

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 03/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
75	39476	9.9112	3	5	7	12	19
76	40377	11.4074	3	5	9	14	22
77	2406	5.0000	1	2	4	7	10
78	32319	6.7837	3	4	6	8	11
79	170615	8.4963	3	4	7	11	16
80	8981	5.6562	2	3	5	7	10
81	4	18.2500	3	3	4	8	58
82	62447	6.9403	2	3	5	9	14
83	6598	5.5518	2	3	4	7	10
84	1539	3.3197	1	2	3	4	6
85	20738	6.3135	2	3	5	8	12
86	2115	3.6648	1	2	3	5	7
87	60486	6.2986	1	3	5	8	12
88	395676	5.1294	2	3	4	6	9
89	529122	5.9478	2	3	5	7	11
90	53985	4.1475	2	3	4	5	7
91	57	4.4561	2	2	3	5	9
92	13873	6.3521	2	3	5	8	12
93	1692	4.0969	1	2	3	5	7
94	12158	6.3088	2	3	5	8	12
95	1621	3.7224	1	2	3	5	7
96	62414	4.6281	2	3	4	6	8
97	31618	3.6509	1	2	3	5	7
98	17	4.3529	1	2	3	4	6
99	19205	3.2061	1	1	2	4	6
100	7656	2.1813	1	1	2	3	4
101	20236	4.3987	1	2	3	5	9
102	5196	2.6522	1	1	2	3	5
103	494	47.2510	9	13	25	61	102
104	19992	14.2362	6	8	12	17	25
105	26203	9.7712	4	6	8	11	17
106	3425	11.4923	5	7	10	14	20
107	88610	10.3724	5	7	9	12	17
108	6099	10.2140	3	5	8	13	19
109	60766	7.6912	4	5	6	9	12
110	53054	9.2130	2	5	7	11	18
111	8563	4.7507	1	2	5	6	8
113	42570	12.2362	3	6	9	15	24
114	8788	8.4208	2	4	7	11	16
115	14447	8.1481	1	4	7	11	16
116	101326	4.5123	1	2	3	6	9
117	3750	4.1997	1	1	2	5	9
118	7731	2.6831	1	1	1	3	6
119	1315	4.8783	1	1	3	6	12
120	37900	8.5509	1	2	6	11	19
121	163108	6.3828	2	3	5	8	12
122	79700	3.6981	1	2	3	5	7
123	40952	4.5870	1	1	3	6	11
124	133892	4.3434	1	2	3	5	8
125	80872	2.7656	1	1	2	4	5
126	5210	11.7196	3	6	9	15	22
127	683001	5.2764	2	3	4	7	10
128	9485	5.6128	2	4	5	7	9
129	4174	2.7513	1	1	1	3	6
130	87705	5.6725	2	3	5	7	10
131	27378	4.2134	1	2	4	6	7
132	148681	3.0010	1	1	2	4	6
133	8355	2.3246	1	1	2	3	4
134	36411	3.2406	1	2	3	4	6
135	7338	4.5492	1	2	3	6	9
136	1233	2.7178	1	1	2	3	5
138	195523	3.9935	1	2	3	5	8
139	82943	2.5030	1	1	2	3	5
140	70338	2.6538	1	1	2	3	5
141	91110	3.6692	1	2	3	5	7
142	45981	2.6476	1	1	2	3	5
143	205686	2.1259	1	1	2	3	4
144	82529	5.3248	1	2	4	7	11
145	7242	2.7331	1	1	2	3	5
146	10755	10.3134	5	7	9	12	17

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 03/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
147	2637	6.4137	3	5	6	8	9
148	130066	12.2031	5	7	10	15	22
149	18560	6.5100	4	5	6	8	9
150	19923	11.2795	4	7	10	14	20
151	4860	5.8123	2	3	5	8	10
152	4399	8.1444	3	5	7	9	14
153	2100	5.3838	3	4	5	7	8
154	28872	13.1709	4	7	10	16	25
155	6655	4.2026	1	2	3	6	8
156	4	7.5000	1	1	5	6	18
157	7963	5.3929	1	2	4	7	11
158	4671	2.5359	1	1	2	3	5
159	16456	4.9981	1	2	4	6	10
160	11727	2.6592	1	1	2	3	5
161	11208	4.2057	1	1	3	5	9
162	7217	1.9216	1	1	1	2	4
163	7	3.5714	1	1	2	3	4
164	4857	8.4293	4	5	7	10	15
165	2086	4.7895	2	3	5	6	8
166	3559	5.0441	2	2	4	6	10
167	3316	2.6001	1	2	2	3	5
168	1361	4.7649	1	2	3	6	10
169	843	2.3238	1	1	2	3	5
170	12291	10.9867	2	4	8	14	22
171	1408	4.5014	1	2	4	6	9
172	30682	6.9445	2	3	5	9	14
173	2707	3.6679	1	1	3	5	7
174	242053	4.7969	2	3	4	6	9
175	32431	2.9309	1	2	3	4	5
176	15194	5.2285	2	3	4	6	10
177	9272	4.5310	2	2	4	6	8
178	3619	3.0683	1	2	3	4	6
179	12384	5.9738	2	3	5	7	11
180	86181	5.3581	2	3	4	7	10
181	26423	3.4153	1	2	3	4	6
182	245515	4.3381	1	2	3	5	8
183	84480	2.9129	1	1	2	4	5
184	80	2.9500	1	2	2	4	6
185	4826	4.5089	1	2	3	6	9
186	3	9.3333	1	1	9	18	18
187	683	3.9253	1	1	3	5	8
188	76140	5.5645	1	2	4	7	11
189	12060	3.1404	1	1	2	4	6
190	51	6.9608	2	3	4	5	8
191	8941	13.8186	4	6	10	17	27
192	1122	6.5294	2	4	6	8	11
193	5303	12.5218	5	7	10	16	22
194	721	6.7906	2	4	6	8	12
195	4350	10.1616	4	6	9	12	17
196	1166	5.7196	2	4	5	7	10
197	18895	8.9383	3	5	7	11	16
198	5786	4.5380	2	3	4	6	8
199	1725	9.6614	2	4	7	13	21
200	1081	10.3478	1	3	7	13	23
201	1431	13.7393	3	6	11	17	27
202	26168	6.4060	2	3	5	8	13
203	29251	6.6384	2	3	5	9	13
204	57757	5.7995	2	3	4	7	11
205	23128	6.1790	2	3	5	8	12
206	1970	3.8959	1	2	3	5	7
207	31072	5.0836	1	2	4	6	10
208	10149	2.8924	1	1	2	4	6
209	345519	5.0794	3	3	4	6	8
210	121933	6.8207	3	4	6	8	11
211	31780	4.9358	3	4	4	6	7
212	8	10.5000	1	1	4	9	29
213	9241	9.0019	2	4	7	11	18
216	6008	9.6949	2	4	8	12	20
217	16558	13.2636	3	5	9	16	28
218	21621	5.4328	2	3	4	7	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 03/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
219	19714	3.2188	1	2	3	4	6
220	6	4.0000	1	1	3	7	7
223	13397	2.8551	1	1	2	3	6
224	11274	1.9346	1	1	2	2	3
225	5805	4.8558	1	2	3	6	11
226	5230	6.5887	1	2	4	8	14
227	4702	2.7052	1	1	2	3	5
228	2373	3.7981	1	1	2	5	8
229	1118	2.4785	1	1	2	3	5
230	2395	5.2551	1	2	3	6	11
231	11467	4.9383	1	2	3	6	11
232	811	2.8792	1	1	1	3	7
233	5159	7.5251	1	3	6	10	15
234	3186	3.4203	1	1	3	4	7
235	5095	5.1460	1	2	4	6	9
236	38644	4.8192	1	3	4	6	9
237	1698	3.4953	1	2	3	4	6
238	8028	8.5896	3	4	6	10	16
239	49410	6.2190	2	3	5	8	12
240	11462	6.6902	2	3	5	8	13
241	3138	3.8368	1	2	3	5	7
242	2455	6.6550	2	3	5	8	13
243	88325	4.6695	1	2	4	6	9
244	12281	4.8027	1	2	4	6	9
245	5158	3.4420	1	2	3	4	6
246	1402	3.8759	1	2	3	5	7
247	16979	3.4022	1	1	3	4	7
248	10612	4.8149	1	2	4	6	9
249	11431	3.6726	1	1	2	4	8
250	3495	4.1021	1	2	3	5	7
251	2432	2.8647	1	1	2	4	5
253	19997	4.7768	1	3	4	6	9
254	10514	3.1844	1	2	3	4	6
255	1	3.0000	3	3	3	3	3
256	6097	5.0576	1	2	4	6	10
257	16468	2.7380	1	1	2	3	5
258	16096	1.9335	1	1	2	2	3
259	3805	2.6915	1	1	1	2	6
260	4920	1.4191	1	1	1	2	2
261	1875	2.2704	1	1	1	3	5
262	622	3.9807	1	1	3	5	8
263	23616	11.6630	3	5	8	14	23
264	4081	7.0034	2	3	5	8	14
265	3785	6.7974	1	2	4	8	14
266	2669	3.2345	1	1	2	4	7
267	233	4.2060	1	1	3	6	9
268	910	3.5824	1	1	2	4	7
269	8868	8.2049	2	3	6	10	17
270	2662	3.4530	1	1	2	4	7
271	20588	7.1370	2	4	6	9	13
272	5506	6.1593	2	3	5	8	12
273	1290	4.0233	1	2	3	5	8
274	2357	6.5965	1	3	5	8	13
275	249	4.3373	1	1	3	5	9
276	1189	4.7258	1	2	4	6	8
277	88891	5.7267	2	3	5	7	10
278	30673	4.3084	2	3	4	5	8
279	3	2.3333	1	1	2	4	4
280	15826	4.1974	1	2	3	5	8
281	7203	3.0314	1	1	3	4	6
282	3	1.6667	1	1	2	2	2
283	5701	4.5869	1	2	4	6	9
284	1863	3.0934	1	1	2	4	6
285	6259	10.2903	3	5	8	13	20
286	2081	6.4248	2	3	5	7	13
287	5745	10.5220	3	5	7	12	21
288	2705	5.7360	2	3	4	6	9
289	4801	3.0165	1	1	2	3	7
290	8818	2.3115	1	1	2	2	4
291	66	1.8333	1	1	1	2	3

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 03/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
292	4994	10.2367	2	4	8	13	20
293	385	5.3714	1	2	4	7	11
294	88615	4.6095	1	2	4	6	9
295	3318	3.7372	1	2	3	5	7
296	240050	5.1602	2	2	4	6	10
297	44040	3.4064	1	2	3	4	6
298	95	2.9158	1	1	2	4	5
299	1192	5.3079	1	2	4	7	11
300	16118	6.1471	2	3	5	8	12
301	3221	3.6107	1	2	3	4	7
302	7924	8.8892	4	5	7	10	15
303	19568	8.4192	4	5	7	10	15
304	11900	8.7432	2	4	6	11	18
305	3011	3.6430	1	2	3	5	7
306	7368	5.6221	1	2	3	8	13
307	2096	2.2457	1	1	2	3	4
308	7520	6.2090	1	2	4	8	14
309	4120	2.2998	1	1	2	3	4
310	24033	4.4040	1	1	3	6	10
311	8027	1.8343	1	1	1	2	3
312	1499	4.4957	1	1	3	6	10
313	594	2.3300	1	1	1	3	5
314	1	3.0000	3	3	3	3	3
315	30492	7.1080	1	1	4	9	16
316	105482	6.6227	2	3	5	8	13
317	1536	2.8561	1	1	2	3	6
318	5627	6.0105	1	3	5	8	12
319	428	2.7477	1	1	2	3	6
320	188146	5.3180	2	3	4	6	10
321	30418	3.7849	1	2	3	5	7
322	61	4.1475	2	2	3	5	8
323	17410	3.2221	1	1	2	4	7
324	7562	1.8803	1	1	1	2	3
325	8239	3.8229	1	2	3	5	7
326	2705	2.6699	1	1	2	3	5
327	11	3.0909	1	1	3	4	5
328	668	3.6722	1	1	3	5	8
329	76	2.0000	1	1	1	2	4
331	46575	5.5475	1	3	4	7	11
332	4939	3.2909	1	1	2	4	7
333	290	4.9828	1	2	3	6	10
334	10491	4.8593	2	3	4	6	8
335	11916	3.3087	2	2	3	4	5
336	37713	3.4950	1	2	2	4	7
337	30390	2.1186	1	1	2	3	3
338	1232	5.1080	1	2	3	7	11
339	1628	4.6161	1	1	3	6	11
340	1	1.0000	1	1	1	1	1
341	3766	3.0316	1	1	2	3	6
342	675	3.2207	1	2	2	4	6
344	3519	2.3743	1	1	1	2	5
345	1280	3.7914	1	1	2	4	8
346	4489	5.9082	1	3	4	7	12
347	366	2.9372	1	1	2	4	6
348	3077	4.1677	1	2	3	5	8
349	626	2.5335	1	1	2	3	5
350	6325	4.4024	1	2	4	5	8
352	766	3.9621	1	2	3	5	8
353	2557	6.4490	2	3	5	7	12
354	7609	5.8406	3	3	4	7	11
355	5530	3.2790	2	3	3	4	5
356	25303	2.2920	1	1	2	3	4
357	5580	8.4925	3	4	7	10	16
358	20492	4.3132	2	3	3	5	7
359	30149	2.7284	2	2	3	3	4
360	16035	2.8549	1	2	2	3	5
361	386	2.9948	1	1	2	3	5
363	2875	3.4650	1	2	2	3	7
364	1666	3.8427	1	1	3	5	8
365	1737	7.2239	1	3	5	9	16

