TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
010118	01	5240	
010120	01	5160	
010121	01	5240	
010126	01	2180	
010150	01	5240	
010158	01	2650	
020008	02	0380	
030007	03	2620	
030012	03	6200	
030033	03	2620	
030043	03	8520	
040014	04	4400	
040017	04	7920	
040019	04	4920	
040020	3700	4920	
040026	04	4400	
040027	04	7920	
040041	04	4400	
040045	04	26	
040066	04	4400	
040069	04	4920	
040076	04	4400	
040078	04	4400	
040080	04	3700	
040088	04	7680	
040091	04	8360	
040107	04	8360	
040119	04	4400	
050042	05	6690	
050045	05		7320
050069	5945	4480	
050071	7400	5775	
050073	8720	5775	
050076	7360	5775	
050101	8720	5775	
050150	05	6920	
050174	7500	8720	
050192	2840	05	
050228	7360	5775	
050230	5945	4480	
050236	8735	4480	
050286	8780	05	
050296	05	7120	
050301	05	7500	
050325	05	5170	
050335	05	5170	
050419	05	6690	
050446	0680	05	
050457	7360	5775	
050464	5170	8120	
050469	6780	05	
050494	05	6920	
050510	7360	5775	
050528	4940	05	
050541	7360	5775	
050549	8735	4480	
050569	05	7500	
050594	5945	4480	
050609	5945	4480	
050686	6780	5945	
050701	6780	7320	
060003	1125	2080	2080
060013	06	0200	
060018	06	2995	
060023	2995	6520	
060027	1125	2080	2080
060044	06	2080	
060049	06	2670	
060075	06	2995	
060076	06	3060	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
060096	06	2080	
060103	1125	2080	2080
070006	5483	5600	
070018	5483	5600	
070033	5483	5600	
070034	5483	5600	
070036	3283	5483	
080002	08		0720
080004	2190	9160	
080006	08	2190	
080007	08	2190	
100022	5000	2680	
100023	10	5960	
100024	10	5000	
100045	2020	5960	
100048	6080	10	
100049	10	3980	
100098	10	8960	8960
100103	10	3600	3600
100105	10	2710	
100109	10	5960	
100118	2020	10	
100150	10	5000	
100157	3980	8280	
100176	8960	2710	
100211	8280	3980	
100217	10	2710	
100232	10	5790	2900
100239	8280	7510	
100249	10	8280	
100268	8960	2680	
110001	11	0520	
110002	11	0520	
110003	11	3600	
110016	11	1800	
110023	11	0520	
110025	11	3600	
110029	11	0520	
110038	11	10	
110040	11	0500	0500
110050	11	0520	
110054	11	0520	
110075	11	7520	
110100	11	0600	
110118	11	0120	
110122	11	10	
110150	11	4680	
110168	11	0520	
110187	11	0520	
110188	11	0520	
110189	11	0520	
110190	11	4680	
110205	11	0520	
120015	12	3320	
130002	13	29	
130003	13	50	
130011	13	50	
130018	13	6340	
130049	13	7840	
130060	13	1080	
140012	14	1600	
140015	14	7040	
140031	14	1400	
140032	14	7040	
140034	14	7040	
140040	14	6120	
140043	14	6880	
140046	14	7040	
140058	14	7880	
140064	14	6120	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
140086	14		7040
140093	14	1400	
140102	14	7880	7880
140110	14	6120	
140141	14	7040	7040
140143	14	6120	
140155	3740		1600
140160	14	6880	
140161	14	1600	
140164	14	7040	
140189	14	1400	
140199	14	7040	
140230	14		1400
140234	14	6120	
140245	14		7040
140271	14	7800	7800
150002	2960	1600	
150004	2960	1600	
150006	15	7800	
150008	2960	1600	
150011	15	3480	3480
150015	15	1600	
150027	15		3480
150030	15	3480	3480
150034	2960	1600	
150036	15	3850	
150048	15	2000	
150051	1020		3480
150062	15	3480	3480
150065	15	3480	
150067	15		3480
150069	15	1640	1640
150076	15	7800	
150090	2960	1600	
150096	15	2330	
150105	15	3480	3480
150112	15	3480	3480
150122	15	3480	
150125	2960	1600	1600
150126	2960	1600	1600
150132	2960	1600	
150133	15	2330	
150146	15	2330	
160001	16	2120	
160016	16	2120	
160026	16	2120	
160030	16	2120	
160037	16	24	
160057	16	3500	
160064	16	8920	
160080	16	1960	
160089	16	2120	
160094	16	8920	
160122	16	14	
160147	16	2120	
170001	17	9040	
170006	17	3710	
170010	17	8560	
170012	17	9040	
170013	17	9040	
170014	17	3760	
170020	17	9040	
170022	17	7000	
170023	17	9040	
170025	17	9040	
170033	17	9040	
170058	17	26	
170060	17	28	
170094	17	8440	
170120	17	3710	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
170131	17		8440
170137	4150	17	
170142	17	8440	
170145	17	8560	
170166	17	0320	
170175	17	9040	
180005	18	3400	
180011	18	4280	
180012	18	4520	
180013	18	5360	
180016	18	4520	
180018	18	4280	
180027	18	1660	
180028	18	3400	
180029	18	3660	
180044	18	3400	
180048	18	4280	
180054	18	1660	
180065	18	1640	
180066	18	5360	
180069	18	3400	
180078	18	3400	
180102	18	1660	
180104	18	1660	
180116	18	1660	
180124	18	5360	
180127	18	4520	
180132	18	4280	
180139	18	4280	
190001	19	5560	5560
190003	19	3880	
190010	19	5560	5560
190014	19	3880	
190015	19	5560	
190018	19	3880	
190025	19	3880	
190048	3350	19	
190054	19	3880	
190083	19	5200	
190086	19	5200	
190099	19	3880	
190106	19	3880	
190110	3880	19	
190131	19	5560	
190218	19	0220	
200020	6403	1123	1123
200024	4243	6403	
200034	4243	6403	
200039	20	6403	
200040	6403		1123
200063	20	6403	
220060	1123	0743	
220077	8003	3283	
230015	23	3720	
230022	23	3720	
230027	23	3000	3000
230030	23	6960	
230036	23	6960	
230037	23	0440	
230040	23	3720	3720
230054	23	3080	
230078	0870	23	
230080	23	6960	
230093	23	3000	
230096	23	3720	
230097	23	3000	
230105	23	6960	
230106	23	3000	
230121	23	2640	2640
230188	23	6960	6960

