urban areas (populations of 1 million of fewer)	1,180	599	631	5.2	1.5
Rural areas	2,066	402	427	6.2	3.0
Teaching Status:					
Non-teaching	3,818	517	540	4.5	1.7
Fewer than 100 Residents	840	647	682	5.4	1.3
100 or more Residents	239	889	936	5.3	1.3
Urban DSH:					
100 or more beds	1,397	693	727	4.9	1.3
Less than 100 beds	87	444	467	5.1	1.1
Rural DSH:					
Sole Community (SCH/EACH)	156	364	383	5.2	2.5
Referral Center (RRC/EACH)	47	462	494	7.0	4.5
Other Rural:					
100 or more beds	64	384	400	4.3	2.8
Less than 100 beds	117	320	340	6.3	3.3
Urban teaching and DSH:					
Both teaching and DSH	699	761	801	5.3	1.2
Teaching and no DSH	327	659	696	5.5	1.3

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE (FY 1998 COMPARED TO FY 1999)—Continued

	Number of hospitals	Average FY 1998 payments/case	Average FY 1999 payments/case	All changes	Portion attributable to federal rate change
No teaching and DSH	785	585	610	4.3	1.3
No teaching and no DSH	1,020	558	579	3.7	1.3
Rural Hospital Types:					
Non special status hospitals	894	367	389	6.0	2.6
RRC/EACH	137	475	506	6.5	3.9
SCH/EACH	632	391	416	6.2	2.4
Medicare-dependent hospitals (MDH)	349	324	355	9.5	3.6
SCH, RRC and EACH	54	483	500	3.5	3.1
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY98 and FY99:					
Reclassified During Both FY98 and FY99	311	540	566	4.8	1.7
Reclassified During FY99 Only	178	487	537	10.4	6.8
Reclassified During FY98 Only	110	580	587	1.2	−1.4
FY99 Reclassifications:					
All Reclassified Hospitals	489	520	555	6.8	3.5
All Nonreclassified Hospitals	4,449	614	646	5.1	1.5
All Urban Reclassified Hospitals	95	663	708	6.8	2.3
Urban Nonreclassified Hospitals	2,624	659	689	4.7	1.2
All Reclassified Rural Hospitals	394	462	494	6.8	4.2
Rural Nonreclassified Hospitals	1,757	369	391	6.0	2.4
Other Reclassified Hospitals (Section 1886 (D)(8)(B))	27	461	476	3.3	1.1
Type of Ownership:					
Voluntary	2,847	622	653	5.1	1.5
Proprietary	656	617	634	2.8	1.1
Government	1,329	530	563	6.2	1.9
Medicare Utilization as a Percent of Inpatient Days:					
0–25	238	685	725	5.8	1.1
25–50	1,260	724	759	4.7	1.3
50–65	1,970	565	594	5.2	1.6

Appendix B: Technical Appendix on the Capital Cost Model and Required Adjustments

Under section 1886(g)(1)(A) of the Act, we set capital prospective payment rates for FY 1992 through FY 1995 so that aggregate prospective payments for capital costs were projected to be 10 percent lower than the amount that would have been payable on a reasonable cost basis for capital-related costs in that year. To implement this requirement, we developed the capital acquisition model to determine the budget neutrality adjustment factor. Even though the budget neutrality requirement expired effective with FY 1996, we must continue to determine the recalibration and geographic reclassification budget neutrality adjustment factor, and the reduction in the Federal and hospital-specific rates for exceptions payments. To determine these factors, we must continue to project capital costs and payments.

We have used the capital acquisition model since the start of prospective payments for capital costs. We now have 4 years of cost reports under the capital prospective payment system. For FY 1998, we developed a new capital cost model to replace the capital acquisition model. This revised model makes use of the data from these cost reports.

The following cost reports are used in the capital cost model for this proposed rule: The December 31, 1997 update of the cost reports for PPS–IX (cost reporting periods beginning in FY 1992), PPS–X (cost reporting periods beginning in FY 1993), PPS–XI (cost reporting periods beginning in FY 1994), and PPS–XII (cost reporting periods beginning in FY 1995). In addition, to model payments, we use the January 1, 1998 update of the provider-specific file, and the March 1994 update of the intermediary audit file.

Since hospitals under alternative payment system waivers (that is, hospitals in Maryland) are currently excluded from the capital prospective payment system, we excluded these hospitals from our model.

We developed FY 1992 through FY 1998 hospital-specific rates using the provider-specific file and the intermediary audit file. (We used the cumulative provider-specific file, which includes all updates to each hospital's records, and chose the latest record for each fiscal year.) We checked the consistency between the provider-specific file and the intermediary audit file. We ensured that increases in the hospital-specific rates were at least as large as the published updates (increases) for the hospital-specific rates each year. We were able to match hospitals to the files as shown in the following table:

Source	Number of hospitals
Provider-Specific File Only	99
Provider-Specific and Audit File	4857
Total	4956

Eighty-six of the 4,956 hospitals had unusable or missing data or had no cost reports available. We determined from the cost reports that 27 of the 86 hospitals were paid under the hold-harmless methodology. Since the hospital-specific amount is not used to determine payments for these hospitals, we were able to include these 27 hospitals in the analysis. We used the cost report data of 4,897 hospitals for the analysis. Fifty-nine hospitals could not be used in the analysis because of insufficient information. These hospitals account for approximately 0.3 percent of admissions, therefore, any effects from the elimination of their cost report data should be minimal.

We analyzed changes in capital-related costs (depreciation, interest, rent, leases, insurance, and taxes) reported in the cost reports. We found a wide variance among hospitals in the growth of these costs. For hospitals with more than 100 beds, the distribution and mean of these cost increases were different for large changes in bed-size (greater than ±20 percent). We also analyzed changes in the growth in old capital and new capital for cost reports that provided this information. For old capital, we limited the analysis to decreases in old capital. We did this since the opportunity for most hospitals to treat ''obligated'' capital put into service as

old capital has expired. Old capital costs should, therefore, decrease as assets become fully depreciated, and as interest costs decrease as the loan is amortized.

The new capital cost model separates the hospitals into three mutually exclusive groups. Hold-harmless hospitals with data on old capital were placed in the first group. Of the remaining hospitals, those hospitals with fewer than 100 beds comprise the second group. The third group consists of all hospitals that did not fit into either of the groups. Each of these groups displayed unique patterns of growth in capital costs. We found that the gamma distribution is useful in explaining and describing the patterns of increase in capital costs. A gamma distribution is a statistical distribution that can be used to describe patterns of growth rates, with greatest proportion of rates being at the low end. We use the gamma distribution to estimate individual hospital rates of increase as follows:

(1) For hold-harmless hospitals, old capital cost changes were fitted to a truncated gamma distribution, that is, a gamma distribution covering only the distribution of cost decreases. New capital costs changes were fitted to the entire gamma distribution allowing for both decreases and increases.

(2) For hospitals with fewer than 100 beds (small), total capital cost changes were fitted to the gamma distribution allowing for both decreases and increases.

(3) Other (large) hospitals were further separated into three groups:

- Bed-size decreases over 20 percent (decrease).
- Bed-size increases over 20 percent (increase).
- Other (no-change).

Capital cost changes for large hospitals were fitted to gamma distributions for each bed-size change group, allowing for both decreases and increases in capital costs. We analyzed the probability distribution of increases and decreases in bed-size for large hospitals. We found the probability somewhat dependent on the prior year change in bed-size and factored this dependence into the analysis. Probabilities of bed-size change were determined. Separate sets of probability factors were calculated to reflect the dependence on prior year change in bed-size (increase, decrease, and no change).

The gamma distributions were fitted to changes in aggregate capital costs for the entire hospital. We checked the relationship between aggregate costs and Medicare per discharge costs. For large hospitals, there was a small variance, but the variance was larger for small hospitals. Since costs are used only for the hold-harmless methodology and to determine exceptions, we decided to use the gamma distributions fitted to aggregate cost increases for estimating distributions of cost per discharge increases.

Capital costs per discharge calculated from the cost reports were increased by random numbers drawn from the gamma distribution to project costs in future years. Old and new capital were projected separately for hold-harmless hospitals. Aggregate capital per discharge costs were projected for all other hospitals. Because the distribution of increases in capital costs varies with changes in bed-size for large hospitals, we first projected changes in bed-size for large hospitals before drawing random numbers from the gamma distribution. Bed-size changes were drawn from the uniform distribution with the probabilities dependent on the previous year bed-size change. The gamma distribution has a shape parameter and a scaling parameter. (We used different parameters for each hospital group, and for old and new capital.)

We used discharge counts from the cost reports to calculate capital cost per discharge. To estimate total capital costs for FY 1997 (the MedPAR data year) and later, we use the number of discharges from the MEDPAR data. Some hospitals have considerably more discharges in FY 1997 than in the years for which we calculated cost per discharge from the cost report data. Consequently, a hospital with few cost report discharges would have a high capital cost per discharge since fixed costs would be allocated over only a few discharges. If discharges increase substantially, the cost per discharge would decrease because fixed costs would be allocated over more discharges. If the projection of capital cost per discharge is not adjusted for increases in discharges, the projection of exceptions would be overstated. We address this situation by recalculating the cost per discharge with the MedPAR discharges if the MedPAR discharges exceed the cost report discharges by more than 20 percent. We do not adjust for increases of less than 20 percent because we have not received all of the FY 1997 discharges, and we have removed some discharges from the analysis because they are statistical outliers. This adjustment reduces our estimate of exceptions payments, and consequently, the reduction to the Federal rate for exceptions is smaller. We will continue to monitor our modeling of exceptions payments and make adjustments as needed.