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 03/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
366	4468	6.7258	1	3	5	8	14
367	584	3.1284	1	1	2	4	6
368	3136	6.4716	2	3	5	8	12
369	3178	3.2498	1	1	2	4	7
370	1151	5.9079	3	3	4	5	10
371	1368	3.6447	2	3	3	4	5
372	964	3.2811	1	2	2	3	5
373	3920	2.2487	1	2	2	3	3
374	130	3.0846	1	2	2	3	4
375	11	2.2727	1	2	2	2	4
376	249	3.0843	1	2	2	4	6
377	51	5.0392	1	1	4	6	12
378	158	2.4177	1	1	2	3	4
379	344	3.4506	1	1	2	4	6
380	60	2.0833	1	1	1	2	5
381	154	2.5065	1	1	1	3	5
382	45	1.2889	1	1	1	1	2
383	1746	3.6174	1	1	2	4	8
384	121	2.1488	1	1	1	2	4
385	1	1.0000	1	1	1	1	1
389	16	13.5000	1	3	6	11	24
390	14	4.0000	1	2	3	6	7
391	1	4.0000	4	4	4	4	4
392	2349	9.6841	3	4	7	12	20
394	1891	7.1364	1	2	4	8	16
395	87678	4.4004	1	2	3	6	9
396	15	4.6667	1	2	4	6	7
397	17705	5.1893	1	2	4	7	10
398	17713	5.9510	2	3	5	7	11
399	1727	3.5634	1	2	3	5	7
400	6490	9.1307	1	3	6	12	20
401	5622	11.2782	2	5	9	15	23
402	1500	4.0933	1	1	3	6	9
403	31997	8.0849	2	3	6	10	17
404	4670	4.2621	1	2	3	6	9
406	2527	9.9201	3	4	7	12	21
407	723	4.4219	1	2	4	5	8
408	2196	8.0255	1	2	5	10	18
409	2831	5.9325	2	3	4	6	12
410	33654	3.9062	1	2	4	5	6
411	13	2.3077	1	1	2	2	5
412	30	2.4000	1	1	2	3	4
413	6491	7.0875	2	3	5	9	14
414	782	4.2813	1	2	3	5	9
415	39080	14.3464	4	6	11	18	28
416	184735	7.3935	2	4	6	9	14
417	18	5.0000	1	2	4	7	9
418	23026	6.1212	2	3	5	7	11
419	15460	4.7254	2	2	4	6	9
420	3116	3.4881	1	2	3	4	6
421	11535	3.7877	1	2	3	5	7
422	83	3.0482	1	2	3	4	6
423	7539	8.1108	2	3	6	10	16
424	1308	13.6338	2	5	9	16	26
425	15852	3.9953	1	2	3	5	8
426	4552	4.4512	1	2	3	5	9
427	1669	4.6207	1	2	3	6	9
428	854	6.9859	1	2	4	8	14
429	26786	6.3438	2	3	5	7	12
430	59892	8.0207	2	3	6	10	16
431	319	6.4326	1	3	5	7	12
432	475	4.7684	1	2	3	5	9
433	5522	3.0996	1	1	2	4	6
439	1356	8.3857	1	3	5	10	18
440	5191	9.0326	2	3	6	11	20
441	604	3.2235	1	1	2	4	7
442	15588	8.4766	1	3	6	10	18
443	3743	3.4320	1	1	3	4	7
444	5303	4.1495	1	2	3	5	8
445	2450	2.8857	1	1	2	4	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued
 [FY2000 MEDPAR update 03/01 Grouper V19.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
447	5497	2.4708	1	1	2	3	5
449	28365	3.7491	1	1	3	5	8
450	6934	1.9980	1	1	1	2	4
451	3	1.3333	1	1	1	2	2
452	22930	4.8560	1	2	3	6	10
453	5091	2.7969	1	1	2	3	5
454	4001	4.5431	1	2	3	5	9
455	939	2.5751	1	1	2	3	5
461	3676	4.3708	1	1	2	5	11
462	13083	11.2728	4	6	10	14	21
463	22068	4.1282	1	2	3	5	8
464	6542	3.0011	1	1	2	4	6
465	248	3.0202	1	1	2	4	6
466	1741	3.7030	1	1	2	4	8
467	1137	3.0633	1	1	2	3	6
468	55027	12.8995	3	6	10	16	26
471	11720	5.5506	3	4	4	6	9
473	7663	12.5910	1	3	7	18	32
475	107894	11.2229	2	5	9	15	22
476	4151	10.8829	2	5	9	14	21
477	25363	8.1252	1	3	6	11	17
478	108182	7.2900	1	3	5	9	15
479	24051	3.4569	1	1	3	4	7
480	562	20.9609	7	9	14	25	44
481	383	24.1253	10	18	22	27	39
482	5737	12.9796	4	7	10	15	25
483	42789	39.4482	14	22	33	49	71
484	331	13.0091	2	6	10	17	26
485	2959	9.7080	4	5	7	11	18
486	2017	12.4408	1	5	10	16	25
487	3506	7.3945	1	3	6	10	15
488	784	16.9031	3	7	12	22	36
489	14140	8.4372	2	3	6	10	17
490	5454	5.3577	1	2	4	6	11
491	12291	3.4475	2	2	3	4	6
492	2698	15.6675	3	5	8	25	34
493	55279	5.7576	1	3	5	7	11
494	30109	2.4447	1	1	2	3	5
495	159	15.0503	7	9	12	17	26
496	1504	9.7088	4	5	7	12	19
497	17585	6.5739	3	4	5	7	11
498	12931	4.1718	2	3	4	5	6
499	30519	4.7011	1	2	3	6	9
500	44330	2.6104	1	1	2	3	5
501	2200	10.9600	4	6	8	13	21
502	585	6.5692	3	4	5	8	11
503	5630	4.0014	1	2	3	5	7
504	118	30.5169	9	15	24	41	55
505	145	3.3517	1	1	1	3	7
506	931	17.4071	4	8	14	22	36
507	293	8.3379	2	4	7	11	18
508	671	7.4918	2	3	5	9	15
509	177	4.5367	1	2	4	6	9
510	1650	7.2358	2	3	5	9	15
511	608	4.8158	1	2	3	6	11
512	340	13.8971	7	8	11	16	25
513	115	10.6000	6	7	8	11	19
514	17025	7.8702	2	3	6	10	16
515	3788	5.9060	1	1	4	8	13
516	68886	4.7702	2	3	4	6	9
517	171423	2.6737	1	1	2	3	6
518	48733	3.5023	1	1	2	4	8
519	6359	5.1030	1	2	3	6	12
520	9489	2.1653	1	1	2	3	4
521	28014	5.9437	2	3	4	7	12
522	6852	9.4658	3	5	8	12	20
523	14954	4.0942	1	2	3	5	7
	11094323						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) JULY 2001

State	Urban	Rural
ALABAMA	0.343	0.410
ALASKA	0.417	0.697
ARIZONA	0.355	0.493
ARKANSAS	0.466	0.445
CALIFORNIA	0.339	0.432
COLORADO	0.422	0.577
CONNECTICUT	0.497	0.506
DELAWARE	0.511	0.450
DISTRICT OF COLUMBIA	0.421	.....
FLORIDA	0.351	0.370
GEORGIA	0.461	0.469
HAWAII	0.412	0.549
IDAHO	0.541	0.561
ILLINOIS	0.404	0.501
INDIANA	0.524	0.533
IOWA	0.486	0.613
KANSAS	0.415	0.637
KENTUCKY	0.479	0.492
LOUISIANA	0.401	0.491
MAINE	0.614	0.540
MARYLAND	0.759	0.819
MASSACHUSETTS	0.511	0.571
MICHIGAN	0.459	0.563
MINNESOTA	0.493	0.592
MISSISSIPPI	0.452	0.446
MISSOURI	0.404	0.475
MONTANA	0.537	0.588
NEBRASKA	0.448	0.610
NEVADA	0.306	0.503
NEW HAMPSHIRE	0.549	0.585
NEW JERSEY	0.394	.....
NEW MEXICO	0.466	0.491
NEW YORK	0.524	0.607
NORTH CAROLINA	0.517	0.463
NORTH DAKOTA	0.620	0.655
OHIO	0.500	0.568
OKLAHOMA	0.409	0.492
OREGON	0.614	0.598
PENNSYLVANIA	0.398	0.526
PUERTO RICO	0.486	0.584
RHODE ISLAND	0.510	.....
SOUTH CAROLINA	0.440	0.463
SOUTH DAKOTA	0.529	0.640
TENNESSEE	0.438	0.453
TEXAS	0.401	0.493
UTAH	0.497	0.582
VERMONT	0.572	0.599
VIRGINIA	0.459	0.496
WASHINGTON	0.582	0.639
WEST VIRGINIA	0.568	0.527
WISCONSIN	0.524	0.613
WYOMING	0.523	0.717

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) JULY 2001

State	Ratio
ALABAMA	0.044
ALASKA	0.058
ARIZONA	0.038
ARKANSAS	0.049
CALIFORNIA	0.034
COLORADO	0.045
CONNECTICUT	0.036
DELAWARE	0.051

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) JULY 2001—Continued

State	Ratio
DISTRICT OF COLUMBIA	0.035
FLORIDA	0.043
GEORGIA	0.051
HAWAII	0.038
IDAHO	0.046
ILLINOIS	0.040
INDIANA	0.056
IOWA	0.049
KANSAS	0.050
KENTUCKY	0.046
LOUISIANA	0.047
MAINE	0.040
MARYLAND	0.013
MASSACHUSETTS	0.053
MICHIGAN	0.044
MINNESOTA	0.047
MISSISSIPPI	0.044
MISSOURI	0.044
MONTANA	0.053
NEBRASKA	0.054
NEVADA	0.030
NEW HAMPSHIRE	0.061
NEW JERSEY	0.036
NEW MEXICO	0.045
NEW YORK	0.051
NORTH CAROLINA	0.046
NORTH DAKOTA	0.074
OHIO	0.047
OKLAHOMA	0.046
OREGON	0.046
PENNSYLVANIA	0.039
PUERTO RICO	0.045
RHODE ISLAND	0.029
SOUTH CAROLINA	0.046
SOUTH DAKOTA	0.059
TENNESSEE	0.048
TEXAS	0.046
UTAH	0.047
VERMONT	0.052
VIRGINIA	0.055
WASHINGTON	0.063
WEST VIRGINIA	0.045
WISCONSIN	0.051
WYOMING	0.065

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 final 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. We estimate the total impact of these changes for FY 2002 payments compared to FY 2001 payments to be approximately a \$1.9 billion increase. As such, this final rule is a major rule as defined in 5 U.S.C. 804(2). Therefore, we have prepared an impact analysis for this final rule.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final 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. 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 (Public Law 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the hospital inpatient prospective payment systems, we classify these hospitals as urban hospitals.

It is clear that the changes being made 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 final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

We have reviewed this final rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that the final rule will not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

Section 202 of the Unfunded Mandate Reform Act of 1995 (Public Law 104–4) also requires that agencies assess anticipated costs and benefits before issuing any final rule that has been preceded by a final rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million. This final rule would not mandate any requirements for State, local, or tribal governments.

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

II. Changes in the Final Rule

Since we published the proposed rule, the market basket estimates for hospitals subject to the inpatient prospective payment system and hospitals and units excluded from the system have both risen by 0.2 percentage points. As a result, the updates are 0.2 percentage points higher than the updates reflected in the impact analysis for the proposed rule. With the exception of these changes, we are generally implementing the policy and

statutory provisions discussed in the proposed rule.