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
230199	23	0870	0870
230235	23	6960	6960
230253	23	2160	
240008	24	6820	
240011	24	5120	
240014	24	5120	
240016	24	2520	
240018	24		5120
240023	24	5120	
240045	24	2240	
240064	24	2240	
240075	24	6980	
240088	24	6980	
240089	24	5120	
240100	24	2985	
240121	24	2240	
240139	24	5120	
240142	24	6980	
240152	24	5120	
250004	25	4920	
250009	25	3580	
250012	25	4920	
250025	25	1	
250030	25	3560	
250031	25	3560	
250034	25	4920	
250042	25	4920	
250058	25	3285	
250069	25	3560	
250078	3285	0920	
250079	25	3560	
250081	25	3560	
250082	25	6240	
250084	25	19	
250088	25	0760	
250094	3285	0920	
250097	25	0760	
250100	25	8600	
250101	25	3560	
250104	25	3560	
250122	25	19	
250126	25	4920	
260006	7000	26	
260009	26	3760	
260011	26	1740	
260015	26	3700	
260017	26	7040	
260022	26	1740	
260025	26	14	
260034	26	3760	
260047	26	1740	
260050	26	7000	
260064	26	1740	
260074	26	1740	
260078	26	7920	
260094	26	7920	
260110	26	7040	7040
260113	26	14	
260116	26	7040	
260119	26	3700	
260120	26	3700	
260127	26	7040	
260131	26	1740	
260183	26	7040	
260186	26	1740	
270002	27	0880	
270003	27	3040	
270011	27	3040	
270016	27	0880	
270017	27	5140	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
270051	27	5140	
270057	27	0880	
270083	27	5140	
280009	28	4360	
280023	28	4360	
280032	28	4360	
280054	28	4360	
280061	28	53	
280065	28	3060	
280077	28	5920	
280111	28	5920	
280125	28	7720	
290006	29	6720	
290019	29	6720	
300003	30	1123	
300005	30	1123	1123
300009	1123	30	
300019	30	22	
300024	30		1123
310001	0875	5600	
310002	5640	5600	
310003	3640	5600	
310015	5640	0875	
310021	8480	5190	
310031	6160	5190	
310038	5015	5600	
310039	5015	5190	
310045	0875	5600	
310048	5015	5640	
310049	3640		5640
310070	5015	5640	
310076	5640	5600	
310087	8760	6160	
310108	5015	5190	
310118	3640		0875
310119	5640	5600	
320005	32	0200	
320006	32	7490	
320011	32	7490	
320013	32	7490	
320063	32	5800	
320065	32	5800	
330001	5660	5600	
330004	33	5660	
330023	2281	5660	
330027	5380	5600	
330084	33	1303	
330085	33	8160	
330103	33		1280
330106	5380	5600	
330126	5660	5600	
330135	5660	5600	
330136	33	8160	
330157	33	8160	
330181	5380	5600	
330182	5380	5600	
330205	5660	5600	
330209	5660	5600	
330224	33	3283	
330235	8160		6840
330239	3610	2360	
330250	33	1303	
330264	5660	5600	
330307	33	8160	
330386	33	5660	
340003	34	3120	
340008	34	2560	
340013	34	1520	
340017	34	0480	
340021	34	1520	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
340023	34	0480	
340027	34	3150	
340039	34	1520	1520
340050	34	2560	
340051	34	3290	
340052	3120	1520	
340064	34	3120	
340068	34	9200	
340071	34	6640	6640
340084	34	1520	
340088	34	0480	
340097	34	3120	
340109	34	5720	5720
340115	34	6640	
340124	34	6640	6640
340126	34	6640	6640
340129	34	1520	
340131	34	3150	
340143	3290	1520	
340144	34	1520	
340147	6895	6640	
350005	35	2985	
350006	35	1010	
350009	35	2520	
350017	35	27	
350043	35	1010	
360002	36		1680
360008	36	3400	
360010	36	0080	
360011	36	1840	
360013	36	2000	
360014	36	1840	
360024	36	1680	1680
360025	36	1680	1680
360036	36	0080	
360037	1680	0080	
360039	36	1840	
360046	3200	1640	1640
360056	3200	1640	1640
360063	36	1680	1680
360065	36	1680	1680
360071	36	4320	4320
360076	3200	1640	1640
360078	0080		1680
360084	1320	0080	
360088	36	1840	
360089	36	8400	
360090	8400		2160
360092	36	1840	1840
360095	36	8400	
360101	1680	0080	
360107	36	8400	
360108	36	4800	
360109	36	1840	
360112	8400	0440	
360121	36	0440	
360132	3200	1640	1640
360142	36		1640
360144	1680	0080	
360159	36	1840	
360175	36	1840	1640
360197	36	1840	1840
360211	8080		6280
370004	37	3710	
370006	37	8560	
370014	37	7640	
370015	37	8560	
370018	37	8560	
370022	37	4200	
370023	37	4200	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
370025	37	8560	
370034	37	2720	
370047	37	7640	
370048	37	8360	
370049	37	5880	
370054	37	5880	
370084	37	2720	
370103	37	45	
370153	37	4200	
370200	37	5880	
380001	38	6440	
380002	38	4890	
380003	38	2400	
380006	38		6440
380027	38	2400	
380040	38	2400	
380047	38	2400	
380050	38	4890	
380051	7080		6440
380065	38	2400	
380070	38	6440	
380084	7080	38	
380090	38	2400	
390006	39	3240	
390008	39	6280	6280
390013	39	3240	
390016	39	6280	6280
390017	39	6280	6280
390030	39	0240	6680
390031	39	0240	6680
390048	39	3240	
390052	39	0280	
390065	39	8840	9280
390079	39	0960	
390091	39	6280	
390093	39	6280	
390110	3680	6280	
390113	39	9320	
390133	0240	6160	
390138	39	8840	
390150	39	6280	
390151	39	8840	
390181	39	6680	6680
390183	39	6680	6680
390189	39	3240	
390197	0240	6160	
390201	39	5660	5640
390263	0240	6160	
400018	40	1310	
410010	6483	1123	
410013	6483	5523	
420020	42	1440	
420036	42	1520	
420059	42	2655	
420062	42	1520	
420068	42	0600	
420070	8140	1760	
420071	42	0600	
420080	42	7520	
420085	5330	9200	
430008	43	24	
430012	43	7760	
430013	43	7760	
430014	43	2520	
430015	43	6660	
430047	43	28	
430048	43	53	
430089	43	7720	
440020	44	3440	
440024	44	1560	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
440050	44	0480	
440058	44	1560	
440059	44	5360	
440067	44	3840	
440068	44	1560	
440073	44	5360	
440083	44	3840	
440143	44	5360	
440148	44	5360	
440175	44	3440	
440180	44	3840	
440182	44	3580	
440185	44	1560	
440186	44	5360	
440187	44	18	
440192	44	5360	
440200	44	5360	
440203	44	1560	
450007	45	7240	
450014	45	8750	
450053	45	8750	
450072	1145	3360	
450080	45	4420	
450085	45	9080	
450098	45	4420	
450099	45	0320	
450113	45	1920	
450140	45	5800	
450144	45	5800	
450146	45	0320	
450155	45	0320	
450163	45	1880	
450178	45	5800	
450187	45	3360	
450192	45	1920	
450194	45	1920	
450196	45		1920
450211	45	3360	
450214	45	3360	
450224	45	8640	
450246	45	8750	
450347	45	3360	
450351	45	2800	
450353	45	1880	
450373	45	4420	
450395	45	3360	
450400	45	8800	
450438	45	0640	
450447	45	1920	
450451	45	2800	
450484	45	3360	
450508	45	8640	
450534	45	0320	
450587	45	40	
450591	1145	3360	
450623	45	1920	
450626	45	8750	
450653	45	5800	
450656	45	8640	
450694	45	3360	
450747	45	1920	
450755	45	4600	
450763	45	320	
460007	46	2620	
460011	46	6520	
460021	46	4120	
460027	46	6520	
460032	46	6520	
460036	46	6520	
460039	46	7160	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY—2003—Continued