The average national capital cost per discharge generated by this model is the combined average of many randomly generated increases. This average must equal the projected average national capital cost per discharge, which we projected separately (outside this model). We adjusted the shape parameter of the gamma distributions so that the modeled average capital cost per discharge matches our projected capital cost per discharge. The shape parameter for old capital was not adjusted since we are modeling the aging of ''existing'' assets. This model provides a distribution of capital costs among hospitals that is consistent with our aggregate capital projections.

Once each hospital's capital-related costs are generated, the model projects capital payments. We use the actual payment parameters (for example, the case-mix index and the geographic adjustment factor) that are applicable to the specific hospital.

To project capital payments, the model first assigns the applicable payment methodology (fully prospective or hold-harmless) to the hospital as determined from the provider-specific file and the cost reports. The model simulates Federal rate payments using the assigned payment parameters and hospital-specific estimated outlier payments. The case-mix index for a hospital is derived from the FY 1997 MedPAR file using the FY 1998 DRG relative weights published in section V. of the Addendum to this proposed rule. The case-mix index is increased each year after FY 1997 based on analysis of past experiences in case-mix increases. Based on analysis of recent case-mix increases, we estimate that case-mix will increase 1.0 percent in FY 1998 and 1.0 percent in FY 1999. (Since we are using FY 1997 cases for our analysis, the FY 1997 increase in case mix has no effect on projected capital payments.)

Changes in geographic classification and revisions to the hospital wage data used to establish the hospital wage index affect the geographic adjustment factor. Changes in the DRG classification system and the relative weights affect the case-mix index.

Section 412.308(c)(4)(ii) requires that the estimated aggregate payments for the fiscal year, based on the Federal rate after any changes resulting from DRG reclassifications and recalibration and the geographic adjustment factor, equal the estimated aggregate payments based on the Federal rate that would have been made without such changes. For FY 1998, the budget neutrality adjustment factor was 1.00015.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we propose to apply separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We propose to apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 since the geographic adjustment factor for Puerto Rico was implemented in 1998.

To determine the factors for FY 1999, we first determined the portions of the Federal national and Puerto Rico rates that would be paid for each hospital in FY 1999 based on its applicable payment methodology. Using our model, we then compared, separately for the national rate and the Puerto Rico rate, estimated aggregate Federal rate payments based on the FY 1998 DRG relative weights and the FY 1998 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 1998 relative weights and the FY 1999 geographic adjustment factor. In making the comparison, we held the FY 1999 Federal rate portion constant and set the other budget neutrality adjustment factor and the exceptions reduction factor to 1.00. We determined that, to achieve budget neutrality for the changes in the national geographic adjustment factor, an incremental budget neutrality adjustment of 0.99995 for FY 1999 should be applied to the previous cumulative FY 1998 adjustment of 1.00015, yielding a cumulative adjustment of 1.00010 through FY 1999. Since this is the first adjustment for Puerto Rico, the incremental and cumulative adjustment for Puerto Rico would be 0.99887 through 1999. We apply these new adjustments then compare estimated aggregate Federal rate payments based on the FY 1998 DRG relative weights and the FY 1999 geographic adjustment factors to estimated aggregate

Federal rate payments based on the FY 1999 DRG relative weights and the FY 1999 geographic adjustment factors. The incremental adjustment for DRG classifications and changes in relative weights would be 1.00328 nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the geographic adjustment factors through 1999 would be 1.00338 nationally, and 1.00215 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental Adjustment			Cumulative	Incremental Adjustment			Cumulative
	Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined		Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined	
1992	.....	.....	.....	1,000.00	.....	.....	.....	.....
1993	.....	.....	0.998.00	0.998.00	.....	.....	.....	.....
1994	.....	.....	1.00531	1.00330	.....	.....	.....	.....
1995	.....	.....	0.99980	1.00310	.....	.....	.....	.....
1996	.....	.....	0.99940	1.00250	.....	.....	.....	.....
1997	.....	.....	0.99873	1.00123	.....	.....	.....	.....
1998	.....	.....	0.99892	1.00015	.....	.....	.....	1.00000
1999	0.99995	1.00328	1.00323	1.00338	0.99887	1.00328	1.00215	1.00215

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the prospective payment system for operating costs. One difference is that, under the operating prospective payment system, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital prospective payment system, there is a single DRG/GAF budget neutrality adjustment factor (the national rate and the Puerto Rico rate are determined separately) for changes in the geographic adjustment factor (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients or the large urban add-on payments.

In addition to computing the DRG/GAF budget neutrality adjustment factor, we used the model to simulate total payments under the prospective payment system.

Additional payments under the exceptions process are accounted for through a reduction in the Federal and hospital-specific rates. Therefore, we used the model to calculate the exceptions reduction factor. This exceptions reduction factor ensures that aggregate payments under the capital prospective payment system, including exceptions payments, are projected to equal the aggregate payments that would have been made under the capital prospective payment system without an exceptions process. Since changes in the level of the payment rates change the level of payments under the exceptions process, the exceptions reduction factor must be determined through iteration.

In the August 30, 1991 final rule (56 FR 43517), we indicated that we would publish each year the estimated payment factors generated by the model to determine payments for the next 5 years. The table below provides the actual factors for fiscal years 1992 through 1998, the proposed factors for fiscal year 1999, and the estimated factors that would be applicable through FY 2003. We caution that these are estimates for fiscal years 2000 and later, and are subject to revisions resulting from continued methodological refinements, receipt of additional data, and changes in payment policy changes. We note that in making these projections, we have assumed that the cumulative national DRG/GAF budget neutrality adjustment factor will remain at 1.00338 (1.00215 for Puerto Rico) for FY 1999 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 1999.

The projections are as follows:

Fiscal year	Update factor	Exceptions reduction factor	Budget neutrality factor	DRG/GAF adjustment factor [1]	Outlier adjustment factor	Federal rate adjustment	Federal rate (after outlier reduction)
1992	N/A	0.9813	0.9602	.....	.9497	.....	415.59
1993	6.07	.9756	.9162	.9980	.9496	.....	417.29
1994	3.04	.9485	.8947	1.0053	.9454	[2].9260	378.34
1995	3.44	.9734	.8432	.9998	.9414	.....	376.83
1996	1.20	.9849	N/A	.9994	.9536	[3].9972	461.96
1997	0.70	.9358	N/A	.9987	.9481	.....	438.92
1998	0.90	.9659	N/A	.9989	.9382	[4].8222	371.51
1999	0.20	.9761	N/A	1.0032	.9378	.....	377.25
2000	0.80	.9749	N/A	[5] 1.0000	[5].9378	.....	379.80
2001	0.80	.9720	N/A	1.0000	.9378	.....	381.70
2002	0.90	[6] 1.0000	N/A	1.0000	.9378	.....	396.23
2003	0.90	[6] 1.0000	N/A	1.0000	.9378	[4] 1.0255	410.01

[1] Note: The incremental change over the previous year.
[2] Note: OBRA 1993 adjustment.
[3] Note: Adjustment for change in the transfer policy.
[4] Note: Balanced Budget Act of 1997 adjustment.
[5] Note: Future adjustments are, for purposes of this projection, assumed to remain at the same level.
[6] Note: We are unable to estimate exceptions payments for the year under the special exceptions provision (§ 412.348(g) of the regulations) because the regular exceptions provision (§ 412.348(e)) expires.

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Appendix C: Report to Congress

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 4 1998

The Honorable Albert Gore, Jr.
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

Section 1886(e)(3) of the Social Security Act (the Act) requires me to report to Congress the initial estimate of the applicable percentage increase in hospital inpatient payment rates for fiscal year (FY) 1999 that I will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for hospitals and units excluded from PPS. This submission constitutes the required report.

Current law mandates, and the President's FY 1999 budget includes, an update for PPS hospitals equal to the market basket rate of increase minus 1.9 percentage points, or, for certain hospitals under the temporary relief provision of section 4401(b) of the Balanced Budget Act of 1997, the market basket rate of increase minus 1.6 percentage points. The President's FY 1999 budget estimated the PPS market basket rate of increase for FY 1999 to be 2.7 percent. Based on this estimate, we recommend an update for hospitals in both large urban and other areas of 0.8 percent, and an update for temporary relief hospitals of 1.1 percent.