III. Impact Analysis for CMS-1131-F and CMS-1178-F

As noted previously, this final rule contains provisions implemented in two interim final rules with comment periods. The first, published August 1, 2000 (65 FR 47026), implemented, or conformed the regulations to, certain statutory provisions relating to Medicare payments to hospitals for inpatient services that were contained in Public Law 106-113. The second, published June 13, 2001 (66 FR 32172), implemented, or conformed the regulations to, certain statutory provisions relating to Medicare payments to hospitals for inpatient services that were contained in Public Law 106-554.

As described in the preamble to this final rule, with the exception of minor changes to the process for receiving, reviewing, and approving new Medicare-dependent small rural hospitals (MDHs), we are not changing the policies described in those interim final rules with comment period. Therefore, the reader should refer to the impact analyses contained in those interim final rules for a discussion of the impacts of these changes. For the impact analysis in the August 1, 2000 interim final rule, the reader should refer to page 47043. For the impact analysis in the June 13, 2001 interim final rule, the reader should refer to page 32184.

IV. Limitations of Our Analysis

As has been the case in our previously published regulatory impact analyses, the following quantitative analysis presents the projected effects of our proposed policy changes, including statutory changes effective for FY 2002, 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. We received two comments on the impact analysis for our May 4, 2001 proposed rule.

Comment: One commenter, who was unable to reconcile the standardized amounts for FY 2002 proposed in the May 4, 2001 **Federal Register** with the standardized amounts published for FY 2001 (65 FR 47126 and 66 FR 32176), expressed concern with the level of detail provided by the impact analysis

and requested a breakdown of the changes reflected in Column 8 of Table 1. The commenter also requested that we release the complete data so that hospitals could evaluate all the proposed FY 2002 policy changes on their own.

Response: As we stated in the proposed rule, column 8 compares our estimate of payments per case, incorporating all changes reflected in this final rule for FY 2002 (including statutory changes), to our estimate of payments per case in FY 2001. It includes the effects of the 2.75 percent update to the standardized amounts and the hospital-specific rates for MDHs and SCHs. It also reflects the 1.1 percentage point difference between the projected percentage of outlier payments in FY 2001 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2001 (6.2 percent), as described in the introduction to this Appendix and the Addendum to this final rule. Additionally, there are differences resulting from the increased number of hospitals receiving DSH payments under Section 211 of Public Law 106-554 and from the increase in SCH rebasing to a 1996 blended rate. There are also interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 7 may not equal the sum of the changes in columns 5 and 6, plus the other impacts that we are able to identify. Since we explain the update for FY 2002 in section II. of the Addendum to this final rule, and since the impact of those changes are the same for all types of hospitals, we do not believe it is necessary to isolate that change in a separate impact column. Also, we would like to note that all of the data used by us in the impact analysis are available to the public. Our impact file is posted on our website following the publication of each proposed and final rule. For information on obtaining the MedPAR file, the Provider-Specific File, and the cost report files on which all of our analysis is based, we refer the reader to section VIII. of this final rule.

Comment: One commenter noted that, in the proposed rule, the budget neutrality factor in footnote 6 of Table 1 was printed as 0.992394 while the same factor was printed as 0.992493 on page 22872 and asked which factor was correct.

Response: Footnote 6 to Table 1 in the proposed rule contained a typographical error. The budget neutrality factor used in the proposed rule was 0.992493 and

was printed correctly on page 22872 of the proposed rule.

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 48 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. We also exclude critical access hospitals (CAHs) from our analysis, due to the special characteristics of these hospitals. Among other short-term, acute care hospitals, only the 68 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 July 2001, we have included 4,795 hospitals in our analysis. This represents about 80 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

The remaining 20 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 final policy changes on these hospitals are discussed below.

VI. Impact on Excluded Hospitals and Units

As of July 2001, there were 1,064 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. Broken down by specialty, there were 507 psychiatric, 210 rehabilitation, 260 long-term care, 77 children's, and 10 cancer hospitals. In addition, there were 1,446 psychiatric units and 926 rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also paid in accordance with § 413.40. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 68 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

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 2002 would be between 0.8 and 3.3 percent, or 0 percent, depending on the hospital's or unit's costs in relation to its limit for the most recent cost reporting period for which information is available.

The impact on excluded hospitals and units of the 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. Graduate Medical Education Impact

A. National Average Per Resident Amount (PRA)

As discussed in detail in section IV.H.2. of this proposed rule, we proposed to implement section 511 of Public Law 106-554, which increased the floor of the locality-adjusted national average (PRA for the purposes of computing direct GME payments for cost reporting periods beginning during FY 2002. The national average PRA payment methodology, as provided in section 311 of Public Law 106-113, establishes a "floor" and "ceiling" based on a locality-adjusted, updated national average PRA for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2005. Section 511 of Public Law 106-554 increased the floor from 70 percent to

equal 85 percent of a locality-adjusted national average PRA for FY 2002.

For this final rule, we have calculated an estimated impact of this policy on teaching hospitals' PRAs for FY 2002, making assumptions about update factors and geographic adjustment factors (GAF) for each hospital. Generally, using FY 1997 data, we calculated a floor based on 70 percent of the national average PRA and a floor based on 85 percent of the national average PRA. We then determined the amount of direct GME payments that would have been paid had the floor remained at 70 percent of the national average PRA. Next, we determined the amount of direct GME payments that would be paid with the floor increased to equal 85 percent of the national average PRA. We subtracted the difference between the two and inflated the difference to FY 2002 to determine the impact of this provision.

The figures we used in this impact, except for the FY 1997 weighted PRA of \$68,464, are estimations and are for demonstrative purposes only. Hospitals must use the methodology stated in section IV.H. of this final rule to revise (if appropriate) their individual PRAs.

In calculating this impact, we used Medicare cost report data for all cost reports ending in FY 1997. We excluded hospitals that file manual cost reports because we did not have access to their Medicare utilization data. We also excluded all teaching hospitals in Maryland, because these hospitals are paid on a Medicare waiver outside of the prospective payment system, and those hospitals' PRAs do not determine their level of direct GME payments. For hospitals that had two cost reporting periods ending in FY 1997, we used the later of the two periods. A total of 1,231 teaching hospitals were included in the analysis.

Using the FY 1997 weighted average PRA of \$68,464, we determined an 85 percent floor of \$58,194 for FY 1997. We then determined that, for cost reporting periods ending in FY 1997, approximately 562 hospitals had PRAs that were below \$58,194 (336 hospitals of these hospitals had PRAs that were below the 70-percent floor, and 226 hospitals had PRAs that were above the 70-percent floor but below the 85-percent floor). The estimated total cost to the Medicare program in FY 2002 of replacing the PRAs of the 562 hospitals with the 85-percent floor is \$105.3 million.

B. Closed Training Programs or Hospitals That Close Their Training Programs

As discussed in IV.H.5, of the preamble of this final rule, we are allowing a hospital to receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another hospital's GME program if the hospital that closed its program agrees to temporarily reduce its FTE cap. We have calculated an estimated impact on the Medicare program for FY 2002 as a result of this policy. We used the best available cost report data from the FY 1997 HCRIS in our analysis.

We estimate that approximately 5 to 10 programs, each with an average of 25 residents, close each year without advance warning, displacing the residents before they complete their training. Therefore, the number of residents displaced each year could be between 125 and 250. We estimated the impact of this change based on direct GME and IME payment amounts in FY 1997 to determine a total GME amount and updated the total with the CPI-U for FY 2002. At most, the estimated impact for this provision for FY 2002 is moving payments of between \$10 and \$20 million among different hospitals. This would result from redirecting these payments from the hospital that closed its program to the hospital(s) that takes on the residents.

VIII. Quantitative Impact Analysis of the Final Policy Changes Under the Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this final rule, we are announcing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We have prepared separate impact analyses of the final 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 March 2001 update of the FY 2000 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 final 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 final 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 sources overall. For individual hospitals, however, some miscategorizations are possible.

Using cases from the March, 2001 update of the FY 2000 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 FY 2002 policy changes to the capital prospective payment system are discussed in section IX. of this Appendix.

The changes discussed separately below are the following:

- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the diagnosis-related group (DRG) relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 1998, compared to the FY 1997 wage data.
- The effects of our final policy to increase the accuracy of the wage index calculation by changing the overhead allocation method used so that the salaries and hours of lower-wage, overhead employees and the overhead wage-related costs associated with the excluded areas of the hospital are more accurately removed when calculating the overhead costs attributable to wages.
- The effects of our final policy to include the contract labor costs of laboratories and pharmacies from Worksheet S-3 Part II Lines 9.01 and 9.02 in the wage index calculation.
- The combined effects of our changes to the wage index data and calculations and the changes in the DRG recalibration.
- The effects of geographic reclassifications by the Medicare Geographic Classification Review Board

(MGCRB) that will be effective in FY 2002.

- The effects of our new policy to hold-harmless other hospitals in an urban area where certain hospitals are reclassified elsewhere by including the wage data of reclassified hospitals in their geographic area as well as the area to which they are reclassified.

- The total change in payments based on FY 2002 policies relative to payments based on FY 2001 policies.

To illustrate the impacts of the FY 2002 final changes, our analysis begins with a FY 2002 baseline simulation model using: the FY 2001 DRG GROUPER (version 18.0); the FY 2001 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total DRG plus outlier payments.

Each final and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2002 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 2001 to FY 2002. Five factors have significant impacts here. The first is the update to the standardized amounts. In accordance with section 1886(d)(3)(A)(iv) of the Act, as amended by section 301 of Public Law 106-554, we updated the large urban and the other areas average standardized amounts for FY 2002 using the most recently forecasted hospital market basket increase for FY 2002 of 3.3 percent minus 0.55 percentage points (for an update of 2.75 percent). Under section 1886(b)(3) of the Act, the updates to the hospital-specific amounts for sole community hospitals (SCHs) and for MDHs are equal to the market basket increase of 3.3 percent minus 0.55 percentage points (for an update of 2.75 percent).

A second significant factor that impacts changes in hospitals' payments per case from FY 2001 to FY 2002 is the change in MGCRB status from one year to the next. That is, hospitals reclassified in FY 2001 that are no longer reclassified in FY 2002 may have a negative payment impact going from FY 2001 to FY 2002; conversely, hospitals not reclassified in FY 2001 that are reclassified in FY 2002 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 change in payments for the category may be below the national mean. This effect may be alleviated somewhat by section 304(a) of Public

Law 106-554, which provided that reclassifications for purposes of the wage index are for a 3 year period.

A third significant factor is that we currently estimate that actual outlier payments during FY 2001 will be 6.2 percent of actual total DRG payments. When the FY 2001 final rule was published, we projected FY 2001 outlier payments would be 5.1 percent of total DRG plus outlier payments; the standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2001 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 2001 payments per case to estimated FY 2002 payments per case.

Fourth, section 213 of Public Law 106-554 provided that all SCHs may receive payment on the basis of their costs per case during their cost reporting period that began during 1996. For FY 2002, eligible SCHs that are rebased receive a hospital-specific rate comprised of the greater of 50-percent of the higher of their FY 1982 or FY 1987 hospital-specific rate or 50-percent of the federal rate, and 50-percent of their FY 1996 hospital-specific rate.

Fifth, sections 302 and 303 of Public Law 106-554 affect payments for indirect medical education (IME) and disproportionate share hospitals (DSH), respectively. These sections increased IME and DSH payments during FY 2001 (effective with discharges on or after April 1, 2001). For FY 2002, section 302 established IME payments at the same level as FY 2001 (6.5 percent), and section 303 established DSH payments at the adjustment the hospital would otherwise receive minus 3 percent.

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 4,795 hospitals included in the analysis. This number is 93 fewer hospitals than were included in the impact analysis in the FY 2001 final rule (65 FR 47191).

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) and rural). There are 2,704 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,561 hospitals located in large urban areas (populations over 1 million), and 1,143 hospitals in other urban areas (populations of 1 million or fewer). In

addition, there are 2,091 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 2002 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 that the number of hospitals paid based on these categorizations (after consideration of geographic reclassifications) are 2,746, 1,632, 1,114, and 2,049, respectively.

The next three groupings examine the impacts of the final changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 3,668 non-teaching hospitals in our analysis, 890 teaching hospitals with fewer than 100 residents, and 237 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.) We note that section 211 of Public Law 106-554 reduced the qualifying DSH threshold to 15 percent for all hospitals (this threshold previously applied to urban hospitals with 100 or more beds and rural hospitals with 500 or more beds). Consequently, many more hospitals qualify for DSH. In the FY 2001 final rule, there were 3,070 hospitals that did not receive a DSH adjustment (65 FR 47192). In Table I, the number of hospitals that did not receive a DSH adjustment declines to 1,879. The number of urban hospitals with fewer than 100 beds receiving DSH increases from 72 prior to section 211 to 316 after its implementation. Among rural hospitals with fewer than 100 beds, 103 received DSH prior to section 211; for FY 2002 that number increases to 454.