Provider number	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
470001	47	1303	
470003	1303	1123	
470011	47	1123	1123
470012	47	6323	
470018	47	1123	
490001	49	3660	
490004	49	1540	
490005	49	8840	
490013	49	1950	
490018	49	4640	
490038	49	3660	
490047	49	8840	
490060	49	3660	
490066	5720	6760	
490079	49	3120	
490126	49	6800	
500002	50	6740	
500003	50	7600	
500007	50	0860	
500016	50	7600	
500041	50	6440	
500059	50	7600	
500072	50	7600	
500079	8200		7600
510001	51	6280	
510002	51	6800	
510006	51	6280	
510024	51	6280	6280
510028	51	1480	
510046	51	1480	
510047	51	6280	
510048	51	3400	
510062	51	1480	
510070	51	1480	
510071	51	1480	
520002	52	8940	
520006	52	8940	
520011	52	2290	
520021	3800	1600	1600
520028	52	4720	
520037	52	8940	
520059	6600	5080	5080
520066	3620	4720	
520071	52	5080	5080
520076	52	5080	
520084	52	4720	
520088	52	5080	
520091	52	23	
520094	6600	5080	5080
520096	6600	5080	5080
520102	52	5080	5080
520107	52	3080	
520113	52	3080	
520116	52	5080	5080
520152	52	3080	
520173	52	2240	
520189	3800	1600	1600
530008	53	1350	
530009	53	1350	
530015	53	6340	
530025	53	2670	
530032	53	7160	