Sole community hospitals (SCHs) are the sole source of care in their area and are afforded special payment protection to maintain access to services for Medicare beneficiaries. SCHs are paid the higher of a hospital-specific rate or the Federal PPS rate. Medicare-dependent, small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their area and are afforded special payment protection to maintain access to services for beneficiaries. MDHs are paid the Federal PPS rate, or, if their hospital-specific rate exceeds the Federal PPS rate, the Federal rate plus 50 percent of the difference between the hospital-specific rate and the Federal rate. Current law mandates that the FY 1999 update to hospital-specific rates for SCHs and MDHs equal the market basket rate of increase minus 1.9 percentage points. Consistent with the President's FY 1999 budget, we recommend an update to hospital-specific rates equal to our recommended increase for PPS hospitals, that is, the market basket rate of increase of 2.7 percent minus 1.9 percentage points, or 0.8 percent.

Page 2 - The Honorable Albert Gore, Jr.

Hospitals and distinct part hospital units excluded from PPS are paid based on their reasonable costs subject to a limit under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Current law mandates that the update for all hospitals and distinct part units excluded from PPS equal the rate of increase in the excluded hospital market basket less a percentage between 0 and 2.5 percentage points, depending on the hospital's costs in relation to its limit. The President's FY 1999 budget incorporates a rate of increase in the TEFRA limit equal to the rate of increase in the excluded hospital market basket (2.7 percent) minus a percentage between 0 and 2.5 percentage points, depending on the hospital's costs in relation to its limit. Therefore, we recommend an increase in the TEFRA limit of between 0.2 and 2.7 percent.

My recommendation for the updates is based on cost projections used in the President's FY 1999 budget. A final recommendation on the appropriate percentage increases for FY 1999 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projection available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including recommendations by the Medicare Payment Advisory Commission (MedPAC). We currently expect that the final estimate of the market basket rate of increase will be lower than the estimate used in the President's FY 1999 budget.

Section 1886(d)(4)(C)(iv) of the Act also requires that I include in my report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time I do not anticipate recommending any adjustment to the DRG weighting factors for FY 1999.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the Speaker of the House of Representatives.

Sincerely,

Donna E. Shalala

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 4 1998

The Honorable Newt Gingrich
Speaker of the House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Section 1886(e)(3) of the Social Security Act (the Act) requires me to report to Congress the initial estimate of the applicable percentage increase in hospital inpatient payment rates for fiscal year (FY) 1999 that I will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for hospitals and units excluded from PPS. This submission constitutes the required report.

Current law mandates, and the President's FY 1999 budget includes, an update for PPS hospitals equal to the market basket minus 1.9 percentage points, or, for certain hospitals under the temporary relief provision of section 4401(b) of the Balanced Budget Act of 1997, the market basket rate of increase minus 1.6 percentage points. The President's FY 1999 budget estimated the PPS market basket rate of increase for FY 1999 to be 2.7 percent. Based on this estimate, we recommend an update for hospitals in both large urban and other areas of 0.8 percent, and an update for temporary relief hospitals of 1.1 percent.

Sole community hospitals (SCHs) are the sole source of care in their area and are afforded special payment protection to maintain access to services for Medicare beneficiaries. SCHs are paid the higher of a hospital-specific rate or the Federal PPS rate. Medicare-dependent, small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their area and are afforded special payment protection to maintain access to services for beneficiaries. MDHs are paid the Federal PPS rate, or, if their hospital-specific rate exceeds the Federal PPS rate, the Federal rate plus 50 percent of the difference between the hospital-specific rate and the Federal rate. Current law mandates that the FY 1999 update to hospital-specific rates for SCHs and MDHs equal the market basket rate of increase minus 1.9 percentage points. Consistent with the President's FY 1999 budget, we recommend an update to hospital-specific rates equal to our recommended increase for PPS hospitals, that is, the market basket rate of increase of 2.7 percent minus 1.9 percentage points, or 0.8 percent.

Page 2 - The Honorable Newt Gingrich

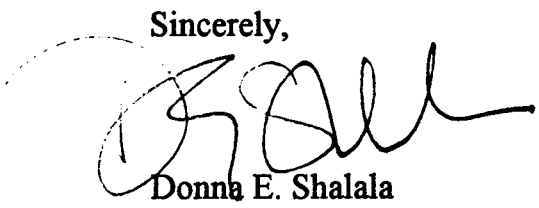
Hospitals and distinct part hospital units excluded from PPS are paid based on their reasonable costs subject to a limit under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Current law mandates that the update for all hospitals and distinct part units excluded from PPS equal the rate of increase in the excluded hospital market basket less a percentage between 0 and 2.5 percentage points, depending on the hospital's costs in relation to its limit. The President's FY 1999 budget incorporates a rate of increase in the TEFRA limit equal to the rate of increase in the excluded hospital market basket (2.7 percent) minus a percentage between 0 and 2.5 percentage points, depending on the hospital's costs in relation to its limit. Therefore, we recommend an increase in the TEFRA limit of between 0.2 and 2.7 percent.

My recommendation for the updates is based on cost projections used in the President's FY 1999 budget. A final recommendation on the appropriate percentage increases for FY 1999 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projection available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including recommendations by the Medicare Payment Advisory Commission (MedPAC). We currently expect that the final estimate of the market basket rate of increase will be lower than the estimate used in the President's FY 1999 budget.

Section 1886(d)(4)(C)(iv) of the Act also requires that I include in my report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time I do not anticipate recommending any adjustment to the DRG weighting factors for FY 1999.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the Speaker of the House of Representatives.

Sincerely,



Donna E. Shalala

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Appendix D: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Several provisions of the Act address the setting of update factors for inpatient services furnished in FY 1999 by hospitals subject to the prospective payment system and those excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XIV) of the Act sets the FY 1999 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 1.9 percent for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 1999 percentage increase in the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act, that is, the same update factor as all other hospitals subject to the prospective payment system, or the rate of increase in the market basket minus 1.9 percentage points. (We note that, as provided in section 4401(b) of the Balanced Budget Act of 1997, certain hospitals that do not receive indirect medical education or disproportionate share payments and are not designated as Medicare-dependent, small rural hospitals will receive an update that is 0.3 percent higher than the update for other prospective payment hospitals. Section 1886(b)(3)(B)(ii) of the Act sets the FY 1999 percentage increase in the rate of increase limits for hospitals excluded from the prospective payment system equal to the rate of increase in the excluded hospital market basket minus a percentage between 0 and 2.5 percent percentage points, depending on the hospital's costs in relation to its limit.

In accordance with section 1886(d)(3)(A) of the Act, we are proposing to update the standardized amounts, the hospital-specific rates, and the rate-of-increase limits for hospitals excluded from the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the fourth quarter 1997 forecast of the FY 1999 market basket increase of 2.6 percent for hospitals subject to the prospective payment system, the proposed updates to the standardized amounts are 0.7 percent (that is, the market basket rate of increase minus 1.9 percent) for hospitals in both large urban and other areas. The proposed update to the hospital-specific rate applicable to sole community and Medicare-dependent, small rural hospitals is also 0.7 percent. The proposed update for hospitals excluded from the prospective payment system is the percentage increase in the excluded hospital market basket (currently estimated at 2.5 percent) less a percentage between 0 and 2.5 percentage points, or an update equal to between 0 and 2.5 percent.

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish the update factors recommended under section 1886(e)(4) of the Act. Accordingly, this appendix provides the recommendations of appropriate update factors, the analysis underlying our recommendations, and our responses to the MedPAC recommendations concerning the update factors.

In its March 1, 1998 report, MedPAC stated that the legislated update of market basket increase minus 1.9 percentage points will provide a reasonable level of payment to hospitals. Although MedPAC suggests that a somewhat lower update could be justified in light of changes in the utilization and provision of hospital inpatient care, the Commission does not believe it is necessary to recommend a lower update for FY 1999. MedPAC did not make a separate recommendation for the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals. We discuss MedPAC's recommendations concerning the update factors and our responses to these recommendations below.

II. Secretary's Recommendations

Under section 1886(e)(4) of the Act, we are recommending that an appropriate update factor for the standardized amounts is 0.7 percent for hospitals located in large urban and other areas. We are also recommending an update of 0.7 percent to the hospital-specific rate for sole community hospitals and Medicare-dependent, small rural hospitals. These figures are consistent with the President's FY 1999 budget recommendations, which reflect the update provided by section 4401(a) of the Balanced Budget Act of 1997. We believe these recommended update factors would ensure that Medicare acts as a prudent purchaser and provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund. When the President's budget was submitted, the market basket rate of increase was projected at 2.7 percent. As noted above, this proposed recommendation is based on the most recent forecast of the market basket, 2.6 percent.

We recommend that hospitals excluded from the prospective payment system receive an update of between 0 and 2.5 percent. The update for excluded hospitals and units is equal to the increase in the excluded hospital operating market basket, less a percentage between 0 and 2.5 percentage points depending on the hospital's or unit's costs in relation to its rate-of-increase limit. The market basket rate of increase is currently forecast at 2.5 percentage points. This recommendation is consistent with the President's FY 1999 budget, although we note that the market basket rate of increase was forecast at 2.7 percent when the budget was submitted.

As required by section 1886(e)(4) of the Act, we have taken into consideration the recommendations of MedPAC in setting these recommended update factors. Our responses to the MedPAC recommendations concerning the update factors are discussed below.