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 five rows examine the impacts of the final changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and

MDHs), as well as rural hospitals not receiving a special payment designation. The RRCs (165), SCHs (680), MDHs (329), and SCH and RRCs (70) shown here were not reclassified for purposes of the standardized amount. There are 15 RRCs, 1 MDH, 4 SCHs, and 1 SCH and RRC that will be reclassified as urban for the standardized amount in FY 2002 and, therefore, are not included in these rows.

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 1999 Medicare cost report files, if available (otherwise FY 1998 data are used). Data needed to determine ownership status or Medicare utilization percentages were unavailable for 52 and 78 hospitals, respectively. For the most part, these appear to be new hospitals, without cost reports on file for FY 1999.

The next series of groupings concern the geographic reclassification status of hospitals. The first grouping displays all hospitals that were reclassified by the MGCRB for FY 2002. The next two groupings separate the hospitals in the first group by urban and rural status. 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 2002 OPERATING PROSPECTIVE PAYMENT SYSTEM
[Percent changes in payments per case]

	Num. of hosps. ¹	DRG re-calib. ²	New wage data ³	New overhead alloc. ⁴	Include contract labor ⁵	DRG & WI changes ⁶	MCGRB reclassification ⁷	Reclassification hold-harmless policy ⁸	All FY 2002 changes ⁹
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
By Geographic Location									
All hospitals	4,795	0.3	0.2	-0.1	-0.1	0.0	-0.2	0.2	2.1
Urban hospitals	2,704	0.3	0.2	-0.1	-0.1	0.0	-0.7	0.2	1.9
Large urban areas (populations over 1 million)	1,561	0.4	0.0	-0.1	-0.1	-0.1	-0.8	0.3	1.8
Other urban areas (populations of 1 million or fewer)	1,143	0.2	0.5	-0.2	-0.1	0.2	-0.5	0.1	2.0
Rural hospitals	2,091	0.0	0.0	0.2	0.2	-0.2	2.6	0.0	3.4
Bed Size (Urban):									
0-99 beds	695	-0.1	0.1	0.1	0.1	0.0	-0.8	0.2	2.6
100-199 beds	948	0.3	-0.1	0.2	0.2	0.0	-0.7	0.3	2.1
200-299 beds	529	0.3	0.2	0.0	0.0	0.1	-0.7	0.3	2.0
300-499 beds	383	0.3	0.4	-0.3	-0.2	0.0	-0.7	0.2	1.8
500 or more beds	149	0.5	0.4	-0.4	-0.4	0.0	-0.6	0.1	1.6
Bed Size (Rural):									
0-49 beds	1,226	-0.2	0.1	0.2	0.1	-0.3	0.3	0.0	3.4
50-99 beds	520	-0.1	0.0	0.2	0.1	-0.3	1.0	0.0	3.5
100-149 beds	203	0.0	0.0	0.3	0.2	-0.1	3.3	0.1	3.4
150-199 beds	75	0.1	-0.2	0.2	0.2	-0.2	5.2	0.0	3.6
200 or more beds	67	0.1	-0.1	0.1	0.1	-0.2	4.8	0.0	3.3
Urban by Region:									
New England	138	0.3	1.6	-0.3	-0.2	1.2	-0.3	0.2	3.0
Middle Atlantic	416	0.4	-0.5	0.0	0.1	-0.4	-0.7	0.6	1.3
South Atlantic	393	0.4	0.5	-0.1	-0.1	0.4	-0.8	0.3	2.4
East North Central	459	0.2	0.1	-0.2	-0.2	-0.3	-0.5	0.1	1.7
East South Central	160	0.3	1.0	-0.1	-0.1	0.8	-0.7	0.0	3.0
West North Central	187	0.2	0.4	-0.3	-0.3	-0.1	-0.7	0.0	1.7
West South Central	340	0.3	-0.2	-0.2	-0.1	-0.4	-0.7	0.0	1.3
Mountain	136	0.2	0.8	-0.3	-0.3	0.3	-0.7	0.0	2.2
Pacific	429	0.5	0.0	0.1	0.1	0.1	-0.8	0.3	1.9

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2002 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued
 [Percent changes in payments per case]

	Num. of hosps. ¹	DRG re-calib. ²	New wage data ³	New overhead alloc. ⁴	Include contract labor ⁵	DRG & WI changes ⁶	MCGRB reclassification ⁷	Reclassification hold-harmless policy ⁸	All FY 2002 changes ⁹
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Puerto Rico	46	0.1	2.1	-0.8	-0.9	1.1	-0.8	0.2	3.3
Rural by Region:									
New England	50	0.0	0.0	0.1	0.1	-0.3	2.9	0.0	3.7
Middle Atlantic	75	0.1	0.1	0.1	0.1	-0.1	2.3	0.0	3.2
South Atlantic	269	0.1	-0.1	0.2	0.2	-0.2	2.9	0.0	3.6
East North Central	276	-0.2	0.0	0.1	0.2	-0.4	2.2	0.0	2.9
East South Central	263	0.0	-0.1	0.2	0.2	-0.2	3.2	0.0	3.7
West North Central	481	-0.3	0.3	0.2	0.1	-0.1	1.8	0.0	2.6
West South Central	333	0.0	0.3	0.2	0.2	0.1	3.6	0.0	4.8
Mountain	195	0.0	-0.1	0.2	0.1	-0.3	1.7	0.0	3.0
Pacific	144	0.1	-0.9	0.2	0.2	-0.9	2.3	0.0	2.8
Puerto Rico	5	-0.3	6.1	0.2	0.1	5.6	-0.7	0.2	9.9
By Payment Classification:									
Urban hospitals	2,746	0.3	0.2	-0.1	-0.1	0.0	-0.6	0.2	1.9
Large urban hospitals (populations over 1 million)	1,632	0.4	0.0	-0.1	-0.1	-0.1	-0.7	0.3	1.9
Other urban hospitals (populations of 1 million or fewer)	1,114	0.2	0.5	-0.2	-0.1	0.2	-0.5	0.1	2.0
Rural hospitals	2,049	0.0	0.0	0.2	0.2	-0.2	2.4	0.0	3.4
Teaching Status:									
Non-teaching	3,668	0.1	0.0	0.2	0.2	0.0	0.2	0.2	2.4
Fewer than 100 Residents	890	0.2	0.4	-0.2	-0.1	0.1	-0.6	0.2	2.0
100 or more Residents	237	0.6	0.3	-0.5	-0.4	0.0	-0.5	0.1	1.7
Urban DSH:									
Non DSH	1,879	0.1	0.2	-0.1	-0.1	-0.1	-0.1	0.2	1.9
100 or more beds	1,379	0.4	0.2	-0.1	-0.1	0.1	-0.7	0.2	1.9
Less than 100 beds	316	0.1	-0.1	0.3	0.3	0.0	-0.7	0.2	4.0
Rural DSH:									
Sole Community (SCH)	545	0.0	0.0	0.1	0.1	-0.3	0.3	0.0	3.1
Referral Center (RRC)	152	0.2	-0.1	0.2	0.2	-0.1	5.2	0.0	3.8
Other Rural:									
100 or more beds	70	0.0	0.1	0.3	0.3	0.1	1.5	0.1	3.7
Less than 100 beds	454	-0.1	-0.1	0.2	0.2	-0.4	0.6	0.0	4.5
Urban teaching and DSH:									
Both teaching and DSH	758	0.5	0.3	-0.3	-0.2	0.1	-0.7	0.2	1.9
Teaching and no DSH	298	0.2	0.4	-0.3	-0.3	-0.1	-0.5	0.3	1.8
No teaching and DSH	937	0.3	0.0	0.2	0.2	0.1	-0.6	0.2	2.2
No teaching and no DSH	753	0.1	-0.1	0.1	0.1	-0.1	-0.6	0.2	1.8
Rural Hospital Types:									
Non-special status	805	-0.2	0.0	0.3	0.2	-0.2	0.9	0.0	3.8
RRC	165	0.1	-0.1	0.2	0.2	-0.1	6.3	0.1	3.7
SCH	680	0.0	0.0	0.1	0.1	-0.3	0.3	0.0	2.7
Medicare-dependent hospitals (MDH)	329	-0.2	0.2	0.1	0.1	-0.2	0.4	0.0	3.6
SCH and RRC	70	0.0	0.0	0.1	0.1	-0.3	2.1	0.0	2.9
Type of Ownership:									
Voluntary	2,765	0.3	0.1	-0.1	-0.1	-0.1	-0.3	0.2	2.0
Proprietary	717	0.3	0.1	0.0	0.0	0.1	0.0	0.1	2.4
Government	1,261	0.3	0.4	-0.1	0.0	0.3	0.0	0.0	0.0
Unknown	52	-0.4	0.6	0.1	0.1	-0.1	-1.8	1.0	1.6
Medicare Utilization as a Percent of Inpatient Days:									
0-25	396	0.7	0.2	0.0	0.0	0.5	-0.4	0.2	2.5
25-50	1,886	0.4	0.2	-0.2	-0.2	0.0	-0.6	0.2	1.9
50-65	1,843	0.1	0.2	0.0	0.0	0.0	0.1	0.2	2.4
Over 65	592	0.1	-0.2	0.2	0.2	-0.1	0.3	0.2	2.2
Unknown	78	0.3	-0.3	-0.1	0.0	-0.6	0.8	0.2	0.7
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2002 Reclassifications:									
All Reclassified Hospitals	628	0.2	0.2	0.0	0.0	0.0	5.0	0.1	3.3
Standardized Amount Only	74	0.1	-0.4	0.3	0.4	-0.3	2.2	0.4	3.8
Wage Index Only	391	0.2	0.0	0.0	0.0	-0.1	5.5	0.1	2.8
Both	58	0.2	0.3	0.1	0.1	0.1	5.1	0.0	0.6
All Nonreclassified Hospitals	4,246	0.3	0.2	-0.1	0.1	0.0	0.8	0.2	2.1
All Reclassified Urban Hospitals	117	0.4	0.7	-0.3	-0.3	0.2	4.2	0.1	2.6
Standardized Amount Only	14	0.2	-0.3	0.5	0.5	-0.1	0.4	0.3	2.6
Wage Index Only	83	0.4	0.7	-0.5	-0.4	0.2	4.5	0.1	2.4
Both	20	0.2	0.7	0.2	0.3	0.8	4.7	0.5	3.5
Urban Nonreclassified Hospitals	2,549	0.3	0.2	-0.1	-0.1	0.0	-1.0	0.2	1.8
Reclassified Rural Hospitals	511	0.1	0.0	0.2	0.2	-0.2	5.5	0.0	3.7
Standardized Amount Only	16	0.0	-0.1	0.2	0.2	-0.3	3.8	0.0	2.3
Wage Index Only	472	0.1	0.0	0.2	0.2	-0.2	5.3	0.0	3.7
Both	23	0.0	0.2	0.1	0.1	-0.1	9.3	0.0	4.0
Rural Nonreclassified Hospitals	1,577	-0.1	0.0	0.2	0.1	-0.3	-0.6	0.0	3.0

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2002 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued
[Percent changes in payments per case]

	Num. of hosps. ¹	DRG re- calib. ²	New wage data ³	New overhead alloc. ⁴	Include contract labor ⁵	DRG & WI changes ⁶	MCGRB reclassi- fication ⁷	Reclassi- fication hold- harmless policy ⁸	All FY 2002 changes ⁹
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Other Reclassified Hospitals (Section 1886(D)(8)(B)) ..	41	0.1	0.6	0.1	0.1	0.4	0.8	-0.7	4.2

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 2000, and hospital cost report data are from reporting periods beginning in FY 1999 and FY 1998.

² This column displays the payment impact of the recalibration of the DRG weights based on FY 2000 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

³ This column shows the payment effects of updating the data used to calculate the wage index with data from the FY 1998 cost reports.

⁴ This column displays the impact of removing the salaries and hours of lower-wage, overhead employees and the overhead wage-related costs associated with the excluded areas of the hospital from the wage index calculation.

⁵ This column displays the impact of including contract pharmacy and contract laboratory costs and hours in the wage index calculation.

⁶ 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, the revised overhead allocation, the laboratory and pharmacy contract labor costs, 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 1, 2, 3, and 4, and the FY 2002 budget neutrality factor of .995821.

⁷ Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2002 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2002. Reclassification for prior years has no bearing on the payment impacts shown here.