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]

DRG	Cases	Mean + 1 standard deviation
1	27,704	$66,748
2	14,078	$34,337
3	7	$55,030
4	6,426	$41,870
5	93,104	$23,280
6	398	$14,095
7	14,187	$46,968
8	4,349	$28,253
9	1,737	$24,223
10	18,015	$22,246
11	3,398	$15,519
12	49,619	$15,429
13	6,637	$13,922
14	235,975	$21,928
15	101,681	$16,969
16	9,257	$21,632
17	2,870	$11,541
18	28,000	$17,036
19	8,672	$12,308
20	5,616	$51,920
21	1,429	$27,335
22	2,722	$18,422
23	11,189	$14,276
24	55,342	$17,340
25	27,205	$10,640
26	34	$13,463
27	3,839	$23,063
28	12,339	$23,674
29	4,928	$12,505
31	3,814	$15,329
32	1,891	$9,174
34	22,336	$17,368
35	7,323	$11,138
36	2,481	$10,985
37	1,418	$18,071
38	93	$9,775
39	666	$10,551
40	1,524	$14,863
42	1,936	$11,289
43	110	$8,855
44	1,295	$11,245
45	2,598	$12,352
46	3,373	$13,685
47	1,350	$9,302
49	2,337	$31,134
50	2,477	$13,972
51	251	$16,197
52	238	$13,055
53	2,517	$20,530
55	1,564	$16,073
56	526	$16,460
57	692	$17,299
59	127	$13,165
60	6	$10,986
61	243	$21,950
62	3	$6,623
63	2,900	$25,070
64	3,131	$23,886
65	39,014	$9,512
66	7,668	$9,851
67	439	$13,316
68	8,752	$11,567
69	3,034	$8,666
70	25	$8,029
71	87	$12,279
72	926	$12,429
73	7,070	$13,912
75	39,852	$53,451

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
76	41,676	$50,324
77	2,444	$21,281
78	35,270	$22,207
79	166,273	$29,036
80	8,304	$15,356
81	2	$17,479
82	63,407	$25,645
83	6,390	$16,990
84	1,558	$8,753
85	21,262	$21,607
86	2,179	$12,312
87	59,447	$24,541
88	396,490	$15,658
89	502,217	$18,132
90	46,781	$10,653
91	57	$12,409
92	14,806	$21,600
93	1,710	$13,018
94	12,571	$20,639
95	1,679	$10,242
96	53,684	$13,018
97	28,583	$9,626
98	15	$16,431
99	21,274	$12,269
100	8,941	$9,245
101	21,119	$14,939
102	5,557	$9,489
103	428	$349,756
104	19,511	$130,539
105	27,278	$94,418
106	3,307	$121,657
107	85,660	$86,239
108	6,200	$95,309
109	59,511	$64,065
110	53,164	$71,438
111	9,392	$42,529
113	41,401	$49,111
114	8,849	$29,028
115	15,270	$58,727
116	109,194	$38,515
117	4,176	$23,091
118	8,104	$27,103
119	1,316	$22,646
120	37,306	$39,416
121	167,277	$27,051
122	81,670	$17,860
123	41,145	$28,071
124	138,236	$23,982
125	89,996	$18,048
126	5,015	$48,094
127	681,606	$17,412
128	8,240	$12,365
129	4,100	$19,186
130	88,663	$16,401
131	27,776	$9,821
132	152,256	$11,138
133	8,915	$9,314
134	39,612	$10,344
135	7,552	$15,416
136	1,237	$10,011
138	203,304	$14,336
139	89,960	$8,832
140	66,409	$9,140
141	102,377	$12,604
142	51,706	$9,672
143	250,001	$9,216
144	88,480	$21,330
145	7,594	$10,378