III. MedPAC Recommendation for Updating the Prospective Payment System Standardized Amounts

For FY 1999, MedPAC's update framework would support an update of the increase in the hospital market basket minus a figure between 4.4 percentage points and 1.1 percentage points. MedPAC notes that costs per case have grown more slowly than payments per case since 1992 and, as a result, overall Medicare operating margins for hospitals have been rising. MedPAC predicts that Medicare operating margins will continue to be quite favorable even with the payment reductions enacted by the Balanced Budget Act of 1997. MedPAC further notes that Medicare payments are just one of many factors that affect hospital margins. Thus, while MedPAC agrees with the proposed update of market basket increase minus 1.9 percentage points for 1999, that update is closer to the higher end than the lower end of MedPAC's update framework. The Commission emphasizes that, because of uncertainty about the future and the extent of changes in productivity and service delivery, its recommendation applies for only one year. MedPAC's estimate of the market basket increase is 2.5 percent, which is 0.1 percentage points below HCFA's current estimate. MedPAC's market basket estimate focuses on employee compensation changes in the hospital industry and the economy in general, while HCFA's market basket forecast gives less weight to the projected changes in the hospital industry's wages. Thus, MedPAC's update framework reflects a 0.1 percent adjustment for this difference.

Response: We agree with MedPAC's recommendation of an update for FY 1999 for prospective payment system hospitals of market basket minus 1.9 percentage points. Our recommendation is supported by the following analyses that measure changes in hospital productivity, scientific and technological advances, practice pattern changes, and changes in case mix:

a. Productivity

Service level productivity is defined as the ratio of total service output to full-time equivalent employees (FTEs). While we recognize that productivity is a function of many variables (for example, labor, nonlabor material, and capital inputs), we use a labor productivity measure since this update framework applies to operating payment. To recognize that we are apportioning the short run output changes to the labor input and not considering the nonlabor inputs, we weight our productivity measure for operating costs by the share of direct labor services in the market basket rate of increase to determine the expected effect on cost per case.

Our recommendation for the service productivity component is based on historical trends in productivity and total output for both the hospital industry and the general economy, and projected levels of future hospital service output. MedPAC's predecessor, the Prospective Payment Assessment Commission (ProPAC), estimated cumulative service productivity growth to be 4.9 percent from 1985–1989, or 1.2 percent annually. At the same time, MedPAC estimated total output growth at 3.4 percent

annually, implying a ratio of service productivity growth to output growth of 0.35.

Since it is not possible at this time to develop a productivity measure specific to Medicare patients, we examined productivity (output per hour) and output (gross domestic product) for the economy. Depending on the exact time period, annual changes in productivity range from 0.3 to 0.35 percent of the change in output (that is, a 1.0 percent increase in output would be correlated with a 0.3 to 0.35 percent change in output per hour).

Under our framework, the recommended update is based in part on expected productivity—that is, projected service output during the year, multiplied by the historical ratio of service productivity to total service output, multiplied by the share of labor in total operating inputs, as calculated in the hospital market basket rate of increase. This method estimates an expected labor productivity improvement in the same proportion to expected total service growth that has occurred in the past and assumes that, at a minimum, growth in FTEs changes proportionally to the growth in total service output. Thus, the recommendation allows for unit productivity to be smaller than the historical averages in years that output growth is relatively low and larger in years that output growth is higher than the historical averages. Based on the above estimates from both the hospital industry and the economy, we have chosen to employ the range of ratios of productivity change to output change of 0.30 to 0.35.

The expected change in total hospital service output is the product of projected growth in total admissions (adjusted for outpatient usage), projected real case-mix growth, and expected quality enhancing intensity growth, net of expected decline in intensity due to reduction of cost ineffective practice. Case-mix growth and intensity numbers for Medicare are used as proxies for those of the total hospital, since case-mix increases (used in the intensity measure as well) are unavailable for non-Medicare patients. Thus, expected output growth is simply the sum of the expected change in intensity (0.0 percent), projected admissions change (−2.0 percent for FY 1999), and projected real case-mix growth (0.8 percent), or −1.2 percent. The share of direct labor services in the market basket rate of increase (consisting of wages, salaries, and employee benefits) is 61.4 percent.

Multiplying the expected change in total hospital service output (−1.2 percent) by the ratio of historical service productivity change to total service growth of 0.30 to 0.35 and by the direct labor share percentage 61.4, provides our productivity standard of −0.2 to −0.3 percent.

MedPAC believes that the update should also take into account the effects of product change. MedPAC analysis indicates that between 1992 and 1996, the decline in length of stay and corresponding increase in the intensity of services per day resulted in a net reduction of about 11 percent for services provided per hospital admission. In the past, ProPAC expected hospitals to achieve productivity gains ranging from 0.5 percent to 2.0 percent per year. This year, recognizing changes in lengths of stay and sites of service, MedPAC believes a product adjustment in the range of −3.0 to −1.0 percentage points is appropriate. In addition, MedPAC's update framework contains a productivity adjustment of between −0.7 to −0.3 percent, which is slightly more optimistic than our estimate.

b. Intensity

We base our intensity standard on the combined effect of three separate factors: Changes in the use of quality enhancing services, changes in the use of services due to shifts in within-DRG severity, and changes in the use of services due to reductions of cost-ineffective practices. For FY 1999, we recommend an adjustment of 0.0 percent. The basis of this recommendation is discussed below.

We have no empirical evidence that accurately gauges the level of quality-enhancing technology changes. A study published in the Winter 1992 issue of the Health Care Financing Review, ''Contributions of case mix and intensity change to hospital cost increases'' (p. 151–163), suggests that one-third of the intensity change is attributable to high-cost technology. The balance was unexplained but the authors speculated that it is attributable to fixed costs in service delivery.

Typically, a specific new technology increases cost in some uses and decreases cost in other uses. Concurrently, health status is improved in some situations while in other situations it may be unaffected or even worsened using the same technology. It is difficult to separate out the relative significance of each of the cost increasing effects for individual technologies and new technologies.

All things being equal, per-discharge fixed costs tend to fluctuate in inverse proportion to changes in volume. Fixed costs exist whether patients are treated or not. If volume is declining, per-discharge fixed costs will rise, but the reverse is true if volume is increasing.

Following methods developed by HCFA's Office of the Actuary for deriving hospital output estimates from total hospital charges, we have developed Medicare-specific intensity measures based on a 5-year average using FY 1993–FY 1997 MedPAR billing data. Case-mix constant intensity is calculated as the change in total Medicare charges per discharge adjusted for changes in the average charge per unit of service as measured by the Medical CPI hospital component and changes in real case mix. Thus, in order to measure changes in intensity, one must measure changes in real case mix.

For FY 1993–FY 1997, observed case mix index change ranged from a low of 0.8 percent to a high of 1.7 percent, with a 5-year average change of 1.3 percent. Based on evidence from past studies of case-mix change, we estimate that real case mix change fluctuates between 1.0 and 1.4 percent and the observed values generally fall in this range. The average percentage change in charge per discharge was 3.4 percent and the average annual change in the medical CPI was 5.7 percent. Dividing the change in charge per discharge by the quantity of the real case-mix index change and the medical CPI, yields an average annual change in intensity of −3.4 percent. Assuming the technology/fixed cost ratio still holds, technology would account for a −1.1 percent annual decline while fixed costs would account for a −2.3 percent annual decline. The decline in fixed costs per discharge makes intuitive sense as volume, measured by total discharges, as increased during the period. Since we estimate that intensity has declined during that period, we are recommending a 0.0 percent intensity adjustment for FY 1999.

c. Quality Enhancing New Science and Technology

For FY 1999, MedPAC has computed the adjustment for scientific and technological advances to be a future-oriented policy target intended to provide additional funds for hospitals to adopt quality-enhancing, cost increasing health care innovations. As in past recommendations, MedPAC has included an adjustment ranging from 0.3 to 1.0 percentage points. MedPAC believes that the cost-competitive environment now faced by hospitals may dampen the adoption of new technologies as they closely evaluate their relative costs and benefits. Therefore, MedPAC recommends an adjustment of 0.5 percentage points for the increase in operating costs due to scientific and technological advances.

d. Change in Case Mix

Our analysis takes into account projected changes in case mix, adjusted for changes attributable to improved coding practices. For our FY 1999 update recommendation, we are projecting a 1.0 percent increase in the case-mix index. We define real case-mix increase as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs, but do not reflect greater resource requirements. For FY 1999, we believe that real case-mix increase is equal to our projected change in case mix less 0.2 percent. We estimate that changes in coding behavior account for an increase of 0.2 percentage points in our projected case-mix change. Thus, we are projecting an increase of 0.8 percentage points for the real case-mix index.

Unlike ProPAC's case-mix recommendation in previous years, MedPAC did not make a specific percentage change recommendation but rather estimated a range from −0.2 to 0.2 percentage point change based on changes in the 1998 case mix index.

e. Effect of FY 1997 DRG Reclassification and Recalibration

We estimate that DRG reclassification and recalibration for FY 1997 resulted in a 0.0 percent increase in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPER. MedPAC does not make an adjustment for DRG reclassification and recalibration in its update recommendation.

f. Correction for Market Basket Forecast Error

The estimated market basket percentage increase used to update the FY 1997 payment

rates was 2.5 percent. Our most recent data indicate the actual FY 1997 increase was 2.1 percent. The resulting forecast error in the FY 1997 market basket rate of increase is 0.4 percentage points. Under our update framework, we make a forecast error correction if our estimate is off by 0.25 percentage points or more. Therefore, we are recommending an adjustment of −0.4 percentage points to reflect this overestimation of the FY 1997 market basket rate of increase. The following is a summary of the update ranges supported by our analyses compared to MedPAC's framework.