⁸ Shown here are the effects of our policy to hold-harmless other hospitals in an urban area where certain hospitals are reclassified elsewhere by including the wage data of reclassified hospitals in their geographic area as well as the area to which they are reclassified.

⁹ This column shows changes in payments from FY 2001 to FY 2002. It incorporates all of the changes displayed in columns 5, 6, and 7 (the changes displayed in columns 1, 2, 3, and 4 are included in column 5). It also displays the impact of the FY 2002 update, changes in hospitals' reclassification status in FY 2002 compared to FY 2001, and the difference in outlier payments from FY 2001 to FY 2002. It also reflects section 213 of Public Law 106-554, which permitted all SCHs to rebase for a 1996 hospital-specific rate. The sum of these columns may be different from the percentage changes shown here due to rounding and interactive effects.

B. Impact of the Final Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 1)

In column 1 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II. of the preamble to this final 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 2001 DRG relative weights (GROUPEL version 18) to aggregate payments using the final FY 2002 DRG relative weights (GROUPEL version 19). Overall payments increase 0.3 percent due to the DRG reclassification and recalibration. We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we have applied a budget neutrality factor to ensure that the overall payment impact of the DRG (and wage index) changes is budget neutral. This budget neutrality factor of 0.995821 is applied to payments in Column 5.

We estimate that the DRG changes effective with this final rule would result in higher payments to urban hospitals (0.3 percent) and would have a 0 percent impact on payments to rural hospitals. The changes also would result in higher payments to larger hospitals than to smaller hospitals. This impact is consistent for both urban and rural bed size groups.

This distributional impact likely results from the final changes to major diagnostic category (MDC) 5 "Diseases and Disorders of the Circulatory System." As described in section II. of the preamble of this final rule, we are removing cardiac defibrillator cases from DRGs 104 and 105, and creating two new DRGs for these cases. In addition, we are revising the basis of the DRG assignment for cases involving percutaneous transluminal coronary angioplasty based on whether the patient experienced an acute myocardial infarction. Because MDC 5 is a high volume category, refining the categorizations of these cases has a noticeable overall payment impact.

C. Impact of Updating the Wage Data and the Final Changes to the Wage Index Calculation (Columns 2, 3 & 4)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the final wage index for FY 2002 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1997 and before October 1, 1998. As with column 1, the impact of the new data on hospital payments is isolated in column 2 by holding the other payment parameters constant in the two simulations. That is, column 2 shows the percentage changes in payments when going from a model using the FY 2001 wage index (based on FY 1997 wage data before geographic reclassifications to a model using the FY

2002 prereclassification wage index based on FY 1998 wage data).

The wage data collected on the FY 1998 cost reports are similar to the data used in the calculation of the FY 2001 wage index. For a thorough discussion of the data used to calculate the wage index, see section III.B. of the preamble of this final rule. The July 30, 1999 final rule (64 FR 41505) indicated that we would phase-out costs related to GME and certified registered nurse anesthetists (CRNA) from the calculation of the wage index over a 5-year period, beginning in FY 2000. The FY 2001 wage index was based on a blend of 60 percent of an average hourly wage including these costs, and 40 percent of an average hourly wage excluding these costs. For FY 2002, the wage index is based on a blend of 40 percent of an average hourly wage including these costs, and 60 percent of an average hourly wage excluding these costs. This change is reflected in column 2.

The results indicate that the new wage data are estimated to provide a 0.2 percent increase for hospital payments overall (prior to applying the budget neutrality factor, see column 5). In some cases, the results shown in this final rule may be very different from the impacts shown in the proposed rule. This is due to the large number of data revisions submitted by hospitals after the proposed wage index was calculated. Approximately 30 percent of hospitals submitted revisions in the interim.

Rural hospitals are generally estimated to experience a negligible

impact from the new wage data, although rural hospitals in Puerto Rico experience a 6.1 percent increase, likely due to the 13 percent increase in the value of five providers' FY 2002 wage index compared to the wage index for those same providers for FY 2001. Additionally, rural hospitals in West North Central and West South Central experience estimated wage index-driven increases of more than 0.3 percent. Meanwhile, hospitals in the Pacific census division experience a 0.9 percent decrease.

Urban hospitals as a group are estimated to benefit positively from the updated wage data. The other urban hospitals appear to experience a 0.5 percent increase and estimated

payments to urban hospitals overall showed an increase of 0.2 percent. Among urban census divisions, Puerto Rico experiences a 2.1 percent increase, the New England division experiences a 1.6 percent increase, East South Central experiences a 1.0 percent increase, and Middle Atlantic a 0.5 percent decrease.

Columns 3 and 4, respectively, show that the final change to the overhead calculation and the policy to include contract labor costs in the wage index discussed in detail in section III.C. of the preamble of this final rule both appear to benefit rural hospitals and small hospitals. Urban hospitals as a group are impacted by a 0.1 percent decrease to their payments from each change. Rural hospitals are expected to

receive an estimated 0.2 percent increase in payments due to this policy change.

The following chart compares the shifts in wage index values for labor market areas for FY 2001 relative to FY 2002. This chart demonstrates the impact of the final changes for the FY 2002 wage index relative to the FY 2001 wage index. The majority of labor market areas (335) experience less than a 5-percent change. A total of 28 labor market areas experience an increase of more than 5 percent, with 2 having an increase greater than 10 percent. A total of 11 areas experience decreases of more than 5-percent. Of those, 1 declines by more than 10 percent.

Percentage change in area wage index values	Number of labor market areas	
	FY 2001	FY 2002
Increase more than 10 percent	1	2
Increase more than 5 percent and less than 10 percent	20	26
Increase or decrease less than 5 percent	339	335
Decrease more than 5 percent and less than 10 percent	14	10
Decrease more than 10 percent	1	1

Among urban hospitals, 129 would experience an increase of between 5 and 10 percent, and 3 experience an increase of more than 10 percent. A total of 18 rural hospitals have increases greater than 5 percent, with 5 increasing greater

than 10 percent. On the negative side, 29 urban hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. Four urban hospitals have decreases in their wage index values greater than 10

percent. There are no rural hospitals with decreases in their wage index values greater than 5 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	3	5
Increase more than 5 percent and less than 10 percent	129	13
Increase or decrease less than 5 percent	2,531	2,166
Decrease more than 5 percent and less than 10 percent	29	0
Decrease more than 10 percent	4	0

D. Combined Impact of DRG and Wage Index Changes— Including Budget Neutrality Adjustment (Column 5)

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 final rule, we compared simulated aggregate payments using the FY 2001 DRG relative weights and wage index to simulated aggregate payments using the final FY 2002 DRG relative weights and wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.995821. 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 5. 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 1, 2, 3 and 4, minus approximately 0.4 percent attributable to the budget neutrality factor. There may be some variation of plus or minus 0.1 percent due to rounding.

E. Impact of MGCRB Reclassifications (Columns 6 & 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 5 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2002. As noted below, these decisions may affect hospitals' standardized amount and wage index area assignments. The changes in column 7 reflect the postreclassified wage index values resulting from including the wage data for a reclassified hospital in both the area to

which it is reclassified and the area where the hospital is physically located.

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. 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.

The final FY 2002 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2002. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process for MGCRB decisions.

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 0.990675 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this final rule.) This results in a larger budget neutrality offset than the FY 2001 factor of 0.993187. This larger offset is accounted for by the extension of wage index reclassifications for 3 years as a result of section 304 of Public Law 106-554, and our final policy to hold-harmless the calculation of urban areas' wage indexes for reclassifications out of the area (see column 7). We have identified 162 hospitals that were reclassified for FY 2001, but not FY 2002, that will nonetheless continue to be reclassified due to section 304 of Public Law 106-554.

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.6 percent in column 6. Payments to urban hospitals decline 0.7 percent. Hospitals in other urban areas see a decrease in payments of 0.5 percent, while large urban hospitals lose 0.8 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally decline.

A positive impact is evident among most of the rural hospital groups. The largest increases are in the West South Central, East South Central, New England and the South Atlantic regions. These regions receive increases of 3.6, 3.2, and 2.9 and 2.9, respectively. The rural census division for the Puerto Rico region appears to receive an estimated decrease in payments of 0.7 percent.

Among all the hospitals that were reclassified for FY 2002, the MGCRB changes are estimated to provide a 5.0 percent increase in payments. Urban hospitals reclassified for FY 2002 are anticipated to receive an increase of 4.2 percent, while rural reclassified

hospitals are expected to benefit from the MGCRB changes with a 5.5 percent increase in payments. Overall, among hospitals that were reclassified for purposes of the standardized amount only, a payment increase of 2.2 percent is expected, while those reclassified for purposes of the wage index only show a 5.5 percent increase in payments. Payments to urban hospitals that did not reclassify are expected to decrease by 1.0 percent due to the budget neutrality of MGCRB changes. Those hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive an increase in payments of 0.1 percent.

Column 7 shows the impacts of our final policy to include the wage data for a reclassified hospital in both the area to which it is reclassified and the area where the hospital is physically located. This change affects overall payments by 0.2 percent, partially accounting for the larger budget neutrality factor compared to FY 2001. The payment impacts are generally largest in urban hospital groups, with the largest impact, 0.6 percent, experienced by urban hospitals in the Middle Atlantic census division.

F. All Changes (Column 8)

Column 8 compares our estimate of payments per case, incorporating all changes reflected in this final rule for FY 2002 (including statutory changes), to our estimate of payments per case in FY 2001. It includes the effects of the 2.75 percent update to the standardized amounts and the hospital-specific rates for MDHs and SCHs. It also reflects the 1.1 percentage point difference between the projected percentage of outlier payments in FY 2001 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2001 (6.2 percent), as described in the introduction to this Appendix and the Addendum to this final rule.

We also note that section 211 of Public Law 106-554 changed the criteria for hospitals to qualify for DSH payment status. Since more hospitals are now eligible to receive DSH payments for the full FY 2002, as opposed to for just the second 6 months of FY 2001, DSH payments to providers in FY 2002 would increase and this change is also captured in column 8.

Section 213 of Public Law 106-554 provided that all SCHs may elect to receive payment on the basis of their costs per case during their cost reporting period that began during 1996. For FY 2002, eligible SCHs that rebase receive a hospital-specific rate comprised of 50 percent of the higher of their FY 1982 or FY 1987 hospital-specific rate or their

Federal rate, and 50 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 8 as well.

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 5, 6, and 7, plus the other impacts that we are able to identify.

Hospitals in urban areas experience a 1.9 percent increase in payments per case compared to FY 2001. The net 0.5 percent negative impact due to reclassification (columns 6 and 7) is offset by a similar negative impact for FY 2001 of 0.4 percent (65 FR 47196). Hospitals in rural areas, meanwhile, experience a 3.4 percent payment increase. This is primarily due to the change in the DSH threshold to 15 percent for all hospitals enacted by section 211 of Public Law 106-554 effective for discharges on or after April 1, 2001, and the positive effect of the reclassification changes (2.6 percent increase).

The impact of lowering the DSH threshold is demonstrated in Column 8, although we would note that the estimated FY 2001 payments do reflect 6 months of payments to hospitals affected by this change. The impacts are seen in the rows displaying urban hospitals with fewer than 100 beds receiving DSH (4.0 percent increase), and all rural DSH categories.

Among urban census divisions, payments increased between 1.3 and 3.3 percent between FY 2001 and FY 2002. The rural census division experiencing the smallest increase in payments was the West North Central region (2.6 percent). The largest increases by rural hospitals is in Puerto Rico, where payments appear to increase by 9.9 percent, and West South Central, where payments appear to increase by 4.8 percent. All 5 of the rural Puerto Rico hospitals experienced an increase of greater than 10 percent in their wage index values (comparison of FY 2001 and FY 2002). Rural New England, East South Central, and South Atlantic regions also benefited with 3.7, 3.7, and 3.6 percent respectively.

Among special categories of rural hospitals, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) experience payment increases of 2.7 percent, 3.6 percent, and 2.9 percent, respectively. This outcome is primarily related to the fact that hospitals receiving payments under the hospital-specific methodology are not eligible for outlier payments. Therefore,

these hospitals do not experience negative payment impacts from the decline in outlier payments from FY 2001 to FY 2002 (from 6.2 percent of total DRG plus outlier payments to 5.1 percent) as do hospitals paid based on the national standardized amounts.