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
146	10,796	$45,993
147	2,797	$25,903
148	129,351	$59,354
149	19,315	$24,710
150	20,330	$49,351
151	4,962	$22,681
152	4,424	$33,239
153	2,013	$19,418
154	28,996	$73,715
155	7,260	$21,846
156	3	$32,596
157	8,151	$22,041
158	4,560	$10,941
159	17,109	$23,315
160	12,156	$13,554
161	11,153	$19,125
162	7,270	$10,677
163	3	$7,876
164	5,116	$39,084
165	2,184	$20,580
166	3,902	$24,579
167	3,799	$14,801
168	1,381	$22,419
169	869	$12,657
170	12,155	$49,736
171	1,359	$19,892
172	30,603	$24,475
173	2,709	$13,824
174	247,084	$17,229
175	35,141	$9,564
176	15,215	$18,581
177	9,422	$15,760
178	3,756	$11,718
179	12,540	$18,881
180	88,253	$16,534
181	27,085	$9,241
182	260,632	$13,956
183	91,215	$9,962
184	93	$8,646
185	5,069	$15,675
186	3	$17,560
187	666	$14,847
188	79,377	$19,332
189	13,104	$10,335
190	74	$12,681
191	9,220	$77,337
192	1,257	$30,601
193	4,862	$59,463
194	733	$27,612
195	4,151	$50,509
196	1,050	$26,194
197	18,557	$42,811
198	5,667	$20,952
199	1,644	$42,977
200	1,042	$53,497
201	2,013	$67,182
202	26,142	$23,012
203	29,301	$24,716
204	61,516	$20,412
205	24,447	$21,124
206	2,048	$12,455
207	32,101	$19,874
208	10,740	$11,426
209	370,349	$31,852
210	121,438	$29,326
211	32,517	$19,885
212	7	$11,988
213	9,875	$32,709

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
216	6,916	$38,905
217	17,022	$53,503
218	22,732	$25,771
219	20,855	$16,751
223	13,650	$17,145
224	12,431	$12,855
225	6,124	$19,539
226	5,698	$26,964
227	4,915	$13,522
228	2,481	$19,438
229	1,175	$11,756
230	2,406	$21,932
231	12,530	$24,031
232	880	$16,464
233	7,178	$34,665
234	4,607	$21,908
235	5,089	$13,039
236	39,744	$12,220
237	1,743	$9,880
238	8,617	$24,817
239	48,197	$17,565
240	11,800	$23,191
241	3,218	$11,428
242	2,515	$19,784
243	93,611	$12,959
244	13,570	$12,429
245	5,726	$8,349
246	1,346	$9,926
247	19,616	$10,001
248	12,060	$14,559
249	12,649	$11,805
250	3,793	$11,824
251	2,489	$8,063
253	20,842	$12,750
254	10,802	$7,656
256	6,400	$14,186
257	16,692	$14,784
258	16,950	$11,403
259	3,812	$15,230
260	5,072	$11,046
261	1,888	$16,770
262	686	$15,951
263	24,560	$37,753
264	3,982	$19,495
265	4,052	$27,077
266	2,676	$14,584
267	267	$15,879
268	899	$19,361
269	9,060	$29,801
270	2,746	$12,961
271	19,594	$18,154
272	5,470	$17,426
273	1,387	$10,047
274	2,343	$22,054
275	247	$10,261
276	1,326	$11,997
277	93,843	$14,927
278	31,720	$9,470
279	3	$19,964
280	17,038	$12,041
281	7,827	$8,003
283	5,635	$12,585
284	1,950	$7,589
285	6,568	$35,890
286	2,183	$35,565
287	6,457	$32,850
288	3,675	$36,854
289	6,414	$16,097

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
290	9,482	$14,860
291	78	$10,570
292	5,422	$44,164
293	345	$24,530
294	95,355	$13,252
295	3,358	$13,707
296	250,808	$14,775
297	47,716	$8,713
298	103	$10,114
299	1,218	$16,149
300	17,532	$19,436
301	3,639	$11,261
302	7,896	$54,753
303	20,698	$41,205
304	12,041	$40,662
305	3,006	$20,536
306	7,210	$21,938
307	2,164	$10,268
308	7,244	$28,300
309	4,331	$15,304
310	24,587	$19,325
311	8,309	$10,483
312	1,547	$18,439
313	644	$11,749
315	33,708	$36,795
316	115,275	$23,727
317	1,889	$12,419
318	5,736	$21,305
319	494	$11,322
320	193,134	$14,735
321	30,723	$9,566
322	64	$8,657
323	18,621	$14,311
324	7,451	$8,122
325	8,937	$11,466
326	2,802	$7,872
327	2	$10,679
328	685	$13,051
329	105	$8,650
331	49,123	$18,734
332	5,117	$10,727
333	311	$13,719
334	10,262	$24,961
335	12,370	$18,084
336	36,313	$14,365
337	29,498	$9,686
338	1,055	$21,430
339	1,505	$18,435
341	3,670	$21,442
342	723	$13,001
344	3,838	$22,438
345	1,335	$19,558
346	4,559	$18,995
347	373	$10,844
348	3,280	$12,862
349	597	$7,194
350	6,493	$12,462
352	768	$12,805
353	2,655	$31,864
354	7,485	$25,534
355	5,670	$14,447
356	25,920	$12,488
357	5,710	$39,602
358	20,605	$20,138
359	31,042	$13,346
360	15,575	$14,638
361	369	$18,778
362	2	$9,180