TABLE 1.—COMPARISON OF FY 1999 UPDATE RECOMMENDATIONS

	HHS	MedPAC
Market Basket	MB	MB
Difference between HCFA & MedPAC Market Baskets		−0.1
Subtotal	MB	MB
Policy Adjustments Factors:		
Productivity	−0.3 to −0.2	−0.7 to −0.3
Product	(3)	−3.0 to −1.0
Intensity	0.0.	
Science & Technology		0.0 to 0.5
Practice Patterns		(1)
Real Within DRG Change		(2)
Subtotal	−0.3 to −0.2	−3.7 to −0.8
Case-Mix Adjustment Factors:		
Projected Case-Mix Change	−1.0	
Real Across DRG Change	0.8	−0.2 to 0.0
Real Within DRG Change	(3)	0.0 to 0.2
Subtotal	−0.2	−0.2 to 0.2
Effect of 1996 Reclassification & Recalibration	0.0	
Forecast Error Correction	−0.4	−0.4
Total Recommended Update	MB −0.9 to MB −0.8	MB −4.4 to MB −1.1

[1] Included in MedPAC's Productivity Measure.
[2] Included in MedPAC's Case-Mix Adjustment.
[3] Included in HHS' Intensity Factor.

Because we are not recommending a negative adjustment for intensity (as our methodology would suggest is appropriate), the update suggested by our framework appears to be more generous than the recommendation of MedPAC. While the above framework would support an update of the market basket increase minus 0.9 percentage points, we are recommending an update of the market basket increase minus 1.9 percentage points (0.7 percent). We believe that this update factor appropriately adjusts for changes occurring in health care delivery including the relative decrease in use of hospital inpatient services and the corresponding increase in use of hospital outpatient and postacute care services. We agree with MedPAC that a 0.7 percent update for FY 1999 would not disadvantage the hospital industry nor harm Medicare beneficiaries. We also recommend that the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals be increased by the same update, 0.7 percentage points.

IV. MedPAC Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals

MedPAC recommends an update factor equal to a 2.1 percent average increase for TEFRA target amounts for excluded hospitals and units. The update formula enacted by section 4411(a) of the Balanced Budget Act is equal to the increase in the excluded hospital market basket less a percentage point between 0 and 2.5 percent, depending on the hospital's or unit's costs in relation to the target amount. MedPAC's recommendation reflects a reduction of 0.4 percentage points from HCFA's market basket increase forecast of 2.5 percent. The reduction consists of an adjustment of -0.4 percentage points to account for the forecast error in the FY 1997 market basket rate of increase, and no allowance for new technology.

Response: We recommend that hospitals excluded from the prospective payment system also receive a 2.5 percent increase in the market basket used in the update formula for TEFRA target amount updates provided to the prospective payment hospitals. We believe this update would ensure that Medicare acts as a prudent purchaser and would provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund.

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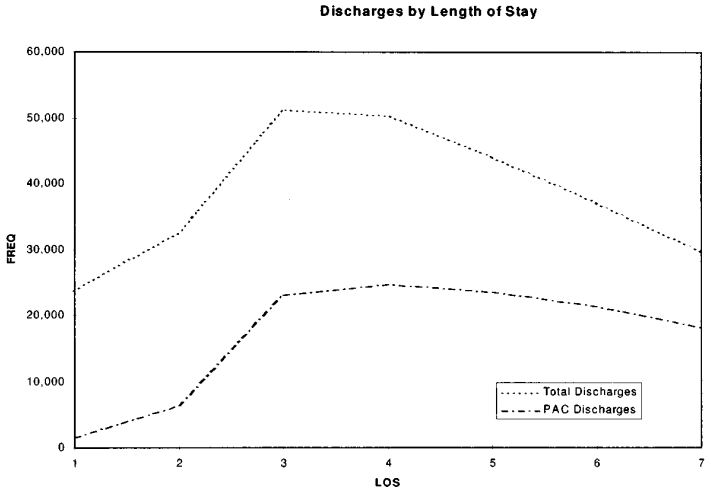
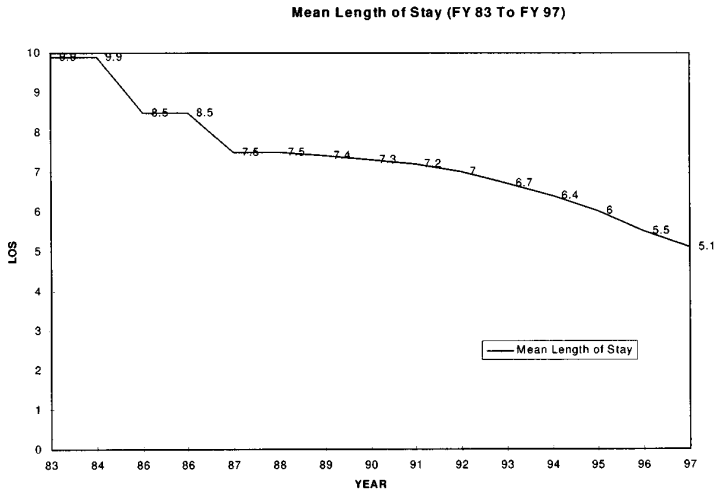
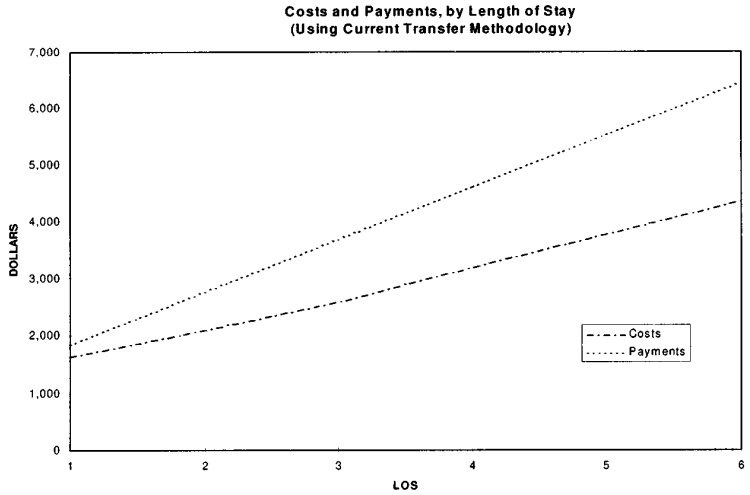
APPENDIX E: DRG Charts

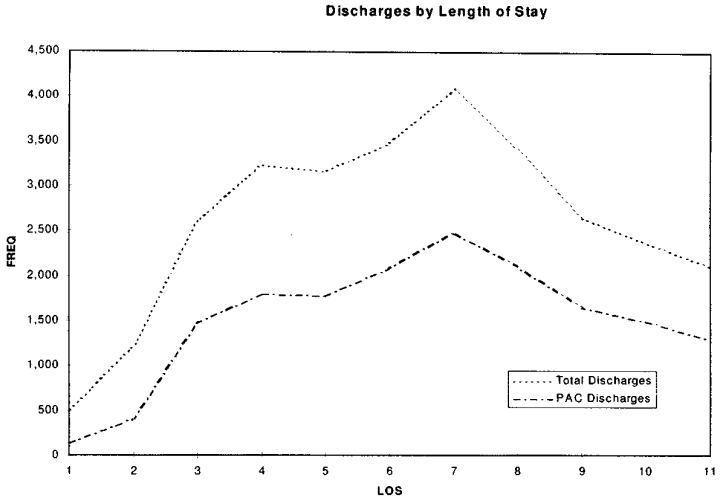
DRG 14
SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA (MEDICAL)