Among hospitals that were reclassified for FY 2002, hospitals overall are estimated to receive a 3.3

percent increase in payments. Urban hospitals reclassified for FY 2002 are anticipated to receive an increase of 2.6 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 3.7 percent increase in payments. Overall, among hospitals reclassified for purposes of the standardized amount only, a payment

increase of 3.8 percent is expected, while those hospitals reclassified for purposes of the wage index only show an expected 2.8 percent increase in payments. Those hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive an increase in payments of 4.2 percent.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2002 OPERATING PROSPECTIVE PAYMENT SYSTEM
[Payments per case]

	Num. of hosp.	Average FY 2001 payment per case ¹	Average FY 2002 payment per case ¹	All FY 2002 changes
	(1)	(2)	(3)	(4)
By Geographic Location				
All hospitals	4,795	6,994	7,141	2.1
Urban hospitals	2,704	7,559	7,703	1.9
Large urban areas (populations over 1 million)	.....	.....	.....	.....
Other urban areas (populations of 1 million or fewer)	1,143	6,853	6,989	2.0
Rural hospitals	2,091	4,808	4,972	3.4
Bed Size (Urban)	695	5,110	5,246	2.6
0–99 beds	.....	.....	.....	.....
100–199 beds	948	6,313	6,444	2.1
200–299 beds	529	7,218	7,364	2.0
300–499 beds	383	8,139	8,283	1.8
500 or more beds	149	9,875	10,035	1.6
Bed Size (Rural)	1,226	3,984	4,118	3.4
0–49 beds	.....	.....	.....	.....
50–99 beds	520	4,526	4,683	3.5
100–149 beds	203	4,858	5,022	3.4
150–199 beds	75	5,336	5,529	3.6
200 or more beds	67	6,188	6,392	3.3
Urban by Region	138	8,014	8,254	3.0
New England	.....	.....	.....	.....
Middle Atlantic	416	8,600	8,713	1.3
South Atlantic	393	7,169	7,338	2.4
East North Central	459	7,215	7,335	1.7
East South Central	160	6,776	6,976	3.0
West North Central	187	7,342	7,470	1.7
West South Central	340	6,998	7,090	1.3
Mountain	136	7,308	7,467	2.2
Pacific	429	8,939	9,109	1.9
Puerto Rico	46	3,207	3,312	3.3
Rural by Region	50	5,740	5,950	3.7
New England	.....	.....	.....	.....
Middle Atlantic	75	5,114	5,277	3.2
South Atlantic	269	4,950	5,128	3.6
East North Central	276	4,813	4,951	2.9
East South Central	263	4,423	4,587	3.7
West North Central	481	4,714	4,839	2.6
West South Central	333	4,249	4,452	4.8
Mountain	195	5,168	5,321	3.0
Pacific	144	6,090	6,263	2.8
Puerto Rico	5	2,521	2,771	9.9
By Payment Classification: Urban hospitals	2,746	7,538	7,682	1.9
Large urban hospitals (populations over 1 million)	1,632	8,026	8,175	1.9
Other urban hospitals (populations of 1 million or fewer)	1,114	6,870	7,006	2.0
Rural hospitals	2,049	4,791	4,954	3.4
Teaching Status	3,668	5,638	5,775	2.4
Non-teaching	.....	.....	.....	.....
Fewer than 100 Residents	890	7,327	7,473	2.0
100 or more Residents	237	11,280	11,473	1.7
Urban DSH	1,879	6,356	6,479	1.9
Non DSH	.....	.....	.....	.....
100 or more beds	1,379	8,152	8,307	1.9
Less than 100 beds	316	4,973	5,173	4.0
Rural DSH	545	4,650	4,796	3.1
Sole Community (SCH)	.....	.....	.....	.....

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2002 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued
[Payments per case]

	Num. of hosp.	Average FY 2001 payment per case ¹	Average FY 2002 payment per case ¹	All FY 2002 changes
	(1)	(2)	(3)	(4)
Referral Center (RRC)	152	5,542	5,754	3.8
Other Rural	70	4,320	4,479	3.7
100 or more beds				
Less than 100 beds	454	3,937	4,115	4.5
Urban teaching and DSH:				
Both teaching and DSH	758	9,081	9,250	1.9
Teaching and no DSH	298	7,577	7,715	1.8
No teaching and DSH	937	6,343	6,481	2.2
No teaching and no DSH	753	5,895	6,002	1.8
Rural Hospital Types				
Non-special status	805	4,048	4,204	3.8
RRC	165	5,433	5,636	3.7
SCH	680	4,884	5,017	2.7
Medicare-dependent hospitals (MDH)	329	3,852	3,991	3.6
SCH and RRC	70	5,902	6,073	2.9
Type of Ownership: Voluntary	2,341	7,149	7,295	2.1
Proprietary	645	6,641	6,773	2.0
Government	962	6,259	6,437	2.8
Unknown	847	7,151	7,293	2.0
Medicare Utilization as a Percent of Inpatient Days:				
0–25	396	9,564	9,807	2.5
25–50	1,886	8,045	8,195	1.9
50–65	1,843	6,040	6,184	2.4
Over 65	592	5,422	5,543	2.2
Unknown	78	10,360	10,433	0.7
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2002 Reclassifications:				
All Reclassified Hospitals	628	6,234	6,438	3.3
Standardized Amount Only	74	5,210	5,409	3.8
Wage Index Only	391	6,103	6,270	2.8
Both	58	6,876	6,919	0.6
All Nonreclassified Hospitals	4,246	7,122	7,269	2.1
All Reclassified Urban Hospitals	117	8,365	8,578	2.6
Standardized Amount Only	14	5,990	6,143	2.6
Wage Index Only	83	9,072	9,294	2.4
Both	20	6,064	6,276	3.5
Urban Nonreclassified Hospitals	2,549	7,539	7,678	1.8
All Reclassified Rural Hospitals	511	5,383	5,584	3.7
Standardized Amount Only	16	5,183	5,302	2.3
Wage Index Only	472	5,387	5,589	3.7
Both	23	5,381	5,597	4.0
Rural Nonreclassified Hospitals	1,577	4,271	4,399	3.0
Other Reclassified Hospitals (Section 1886(D)(8)(B))	41	4,838	5,043	4.2

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

Table II presents the projected impact of the final changes for FY 2002 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2001 with the average estimated per case payments for FY 2002, 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.

IX. Impact for Critical Access Hospitals (CAHs)

There are approximately 365 facilities that qualify as CAHs. These CAHs are paid based on reasonable costs for their services to inpatients and outpatients. We examined several parts of the final rule, as discussed in detail in section VI.B. of the preamble, for their potential impact on CAHs.

A. Exclusion of CAHs From Payment Window Requirements

In this final rule, we are clarifying the policy that CAHs are not subject to the payment window provisions of section

1886(a)(3) of the Act. Existing regulations do not require application of these provisions to CAHs, and we are not aware of specific situations in which they are now being applied. Consequently, we do not expect any increase or decrease in Medicare spending based on this clarification.

B. Availability of CRNA Pass-Through for CAHs

Under existing § 412.113(c), CRNA pass-through payment is available only to hospitals that either qualified for the pass-through of costs of anesthesia services furnished in calendar year

1989, or met certain conditions, including having employed or contracted with a qualified nonphysician anesthetist as of January 1, 1988, to perform anesthesia services. In this final rule, we are specifying that certain CAHs that meet the pass-through criteria would qualify for pass-through payments. Under the existing criterion, we believe the only facilities that could qualify for the pass-through as CAHs are those that would have qualified for the pass-through if they had elected to continue participating in Medicare as hospitals rather than converting to CAH status. We do not expect any increase or decrease in Medicare spending based on the final change in the regulations.

C. Payment for Emergency Room On-Call Physicians

In accordance with the amendments made by section 204 of Public Law 106-544, in this final rule, we are specifying that we will recognize as allowable costs, amounts for reasonable compensation and related costs for emergency room physicians who are on call but who are not present on the premises of a CAH. We expect that at least some CAHs will elect to compensate emergency room physicians for being on call and that, as a result, Medicare spending for CAH services will increase. However, we do not have information to develop a reliable estimate of how many CAHs will make this election, or how much physician compensation costs they will incur for on call time.

D. Treatment of Ambulance Services Furnished by Certain CAHs

In accordance with the provisions of section 205 of Public Law 106-544, we are amending the existing CAH regulations to provide for payment to CAHs for the reasonable costs of ambulance services furnished by a CAH or an entity owned or operated by the CAH if certain statutory requirements are met. We expect that at least some CAHs or entities owned or operated by CAHs will be able to qualify for payment for their ambulance services. To the extent that CAHs or CAH owned or operated entities furnish these services under the conditions specified in the law, ambulance services will be paid for at higher rates than would otherwise apply. As a result, Medicare spending for ambulance services will increase. However, we do not have sufficient information or data to develop a reliable estimate of how many CAHs or entities will qualify or the dollar amount of ambulance service costs they will incur.

E. Qualified Practitioners for Preanesthesia and Postanesthesia Evaluations in CAHs

As discussed in section VI.B. of this final rule, in an effort to eliminate or minimize potential issues relating to beneficiary access to medical services in rural areas, we are allowing CRNAs who administer the anesthesia to conduct the preanesthesia and postanesthesia evaluations in a CAH. As with any licensed independent health care provider, the final change will not permit CRNAs to practice beyond his or her licensed scope of practice.

We believe that this policy will increase flexibility of providers in furnishing medical services in rural areas. However, we do not have information or data to develop a reliable estimate of how many CRNAs would be used to conduct preanesthesia and postanesthesia evaluations in CAHs or what the associated costs would be.

X. Impact of Changes in the Capital Prospective Payment System

A. General Considerations

We now have cost report data for the 8th year of the capital prospective payment system (cost reports beginning in FY 1999) available through the March 2001 update of the 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.

- 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 fiscal 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 2002 capital cost projections. In Appendix B of this final rule, we discuss the assumptions and computations that we employ to generate the amount of obligated capital commitments for use in the FY 2002 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 2002. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the FY 2002 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 2002 capital costs for individual hospitals, but with the most recent data on 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 FY 2002 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 2001 to FY 2002 using a capital cost model. The FY 2002 model, as described in Appendix B of this final 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 1999 as reported on the March 2001 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 April 1, 2001 in the provider-specific file. We used these data to determine the FY 2002 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 1999, 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 1999. All Federal rate payment parameters are assigned to the

applicable hospital. We will continue to pay regular exceptions during cost reporting periods beginning before October 1, 2001 but ending in FY 2002. However, in FY 2003 and later, payments will no longer be made under the regular exceptions provision; hence, we will no longer require the actuarial model described in Appendix B of this final rule.

For purposes of this impact analysis, the FY 2002 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
2000	1.39
2001	1.37
2002	2.58

- We estimate that the Medicare case-mix index will decrease by 0.9 percent in FY 2001 and will increase by 1.0 percent in FY 2002.

- The Federal capital rate and the hospital-specific rate were updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for

forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The FY 2002 update is 1.3 percent (see section IV. of the Addendum to this final rule).

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 2001 to FY 2002. 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. We are no longer displaying a column for the hospital-specific payments in Table III since, beginning with FY 2001, the transition blend percentage for fully prospective hospitals is 100 percent of the Federal rate and zero percent of the hospital-specific rate, and all hospitals (except "new" hospitals under § 412.324(b)) are paid based on 100 percent of the Federal rate for FY 2002. Based on our actuarial model, the breakdown of hospitals is as follows:

CAPITAL TRANSITION PAYMENT METHODOLOGY FOR FY 2002

Type of hospital	Percent of hospitals	Percent of discharges	Percent of capital costs	Percent of capital payments
Low Cost Hospital	66	62	57	61
High Cost Hospital	34	38	43	39

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(c) for putting obligated capital into 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 2001 to FY 2002 using the above described actuarial model. With the

Federal rate, we estimate aggregate Medicare capital payments will increase by 4.27 percent in FY 2002. This increase is noticeably somewhat lower than last year's (5.48 percent) due in part to the fact that because the transition period ends after FY 2001, there is no longer an increase in the Federal blend percentage, which increased from 90 to 100 percent from FY 2000 to FY 2001, for fully prospective hospitals.

TABLE III.—IMPACT OF CHANGES FOR FY 2002 ON PAYMENTS PER DISCHARGE

	Number of hospitals	Discharges	Adjusted federal payment	Average federal percent	Hold harmless payment	Exceptions payment	Total payment	Percent change over FY 2001
FY 2001 Payments per Discharge:								
Low Cost Hospitals	3,127	6,769,127	\$620.00	99.66	\$2.99	\$5.30	\$628.28	.....
Fully Prospective	2,942	6,276,252	621.64	100.00	.....	4.89	626.53	.....
100% Federal Rate	169	456,256	617.75	100.00	.....	6.16	623.91	.....