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
363	2,683	$15,573
364	1,629	$14,738
365	1,834	$34,245
366	4,432	$23,297
367	520	$10,108
368	3,285	$21,162
369	3,279	$10,693
370	1,242	$16,029
371	1,413	$10,589
372	919	$9,639
373	3,876	$6,330
374	116	$12,936
375	8	$21,289
376	262	$8,664
377	29	$24,590
378	169	$15,095
379	408	$6,916
380	76	$6,684
381	181	$10,112
382	25	$2,798
383	1,841	$9,336
384	149	$7,372
389	5	$11,692
392	2,246	$55,515
394	2,326	$31,257
395	100,607	$14,330
396	11	$12,749
397	17,906	$21,719
398	17,113	$22,322
399	1,788	$12,303
400	6,486	$47,400
401	5,836	$50,173
402	1,599	$19,649
403	31,999	$32,078
404	4,588	$15,824
406	2,494	$48,934
407	701	$21,576
408	2,122	$36,343
409	2,515	$21,666
410	30,760	$18,311
411	14	$7,688
412	18	$4,980
413	5,766	$24,842
414	763	$12,866
415	39,905	$66,206
416	181,072	$28,177
417	37	$21,802
418	23,398	$18,311
419	15,719	$15,131
420	2,957	$10,195
421	9,270	$11,869
422	69	$7,590
423	7,269	$31,897
424	1,292	$41,189
425	16,304	$11,890
426	4,481	$9,206
427	1,576	$9,291
428	744	$12,949
429	27,018	$14,174
430	63,051	$12,703
431	320	$10,737
432	411	$11,105
433	5,520	$4,883
439	1,457	$29,345
440	5,435	$32,696
441	612	$15,577
442	16,693	$42,597
443	3,807	$17,673

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
444	5,675	$13,003
445	2,724	$8,465
447	6,278	$8,499
449	30,470	$14,241
450	7,366	$7,229
451	5	$4,039
452	25,215	$18,340
453	5,643	$9,105
454	4,623	$14,423
455	1,096	$8,019
461	4,563	$21,124
462	11,981	$19,956
463	25,204	$12,097
464	7,101	$8,636
465	224	$10,305
466	1,795	$11,397
467	1,043	$9,854
468	54,705	$66,153
470	49	$302,446
471	12,391	$47,581
473	8,235	$63,556
475	104,025	$67,384
476	3,812	$40,882
477	25,600	$32,847
478	108,611	$42,010
479	24,176	$24,354

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
480	622	$176,423
481	726	$123,849
482	5,299	$61,539
483	43,282	$288,420
484	317	$100,224
485	3,028	$50,619
486	1,867	$85,814
487	3,533	$35,194
488	776	$88,052
489	13,548	$32,178
490	5,247	$18,195
491	13,575	$26,985
492	2,874	$74,770
493	58,081	$30,868
494	30,883	$16,784
495	211	$155,662
496	1,841	$98,777
497	19,917	$57,641
498	14,635	$41,713
499	32,659	$24,252
500	49,444	$15,562
501	2,352	$44,432
502	636	$25,677
503	5,888	$20,546
504	123	$281,048
505	147	$31,985

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
506	937	$84,055
507	288	$30,296
508	667	$24,629
509	177	$16,475
510	1,671	$20,337
511	616	$11,613
512	450	$95,226
513	142	$99,439
514	19,241	$104,112
515	4,568	$87,754
516	76,169	$45,006
517	190,940	$36,508
518	51,620	$30,281
519	7,216	$39,899
520	11,045	$25,111
521	28,562	$12,663
522	6,139	$10,035
523	14,802	$6,921
524	136,805	$12,350
525	492	$209,675

[1] Cases are taken from the FY 2001 MedPAR file; DRGs are from GROUPER V20.0.

Appendix A—Regulatory Impact Analysis

I. Introduction

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Public Law 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandate Reform Act of 1995 (Public Law 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We have determined that this proposed rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the total impact of these changes for FY 2003 payments compared to FY 2002 payments to be approximately a $0.3 billion increase.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million to $25 million in any 1 year. For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (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 proposed in this document would affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this proposed rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

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 proposed rule (or a final rule that has been preceded by a proposed 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 proposed rule would not mandate any requirements for State, local, or tribal governments.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this proposed rule in light of Executive Order 13132 and have determined that it will not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

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

II. Objectives

The primary objective of the acute care hospital inpatient prospective payment system is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Trust Fund.

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

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 2003, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effects of these changes on hospitals and our methodology for estimating them.

IV. Hospitals Included In and Excluded From the Acute Care Hospital Inpatient 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 44 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 67 such hospitals in Maryland remain excluded from the hospital inpatient prospective payment system under the waiver at section 1814(b)(3) of the Act.