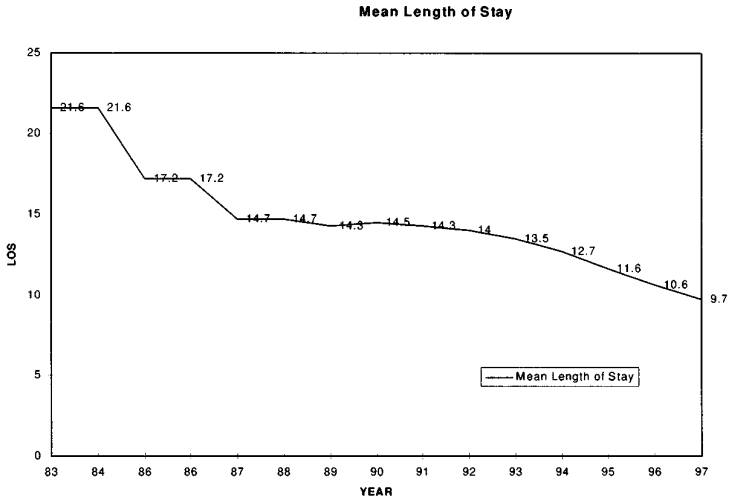


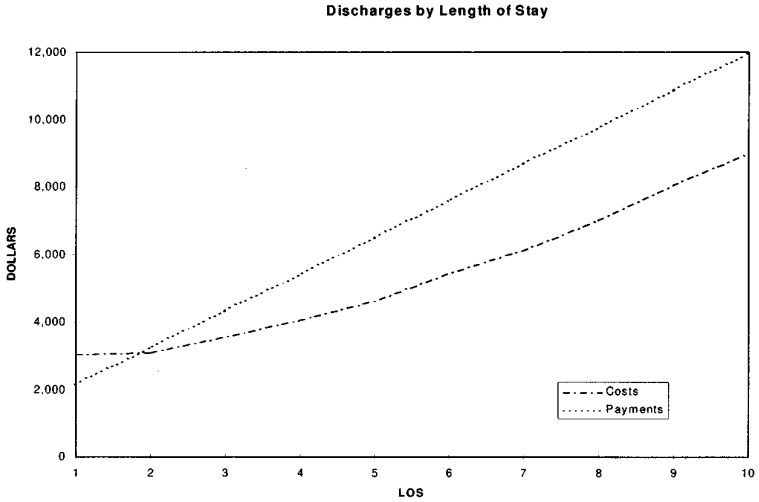




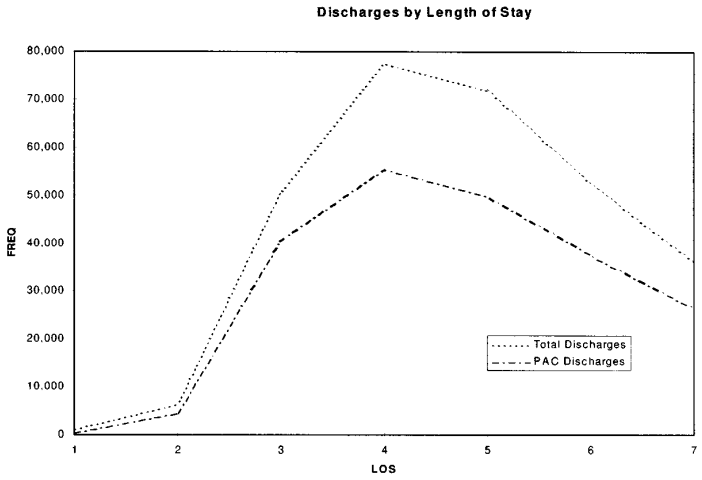
DRG 113
AMPUTATION FOR CIRCULATORY SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE (SURGICAL)

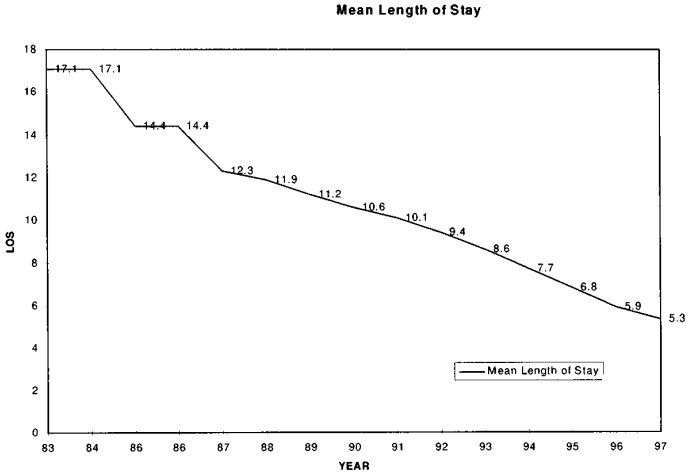


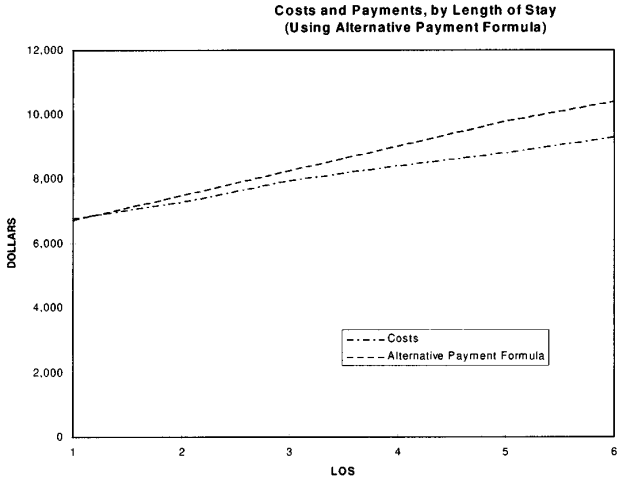




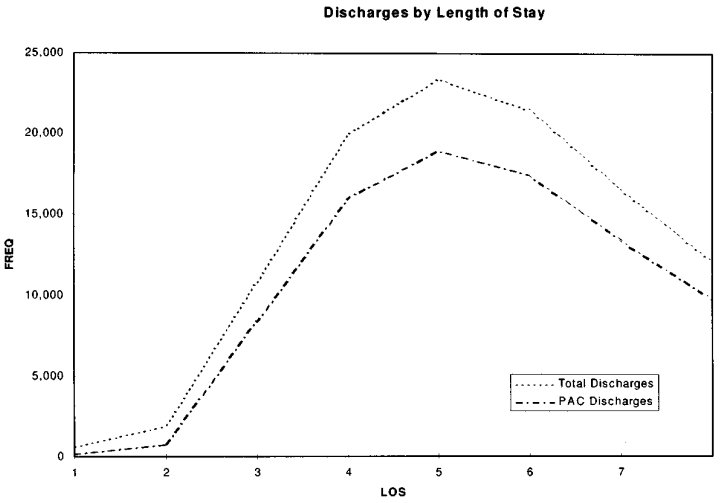
DRG 209
MAJOR JOINT LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY (SURGICAL)

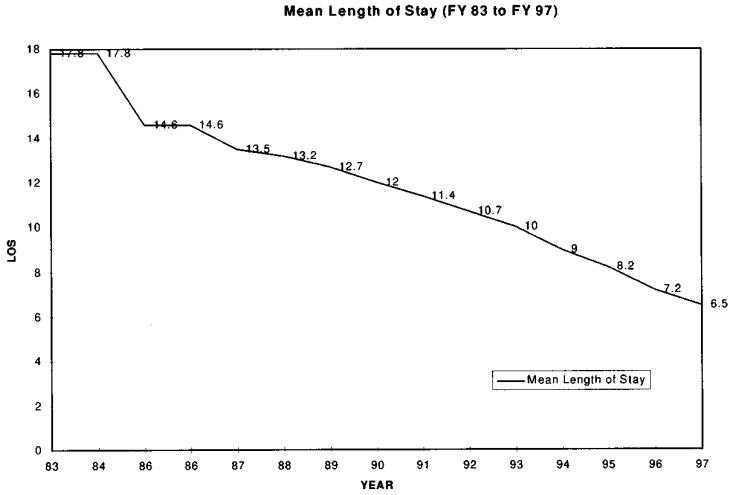


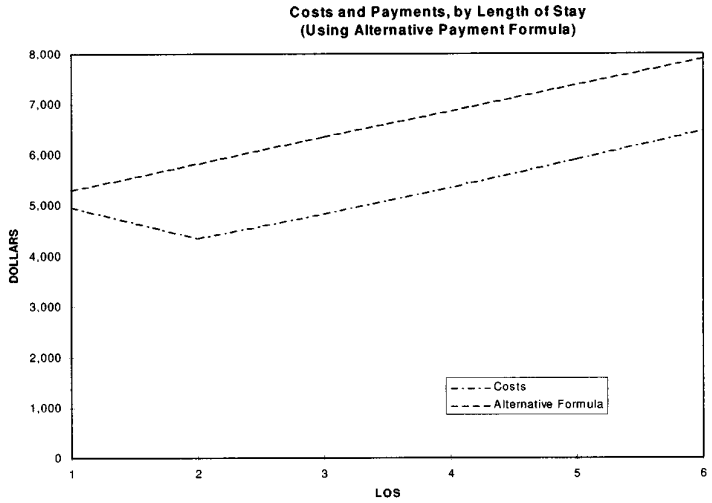




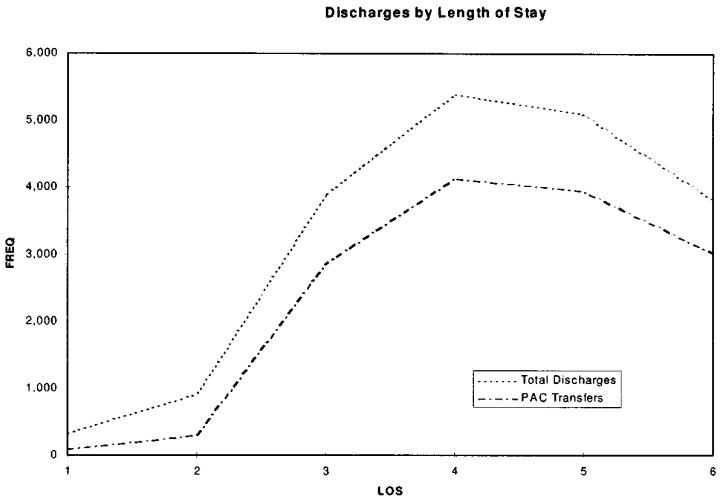
DRG 210
HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 WITH CC (SURGICAL)