TABLE III.—IMPACT OF CHANGES FOR FY 2002 ON PAYMENTS PER DISCHARGE—Continued

	Number of hospitals	Discharges	Adjusted federal payment	Average federal percent	Hold harmless payment	Exceptions payment	Total payment	Percent change over FY 2001
Hold Harmless	16	36,620	366.68	48.18	552.28	64.01	982.96	.....
High Cost Hospitals	1,580	4,165,866	632.93	98.07	16.77	9.18	658.87	.....
100% Federal Rate	1,408	3,837,475	644.77	100.00	.....	7.11	651.88	.....
Hold Harmless	172	328,391	494.55	75.83	212.71	33.31	740.57	.....
Total Hospitals	4,707	10,934,994	624.92	99.04	8.24	6.77	639.94	.....
FY 2002 Payments per Discharge:								
Low Cost Hospitals	3,127	6,877,112	643.74	100.00	.....	2.85	646.59	2.91
Fully Prospective	2,942	6,376,366	643.23	100.00	.....	2.92	646.14	3.13
100% Federal Rate	185	500,747	650.23	100.00	.....	2.07	652.29	4.55
High Cost Hospitals	1,580	4,232,640	667.73	100.00	.....	5.55	673.28	2.19
100% Federal Rate	1,580	4,232,640	667.73	100.00	.....	5.55	673.28	3.28
Total Hospitals	4,707	11,109,753	652.88	100.00	.....	3.88	656.76	2.63

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 2.91 percent, and high capital cost hospitals will experience an average increase of 2.19 percent. These results are due to the fact that there is no longer an increase in the Federal blend percentage with the conclusion of the capital transition period in FY 2001 for fully prospective hospitals. Beginning FY 2002, all hospitals (except "new" hospitals under § 412.324(b)) are paid based on 100 percent of the Federal rate for FY 2002.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage remains at 100 percent from FY 2001 (the last year of the transition period) and since they no longer receive payments based on the hospital-specific rate. The Federal rate payment percentage in FY 2001 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 in FY 2001 will increase from 75.83 percent to 100 percent since the transition period will have ended. All hold-harmless hospitals (except "new" hospitals under § 413.324(b)) will be paid based on 100 percent of the Federal rate in FY 2002. We estimate that high cost hospitals (paid based on 100 percent of the Federal rate) will receive a decrease in exceptions payments from \$7.11 per discharge in FY 2001 to \$5.55 per discharge in FY 2002. This is primarily due to the expiration of the regular exceptions provision in FY 2002.

We are no longer presenting the average hospital-specific rate payment per discharge in Table III because, beginning with FY 2001, the transition blend percentage for fully prospective hospitals is 100 percent of the Federal

rate and zero percent of the hospital-specific rate, and all hospitals (except "new" hospitals under § 412.324(b)) will be paid based on 100 percent of the Federal rate for FY 2002.

As stated previously, we will continue to pay regular exceptions for cost reporting periods beginning before October 1, 2001, but ending in FY 2002. However, in FY 2003 and later, regular exception payments will no longer be made under the regular exceptions provision but eligible hospitals could receive special exception payments under § 412.348(g).

We estimate that regular exceptions payments will decrease from 1.06 percent of total capital payments in FY 2001 to 0.59 percent of payments in FY 2002. These results are primarily due to the expiration of the regular exceptions after FY 2001 and the limited nature of the special exceptions policy in FY 2002. The projected distribution of the exception payments is shown in the chart below:

ESTIMATED FY 2002 EXCEPTIONS PAYMENTS

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	104	46
High Capital Cost	112	54
Total	216	100

In the past we presented a cross-sectional summary of hospital groupings by the capital prospective payment transition period methodology generated by our actuarial model (Appendix B). We are no longer including such a comparison since all hospitals (except "new" hospitals under § 412.324(b)) will be paid based on 100 percent of the Federal rate in FY 2002 with the conclusion of the 10-year capital transition period.

C. Cross-Sectional Analysis of Changes in Aggregate Payments

We used our FY 2002 actuarial model to estimate the potential impact of our changes for FY 2002 on total capital payments per case, using a universe of 4,707 hospitals. The individual hospital payment parameters are taken from the best available data, including: the April 1, 2001 update to the provider-specific file, cost report data, and audit information supplied by intermediaries. In Table IV, we present the results of the cross-sectional analysis using the results of our actuarial model and the aggregate impact of the FY 2002 payment policies. As we explain in Appendix B of this final rule, we were not able to use 88 of the 4,795 hospitals in our database due to insufficient (missing or unusable) data. Consequently, the payment methodology distribution is based on 4,707 hospitals. These data should be fully representative of the payment methodologies that will be applicable to hospitals. Columns 3 and 4 show estimates of payments per case under our model for FY 2001 and FY 2002, respectively. Column 5 shows the total percentage change in payments from FY 2001 to FY 2002. 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 2.28 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 MGRB. 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 for all hold-harmless hospitals being paid based on 100 percent of the Federal rate, and changes in exception payments. The comparisons are provided by: (1)

geographic location, (2) region, and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 2.6 percent in FY 2002. The results show that the effect of the Federal rate change alone is to increase payments by 3.4 percent. In addition to the increase attributable to the Federal rate change, a 0.8 percent decrease is attributable to the effects of all other changes.

Our comparison by geographic location shows an overall increase in payments to hospitals in all areas. This comparison also shows that urban and rural hospitals will experience slightly different rates of increase in capital payments per case (2.7 percent and 2.0 percent, respectively). This difference is due to the lower rate of decrease for urban hospitals relative to rural hospitals (0.7 percent and 1.4 percent, respectively) from the effect of all other changes. Urban hospitals will gain the same as rural hospitals (3.4 percent) from the effects of Federal rate changes alone.

Most regions are estimated to receive increases in total capital payments per case, partly due to the fact that payments to all hospitals (except "new" hospitals under § 412.324(b)) will be based on 100 percent of the Federal rate in FY 2002. Changes by region vary from a minimum increase of 0.7 percent (Mountain rural region) to a maximum

increase of 3.5 percent (East North Central region).

By type of ownership, voluntary hospitals are projected to have the largest rate of increase of total payment changes (2.8 percent, a 3.4 percent increase due to the Federal rate changes, and a 0.6 percent decrease from the effects of all other changes). Similarly, payments to government hospitals will increase 2.2 percent (a 3.4 percent increase due to Federal rate changes, and a 1.2 percent decrease from the effects of all other changes), while payments to proprietary hospitals will increase 0.9 percent (a 3.3 percent increase due to Federal rate changes, and a 2.4 percent decrease from the effects of all other changes). This 2.4 percent decrease from all other changes is primarily due to the estimated decrease in exceptions payments and the change for all hold-harmless hospitals being paid based on 100 percent of the Federal rate.

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 FYs 1999 through 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 also affects the geographic adjustment factor, since that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2002 compared to the effects of reclassification for FY 2001, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 2002 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 2002 as a whole are projected to experience a 2.5 percent increase in payments (a 3.4 percent increase attributable to Federal rate changes and a 0.9 percent decrease attributable to the effects of all other changes). Payments to nonreclassified hospitals will increase slightly more (2.6 percent) than reclassified hospitals (2.5 percent) overall. Payments to nonreclassified hospitals will increase the same as reclassified hospitals from the Federal rate changes (3.4 percent), and they will lose slightly less from the effects of all other changes (0.8 percent compared to 0.9 percent, respectively).

TABLE IV.—COMPARISON OF TOTAL PAYMENTS PER CASE
[FY 2001 Payments compared to FY 2002 payments]

	Number of hospitals	Average FY 2001 payments/case	Average FY 2002 payments/case	All charges	Portion attributable to federal rate change
By Geographic Location:					
All hospitals	4,707	640	657	2.6	3.4
Large urban areas (populations over 1 million)	1,518	742	763	2.9	3.4
Other urban areas (populations of 1 million fewer)	1,110	629	645	2.5	3.4
Rural areas	2,079	433	442	2.0	3.4
Urban hospitals	2,628	693	712	2.7	3.4
0-99 beds	638	504	501	-0.6	3.2
100-199 beds	932	591	604	2.3	3.3
200-299 beds	527	662	681	2.9	3.4
300-499 beds	382	734	757	3.2	3.4
500 or more beds	149	890	917	3.0	3.4
Rural hospitals	2,079	433	442	2.0	3.4
0-49 beds	1,218	364	371	1.7	3.3
50-99 beds	516	406	414	1.9	3.3
100-149 beds	203	443	450	1.8	3.4
150-199 beds	75	482	494	2.4	3.3
200 or more beds	67	541	553	2.2	3.4
By Region:					
Urban by Region	2,628	693	712	2.7	3.4
New England	137	733	757	3.4	3.5
Middle Atlantic	406	776	797	2.6	3.3
South Atlantic	391	665	682	2.5	3.4
East North Central	445	666	690	3.5	3.4
East South Central	156	628	643	2.4	3.4
West North Central	179	687	708	3.0	3.4

TABLE IV.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued
 [FY 2001 Payments compared to FY 2002 payments]

	Number of hospitals	Average FY 2001 payments/case	Average FY 2002 payments/case	All charges	Portion attributable to federal rate change
West South Central	319	659	668	1.4	3.3
Mountain	126	681	690	1.3	3.4
Pacific	423	783	808	3.3	3.4
Puerto Rico	46	290	299	3.1	3.1
Rural by Region	2,079	433	442	2.0	3.4
New England	50	519	530	2.1	3.4
Middle Atlantic	74	453	467	3.1	3.4
South Atlantic	269	449	455	1.2	3.3
East North Central	276	441	452	2.4	3.4
East South Central	260	403	412	2.2	3.4
West North Central	479	421	430	2.3	3.4
West South Central	327	388	393	1.4	3.3
Mountain	195	458	461	0.7	3.2
Pacific	144	513	528	3.0	3.4
By Payment Classification:					
All hospitals	4,707	640	657	2.6	3.4
Large urban areas (populations over 1 million)	1,589	735	756	2.8	3.4
Other urban areas (populations of 1 million or fewer)	1,081	631	647	2.5	3.4
Rural areas	2,037	431	440	2.1	3.4
Teaching Status:					
Non-teaching	3,582	526	536	2.0	3.4
Fewer than 100 Residents	888	668	689	3.1	3.4
100 or more Residents	237	996	1,027	3.1	3.4
Urban DSH:					
100 or more beds	1,374	729	750	2.8	3.4
Less than 100 beds	309	483	486	0.5	3.2
Rural DSH:					
Sole Community (SCH/EACH)	545	395	395	0.1	3.2
Referral Center (RRC/EACH)	152	495	505	1.9	3.4
Other Rural:					
100 or more beds	70	407	418	2.6	3.3
Less than 100 beds	449	366	378	3.0	3.4
Urban teaching and no DSH:					
Both teaching and DSH	757	805	829	3.0	3.4
Teaching and no DSH	297	712	737	3.4	3.4
No teaching and DSH	926	583	596	2.2	3.3
No teaching and no DSH	690	577	587	1.7	3.4
Rural Hospital Types:					
Non special status hospitals	794	381	392	3.1	3.4
RRC/EACH	165	498	513	3.0	3.4
SCH/EACH	680	417	418	0.2	3.2
Medicare-dependent hospitals (MDH)	328	353	363	2.8	3.4
SCH, RRC and EACH	70	500	503	0.6	3.3
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY01 and FY02:					
Reclassified During Both FY01 and FY02	475	560	573	2.4	3.4
Reclassified During FY02 Only	152	558	573	2.7	3.4
Reclassified During FY01 Only	51	489	504	3.0	3.4
FY02 Reclassifications:					
All Reclassified Hospitals	627	559	573	2.5	3.4
All Nonclassified Hospitals	4,159	652	670	2.6	3.4
All Urban Reclassified Hospitals	117	742	765	3.1	3.4
Urban nonreclassified Hospitals	2,473	692	711	2.7	3.4
All Reclassified Rural Hospitals	510	486	496	2.1	3.4
Rural Nonreclassified Hospitals	1,566	384	391	1.8	3.3
Other Reclassified Hospitals (Section 1886(D)(8)(B))	41	439	452	3.0	3.4
Type of Ownership:					
Voluntary	2,327	654	672	2.8	3.4
Proprietary	627	632	637	0.9	3.3
Government	954	558	570	2.2	3.4
Medicare Utilization as a Percent of Inpatient Days:					
0-25	390	831	854	2.7	3.4
25-50	1,873	729	750	3.0	3.4
50-65	1,832	561	576	2.6	3.4
Over 65	585	514	516	0.3	3.3

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 will continue to pay regular exceptions for cost reporting periods beginning before October 1, 2001 but ending in FY 2002. In FY 2003 and later, no payments will be made under the regular exceptions policy; hence, we will not compute a budget neutrality factor for regular exceptions in FY 2003 and later. As described in section V.D. of the preamble of this final rule, the budget neutrality adjustment for special exceptions will be based on historical costs. Consequently, there will be no need to estimate capital costs with the capital acquisition model. We will not publish this appendix after this final rule for the FY 2002 capital rates.