There are approximately 515 critical access hospitals (CAHs). These small, limited service hospitals are paid on the basis of reasonable costs rather than under the acute care hospital inpatient prospective payment system. The remaining 20 percent are specialty hospitals that are excluded from the acute-care, short-term prospective payment system. These hospitals include psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals. The impacts of our final policy changes on these hospitals are discussed below.

Thus, as of February 2002, we have included 4,301 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.

V. Impact on Excluded Hospitals and Hospital Units

As of February 2002, there were 1,065 specialty hospitals excluded from the

acute care hospital inpatient 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 493 psychiatric, 216 rehabilitation, 270 long-term care, 75 children's, and 11 cancer hospitals. In addition, there were 1,436 psychiatric units and 936 rehabilitation units in hospitals otherwise subject to the acute care hospital inpatient prospective payment system. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 67 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

In the past, hospitals and units excluded from the acute care hospital inpatient prospective payment system have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid based on their reasonable costs are subject to TEFRA limits for FY 2003. For these hospitals, the proposed update is the percentage increase in the excluded hospital market basket (currently estimated at 3.4 percent).

Inpatient rehabilitation facilities (IRFs) are paid under the IRF prospective payment system for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2003, the IRF prospective payment is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually (see the August 7, 2001 final rule (66 FR 41316 through 41430)). Therefore, these hospitals are not impacted by this proposed rule.

Effective for cost reporting periods beginning during FY 2003, we have proposed that long-term care hospitals would be paid under a long-term care hospital prospective payment system, where long-term care hospitals receive payment based on a 5-year transition period (see the March 22, 2002 proposed rule (67 FR 13416 through 13494)). However, under this proposed payment system, a long-term care hospital may also elect to be paid at 100 percent of the Federal prospective rate at the beginning of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor, the portion of the proposed prospective payment system transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the long-term care hospital's TEFRA limit by the proposed estimate of the excluded hospital market basket (or 3.4 percent).

The impact on excluded hospitals and hospital 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 rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and hospital units receive. Conversely, for excluded hospitals and hospital 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 hospital 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 hospital units to restrain the growth in their spending for patient services.

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

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for the hospital inpatient prospective payment systems for operating and capital-related costs. We estimate the total impact of these changes for FY 2003 payments compared to FY 2002 payments to be approximately a $0.3 billion increase. We have prepared separate impact analyses of the proposed changes to each system. This section deals with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are taken from the FY 2001 MedPAR file and the most current provider-specific file that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not incorporate cost data, the most recently available hospital cost report data were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these proposed policy changes. Second, due to the interdependent nature of the hospital inpatient prospective payment system, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

Using cases in the FY 2001 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 short-term acute-care hospital inpatient prospective payment systems (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations. The impact of payments under the capital prospective payment system, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of proposed FY 2003 changes to the capital prospective payment system are discussed in section IX. of this Appendix.

The proposed changes discussed separately below are the following:

- The effects of the proposed change to the labor portion of the standardized amounts from 71.1 percent to 72.5 percent.
- The effects of the proposed changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 1999, compared to the FY 1998 wage data, and the effects of removing from the wage data the costs and hours associated with graduate medical education (GME) and certified registered nurse anesthetists (CRNAs).
- The effects of the proposed 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 geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) that will be effective in FY 2003.

• The total change in payments based on FY 2003 policies relative to payments based on FY 2002 policies.

To illustrate the impacts of the FY 2003 proposed changes, our analysis begins with a FY 2003 baseline simulation model using: the FY 2002 DRG GROUPER (version 19.0); the FY 2002 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total DRG plus outlier payments.

Each proposed and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2003 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 2002 to FY 2003. Six 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 are proposing to update the large urban and the other areas average standardized amounts for FY 2003 using the most recently forecasted hospital market basket increase for FY 2003 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 Medicare-dependent small rural hospitals (MDHs) is also 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 2002 to FY 2003 is the change in MGCRB status from one year to the next. That is, hospitals reclassified in FY 2002 that are no longer reclassified in FY 2003 may have a negative payment impact going from FY 2002 to FY 2003; conversely, hospitals not reclassified in FY 2002 that are reclassified in FY 2003 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 is alleviated, however, 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 2002 will be 6.7 percent of total DRG payments. When the FY 2002 final rule was published, we projected FY 2002 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 2002 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2002 payments per case to estimated FY 2003 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. This option was to be phased in over 4 years. For FY 2003, the proportion of payments based on affected SCHs' FY 1996 hospital-specific amount increases from 50 percent to 75 percent.

Fifth, under section 1886(d)(5)(B)(ii) of the Act, the formula for indirect medical education (IME) is reduced beginning in FY 2003. The reduction is from approximately a 6.5 percent increase for every 10 percent increase in the resident-to-bed ratio during FY 2002 to approximately a 5.5 percent increase.