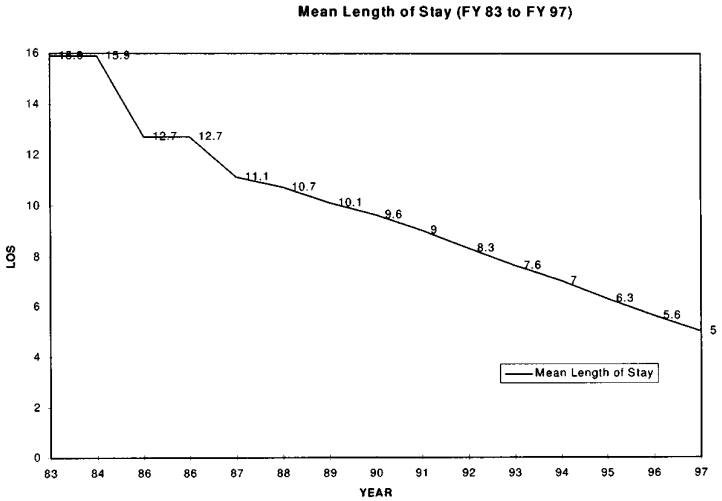


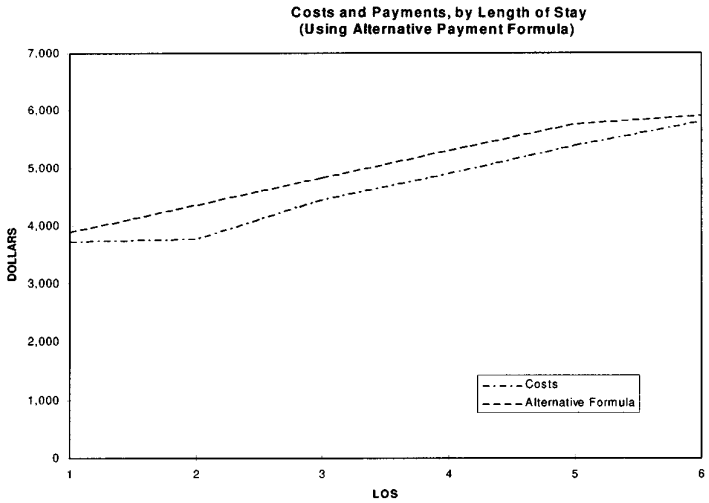




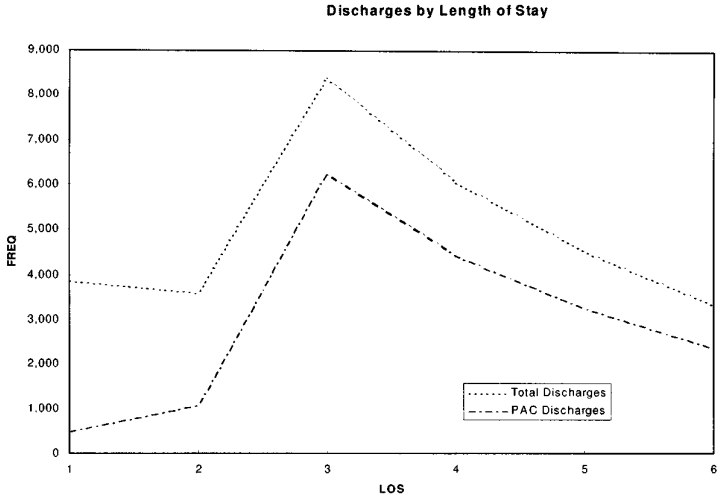
DRG 211
HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC (SURGICAL)

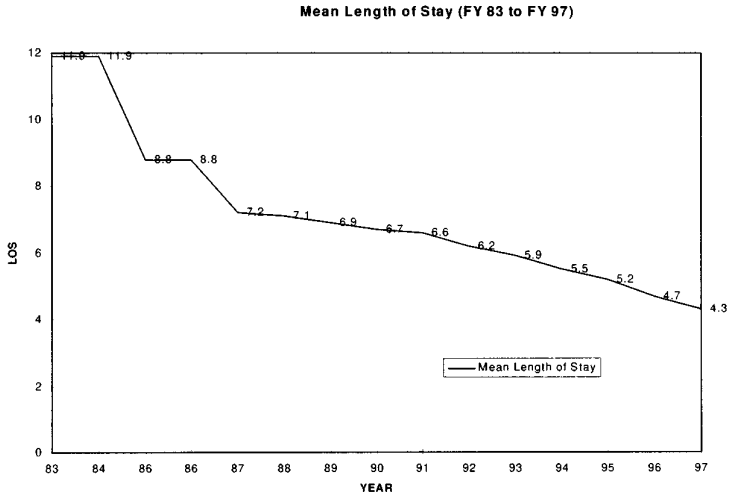


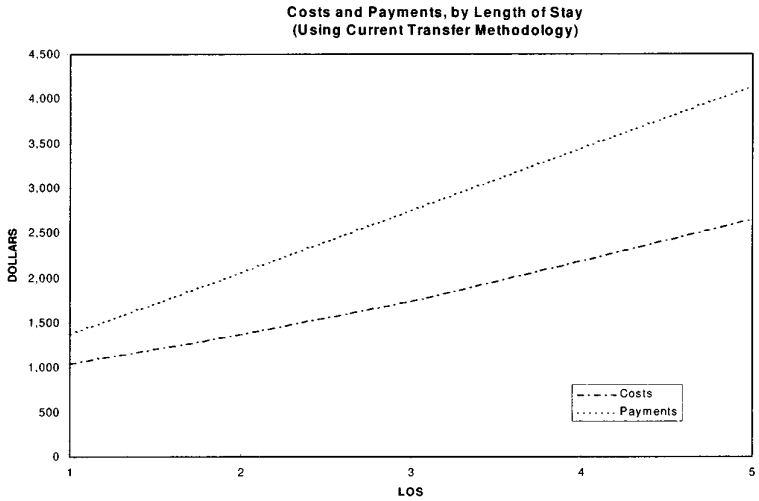




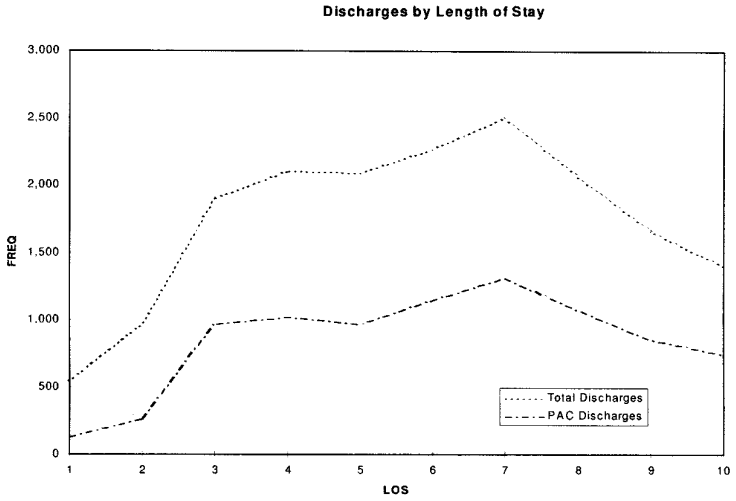
DRG 236
FRACTURE OF HIP PELVIS (MEDICAL)