We used the capital acquisition model from the start of prospective payments for capital costs through FY 1997. We now have 8 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 March 31, 2001 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), PPS-XII (cost reporting periods beginning in FY 1995), PPS-XIII (cost reporting periods beginning in FY 1996), PPS-XIV (cost reporting periods beginning in FY 1997), PPS-XV (cost reporting periods beginning in FY 1998), and PPS-XVI (cost reporting periods beginning in FY 1999). In addition, to model payments, we use the April 1, 2001 update of the provider-specific file, and the March 1995 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 2001 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
No Match	1
Provider-Specific File Only	188
Provider-Specific and Audit File	4,606
Total	4,795

One hundred sixteen of the 4,795 hospitals had unusable or missing data, or had no cost reports available. For 50 of the 116 hospitals, we were unable to determine a hospital-specific rate from the available cost reports. However, there was adequate cost information to determine that these hospitals were paid under the hold-harmless methodology. Since the hospital-specific rate is not used to determine payments for hospitals paid under the hold-harmless methodology, there was sufficient cost report information available to include these 50 hospitals in the analysis. We were able to estimate hospital-specific amounts from the cost reports as shown in the following table.

Cost report	Number of hospitals
PPS-9	1
PPS-12	1
PPS-13	1
PPS-14	1
PPS-15	2
PPS-16	13
Total	19

Hence, we were able to use 69 (50 plus 19) of the 116 hospitals. The remaining 47 of the 116 hospitals could not be used in the analysis because we were not able to estimate their hospital-specific amount. An additional 41 hospitals could not be used in the analysis because we could not determine their capital costs, either because we had no cost reports for them or because there was insufficient cost report data. Accordingly, we used 4,707 hospitals for the analysis. Eighty-eight (47 plus 41) hospitals could not be used in the analysis because of insufficient (missing or unusable) information. These hospitals account for about 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 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 first two 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 the 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 2000 (the MedPAR data year) and later, we use the number of discharges from the MedPAR data. Some hospitals had considerably more discharges in FY 2000 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 2000 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 2000 MedPAR file using the FY 2002 DRG relative weights included in section VI. of the Addendum to this final rule. The case-mix index is increased each year after FY 2000 based on analysis of past experiences in case-mix increases. Based on analysis of recent case-mix increases, we estimate that case-mix will decrease 0.9 percent in FY 2001. We project that case-mix will increase 1.0 percent in FY 2002. (Since we are using FY 2000 cases for our analysis, the FY 2000 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 2001, the budget neutrality adjustment factors were 0.99933 for the national rate and 1.00508 for the Puerto Rico rate. In determining these factors, we used the factors from the first half of FY 2001 (October 2000 through March 2001) published in the August 1, 2000 final rule since section 547 of Public Law 106-554 specifies that the special increases and adjustments in effect between April and October 2001 do not apply for discharges occurring after FY 2001 and should not be included in determining the payment rates in subsequent years.

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

To determine the factors for FY 2002, we first determined the portions of the Federal national and Puerto Rico rates that would be paid for each hospital in FY 2002 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 2001 DRG relative weights and the FY 2001 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 2001 relative weights and the FY 2002 geographic adjustment factor. In making the comparison, we held the FY 2002 Federal rate portion constant and set the other budget neutrality adjustment factor and the regular and special exceptions reduction factors to 1.00. To achieve budget neutrality for the changes in the national geographic adjustment factor, we applied an incremental budget neutrality adjustment of 0.99666 for FY 2002 to the previous cumulative FY 2001 adjustment of 0.99933, yielding a cumulative adjustment of 0.99599 through FY 2002. For the Puerto Rico geographic adjustment factor, we applied an incremental budget neutrality adjustment of 0.98991 for FY 2002 to the previous cumulative FY 2001 adjustment of 1.00508, yielding a cumulative adjustment of 0.99494 through FY 2002. We then compared estimated aggregate Federal rate payments based on the FY 2001 DRG relative weights and the FY 2002 geographic adjustment factors to estimated aggregate Federal rate payments based on the FY 2002 DRG relative weights and the FY 2002 geographic adjustment factors. The incremental adjustment for DRG classifications and changes in relative weights is 0.99668 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 FY 2002 are 0.99268 nationally and 0.99164 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
	Geo-graphic adjustment factor	DRG reclassifications and recalibration	Combined		Geo-graphic adjustment factor	DRG reclassifications and recalibration	Combined	
1992	1.00000	.....	.....	.....	.....
1993	0.99800	0.99800	.....	.....	.....	.....

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

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geo-graphic adjustment factor	DRG reclassifications and recalibration	Combined		Geo-graphic adjustment factor	DRG reclassifications and recalibration	Combined	
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	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001 ¹	0.99846	1.00019	0.99865	0.99933	1.00365	1.00009	1.00374	1.00508
2001 ²	³ 0.99771	³ 1.00009	³ 0.99780	0.99922	³ 1.00365	³ 1.00009	³ 1.00374	1.00508
2002	⁴ 0.99666	⁴ 0.99668	⁴ 0.99335	0.99268	⁴ 0.98991	⁴ 0.99668	⁴ 0.99662	0.99164

¹ Factors effective for the first half of FY 2001 (October 2000 through March 2001).
² Factors effective for the second half of FY 2001 (April 2001 through September 2001).
³ Incremental factors are applied to FY 2000 cumulative factors.
⁴ Incremental factors are applied to the cumulative factors for the first half of FY 2001.

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. For FY 2002 additional payments for the “regular” exceptions are made only for cost reporting periods that begin before October 1, 2001. The adjustment for “special” exceptions payments (see § 412.348(g)) is described in section V.D. of the preamble of this final rule. 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. In modeling exceptions for FY 2002, we calculated exceptions only for qualifying cost reporting periods. 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. Since we will no longer use the model after this final rule for the FY 2002 rates, we will discontinue publishing this table after this final rule for the FY 2002 rates. The table below provides the actual factors for FYs 1992 through 2002, and the estimated factors that would be applicable through FY 2006. We caution that these are estimates for FYs 2003 and later, and are subject to revisions resulting from continued methodological refinements, receipt of additional data, and changes in payment policy. We note that in making these projections, we have assumed that the cumulative national DRG/GAF budget neutrality adjustment factor will remain at 0.99268 (0.99164 for Puerto Rico) for FY 2002 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 2002.

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 8.222	371.51
1999	0.10	.9783	N/A	1.0028	.9392		378.10
2000	0.30	.9730	N/A	.9985	.9402		377.03
2001 ⁵	0.90	.9785	N/A	.9979	.9409		382.03
2002	1.30	⁶ .9929	N/A	0.9933	.9424		390.74
2003	0.70	.9975	N/A	⁷ 1.0000	⁷ .9424	⁴¹ 0.0255	405.39
2004	0.70	.9975	N/A	1.0000	.9424		408.23
2005	0.90	.9975	N/A	1.0000	.9424		411.90
2006	0.90	.9975	N/A	1.0000	.9424		415.61

¹ The incremental change over the previous year.
² OBRA 1993 adjustment.
³ Adjustment for change in the transfer policy.
⁴ Balanced Budget Act of 1997 adjustment.
⁵ Rates are for the first half of FY 2001 (October 1, 2000 through March 31, 2001).
⁶ Product of general exceptions factor (0.9941) and special exceptions factor (0.9988)

⁷ Future adjustments are, for purposes of this projection, assumed to remain at the same level.

Appendix C: 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 2002 by hospitals subject to the prospective payment system and by hospitals or units excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XVII) of the Act, as amended by section 301 of Public Law 106-554, sets the FY 2002 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 0.55 percentage points for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 2002 percentage increase in the hospital-specific rates applicable to SCHs and MDHs 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 0.55 percentage points. Under section 1886(b)(3)(B)(ii) of the Act, the FY 2002 percentage increase in the rate-of-increase limits for hospitals and units excluded from the prospective payment system ranges from the percentage increase in the excluded hospital 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 limit for the most recent cost reporting period for which information is available, or 0 percentage point if costs do not exceed two-thirds of the limit.

In accordance with section 1886(d)(3)(A) of the Act, we are updating the standardized amounts, the hospital-specific rates, and the rate-of-increase limits for hospitals and units excluded from the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the second quarter 2001 forecast of the FY 2002 market basket increase of 3.3 percent for hospitals subject to the prospective payment system, the update to the standardized amounts is 2.75 percent (that is, the market basket rate of increase minus 0.55 percentage points) for hospitals in both large urban and other areas. The update to the hospital-specific rate applicable to SCHs and MDHs is also 2.75 percent. The update for hospitals and units excluded from the prospective payment system can range from the percentage increase in the excluded hospital market basket (currently estimated at 3.3 percent) minus a percentage between 0 and 2.5 percentage points, or 0 percentage point, resulting in an increase in the rate-of-increase limit between 0.8 and 3.3 percent, or 0 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. In its March 1, 2001 report, MedPAC stated that the legislated update of market basket minus 0.55 percentage points would provide a reasonable level of payments to hospitals. MedPAC did not make a separate recommendation for the hospital-specific rate applicable to SCHs and MDHs.

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, we published the FY 2002 update factors recommended by the Secretary as Appendix D of the May 4, 2001 proposed rule (66 FR 22888). In that appendix, we discussed the recommendations of appropriate update factors, the analysis underlying our recommendations, and our response to MedPAC's recommendations concerning the update factors.

I. Secretary's Final Recommendations for Updating the Prospective Payment System Standardized Amounts

In recommending an update, the Secretary takes into account the factors in the update framework, as well as the recommendations of MedPAC, the long-term solvency of the Medicare Trust Funds, and the capacity of the hospital industry to continually provide access to high quality care to Medicare beneficiaries through adequate reimbursement to health care providers.

We received several comments concerning our proposed recommendation.

Comment: One commenter questioned the reason for the difference between the 3.05 percent update to the standardized amounts recommended by the Secretary to the Congress as printed in the May 4, 2001 proposed rule (65 FR 22885) and the 2.55 percent proposed update used to establish the rates printed in the May 4, 2001 proposed rule (65 FR 22738).

Response: The President's FY 2002 budget estimated that the market basket for FY 2002 would be 3.6 percent. This estimate is prepared by the Office of Management and Budget (OMB) by applying future assumptions of economy-wide wage and consumer price index growth to the historical relationship between these factors and the market basket.

The market basket we have historically used to actually update the standardized amounts is estimated by our Office of the Actuary, in conjunction with Global Insights, Inc., DRI-WEFA. Although this estimate is generally very close to the OMB estimate,

there are often some discrepancies due to the timing of the estimate and the differing future assumptions of the input factors.

Our final recommendation of the market basket percentage increase minus 0.55 percentage points for the update for hospitals subject to the prospective payment system, which is consistent with current law, did not differ from the proposed. However, the second quarter forecast of the market basket percentage increase is 3.3 for prospective payment hospitals (up from 3.1 estimated in the proposed rule). Thus, the Secretary's final recommendation is that the update to the prospective payment system standardized amounts for both large urban and other urban areas is 2.75 percent (or consistent with current law, market basket percentage increase minus 0.55 percent). The update to the hospital-specific rate applicable to SCHs and MDHs is also 2.75 percent (or consistent with current law, market basket percentage increase minus 0.55 percentage points).

Comment: Several commenters addressed the recent increases in the price of blood products. One commenter stated the increases represent up to one percent of annual DRG payments for hospitals that perform a significant number of surgeries. The commenters urged us to ensure that the DRG payments reflect price increases associated with rising blood prices.

Response: Section 301(c) of Public Law 106-554 requires the Secretary to consider the price of blood and blood products in the market basket index when the market basket is next rebased and revised and to determine whether those prices are adequately reflected.

III. Secretary's Final Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals and Units

We received no comments concerning our proposed recommendation. Our final recommendation for excluded hospitals and units did not differ from the proposed. However, the second quarter forecast of the market basket percentage increase is 3.3 for excluded hospitals and units (up from 3.0 estimated in the proposed rule). Thus, the Secretary's final recommendation is that the update for hospitals and units excluded from the prospective payment system can range from market basket increase of 3.3 percent minus a percentage between 0 and 2.5 percent, or 0 percent depending on the relationship between the hospital's or unit's costs and its rate-of-increase limit, which results in an increase in the rate-of-increase limit between 0.8 and 3.3 percent, or 0 percent for FY 2002.

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