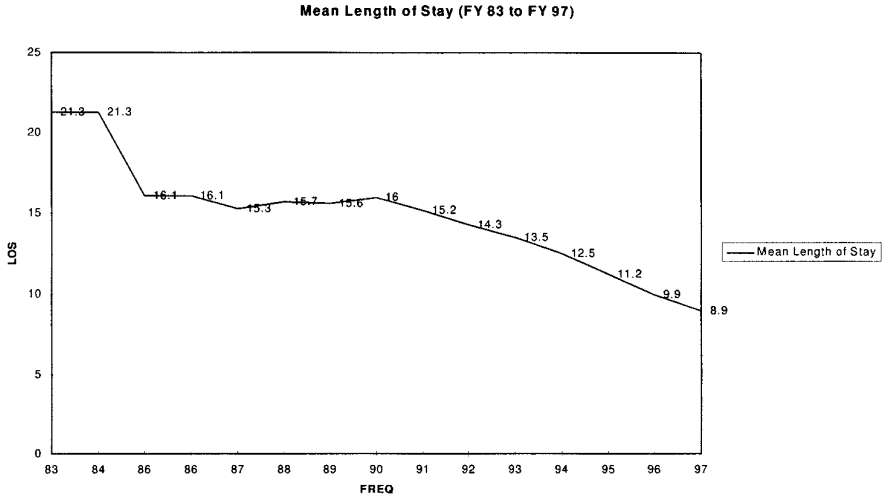


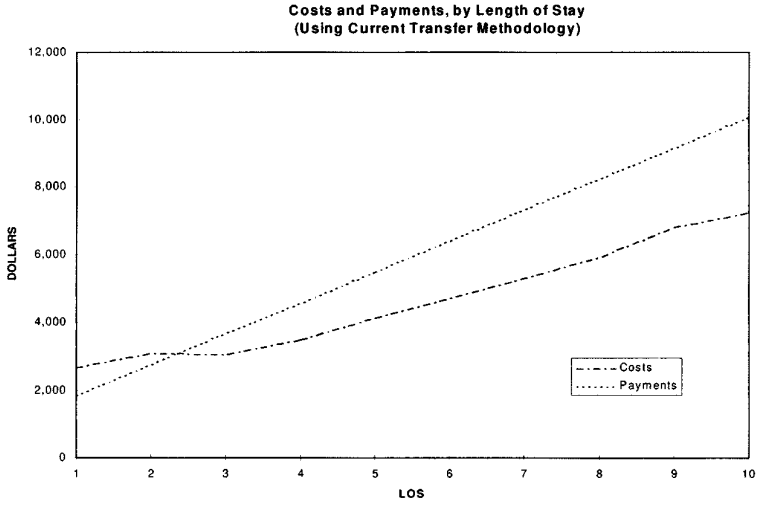




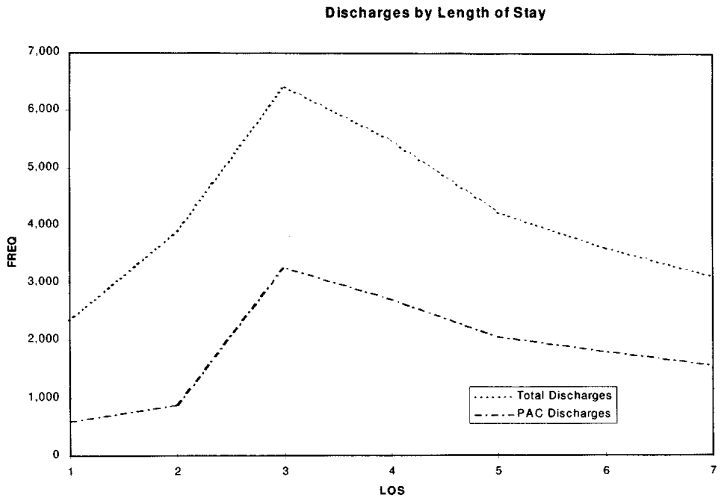
DRG 263
SKIN GRAFT AND/OR DEBRIDEMENT FOR SKIN ULCER OR CELLULITIS WITH CC (SURGICAL)

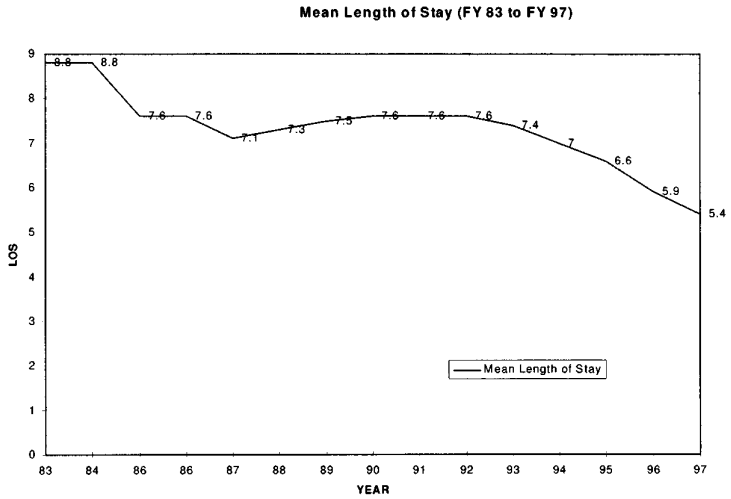


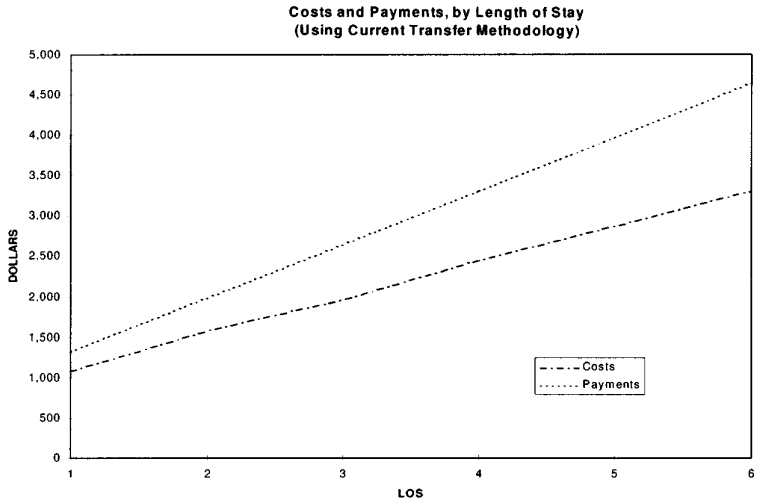




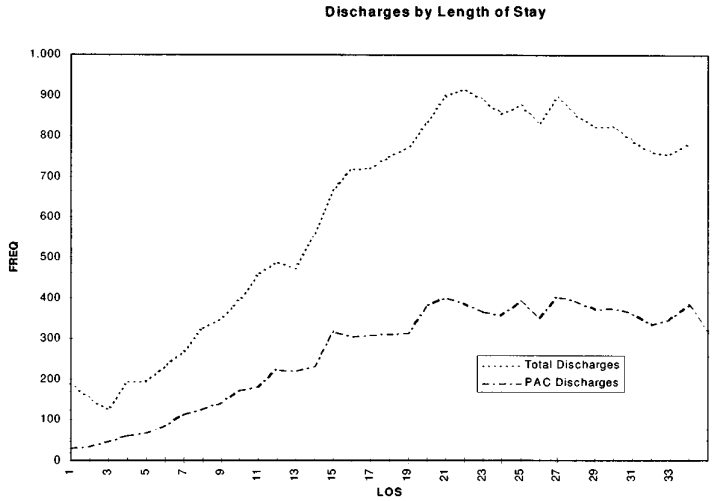
DRG 429
ORGANIC DISTURBANCES MENTAL RETARDATION (MEDICAL)

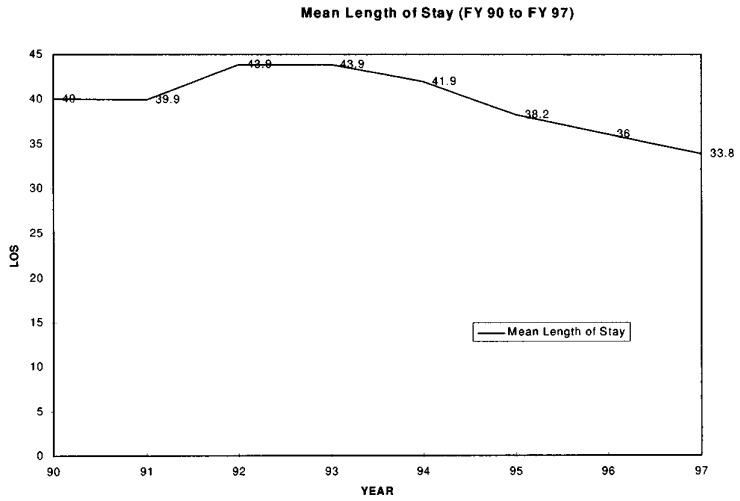


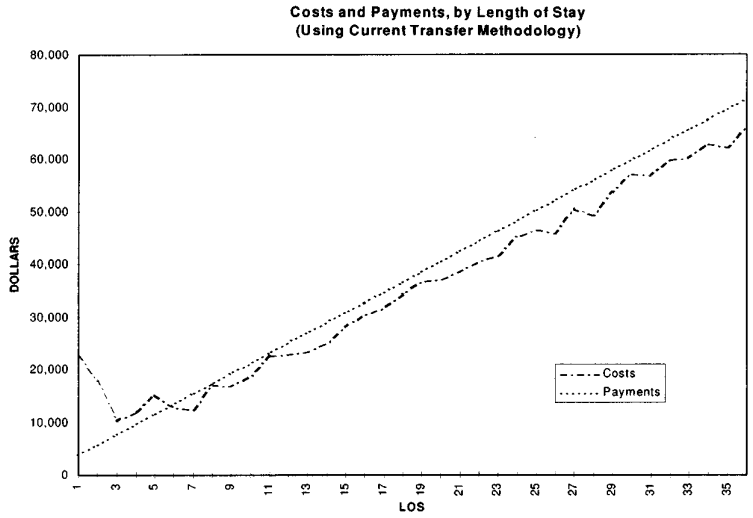




DRG 483
TRACHEOSTOMY EXCEPT FOR FACE, MOUTH, NECK DIAGNOSES (SURGICAL)







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