Sixth, the disproportionate share hospital (DSH) adjustment increases in FY 2003 compared with FY 2002. In accordance with section 1886(d)(5)(F)(ix) of the Act, during FY 2002, DSH payments that the hospital would otherwise receive were reduced by 3 percent. This reduction is no longer applicable beginning with FY 2003.

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 4,301 hospitals included in the analysis. This number is 494 fewer hospitals than were included in the impact analysis in the FY 2002 final rule (66 FR 40087). Of this number, 437 are now CAHs and are excluded from our analysis.

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 2,613 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,511 hospitals located in large urban areas (populations over 1 million), and 1,102 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,688 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 2003 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 2,645, 1,570, 1,075, and 1,656, respectively.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 3,195 nonteaching hospitals in our analysis, 872 teaching hospitals with fewer than 100 residents, and 234 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural after MGCRB reclassifications. Hospitals in the rural DSH categories, therefore, represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (They may, however, have been reclassified for purposes of the wage index.)

The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the proposed 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 (159), SCHs (540), MDHs (216), and hospitals that are both SCH and RRC (75) shown here were not reclassified for purposes of the standardized amount. There are 4 RRCs and 1 SCH and RRC that will be reclassified as urban for the standardized amount in FY 2003 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 were unavailable for 213 hospitals. Similarly, the data needed to determine

Medicare utilization were unavailable for 109 hospitals.

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 2003. 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 2003 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent changes in payments per case]

	Number of hosps.[1] (0)	New labor share[2] (1)	DRG changes.[3] (2)	New wage data[4] (3)	Remove GME & CRNA 80/20[5] (4)	Remove GME & CRNA 100 percent[6] (5)	DRG & WI changes[7] (6)	MCGRB reclassification[8] (7)	All FY 2003 changes[9] (8)
By Geographic Location:									
All hospitals	4,301	0.0	−0.2	0.0	0.0	0.0	0.0	0.0	0.4
Urban hospitals	2,613	0.0	−0.2	−0.1	0.0	0.0	0.0	−0.5	0.1
Large urban areas (populations over 1 million)	1,511	0.1	−0.2	−0.2	0.0	0.0	−0.2	−0.5	−0.3
Other urban areas (populations of 1 million of fewer)	1,102	−0.1	−0.1	0.1	0.0	0.0	0.3	−0.4	0.8
Rural hospitals	1,688	−0.2	−0.4	0.5	0.1	0.1	0.3	2.5	2.1
Bed Size (Urban):									
0–99 beds	647	0.0	−0.2	0.0	0.1	0.1	0.3	−0.6	1.5
100–199 beds	904	0.0	−0.3	−0.1	0.0	0.1	0.0	−0.5	1.0
200–299 beds	528	0.0	−0.3	0.0	0.0	0.1	0.1	−0.4	0.5
300–499 beds	387	0.0	−0.1	−0.2	0.0	0.0	0.0	−0.4	0.1
500 or more beds	147	0.1	−0.2	−0.1	0.0	0.0	−0.1	−0.5	−1.1
Bed Size (Rural):									
0–49 beds	819	−0.2	−0.6	0.6	0.1	0.1	0.2	0.5	2.6
50–99 beds	507	−0.2	−0.5	0.4	0.1	0.1	0.2	1.0	2.4
100–149 beds	216	−0.2	−0.4	0.6	0.1	0.1	0.5	2.9	2.0
150–199 beds	78	−0.2	−0.4	0.5	0.1	0.1	0.5	4.8	1.9
200 or more beds	68	−0.2	−0.3	0.4	0.1	0.1	0.4	4.1	1.4
Urban by Region:									
New England	134	0.2	−0.3	0.1	0.0	0.1	0.9	−0.2	0.0
Middle Atlantic	402	0.2	−0.1	−0.8	0.0	0.0	−0.8	−0.1	−1.8
South Atlantic	380	−0.1	−0.2	0.1	0.1	0.1	0.2	−0.5	0.9
East North Central	431	0.0	−0.2	0.1	0.0	0.0	0.2	−0.5	0.4
East South Central	158	−0.2	−0.2	0.2	0.0	0.0	0.1	−0.7	0.9
West North Central	180	−0.1	−0.3	0.5	0.1	0.1	0.6	−0.7	0.9
West South Central	334	−0.2	−0.2	−0.2	0.1	0.1	−0.1	−0.7	0.4
Mountain	132	0.0	0.0	−0.3	0.1	0.1	0.0	−0.6	0.6
Pacific	416	0.2	−0.4	0.0	0.1	0.1	0.1	−0.5	0.7
Puerto Rico	46	−0.7	−0.4	−0.8	0.0	0.0	−0.7	−0.8	0.0
Rural by Region:									
New England	40	0.0	−0.4	0.2	0.0	0.0	0.0	2.8	1.0
Middle Atlantic	68	−0.1	−0.4	−0.1	0.0	0.0	−0.3	2.5	1.6
South Atlantic	239	−0.2	−0.5	0.4	0.1	0.1	0.2	3.0	1.9
East North Central	225	−0.1	−0.3	0.4	0.1	0.1	0.4	2.1	2.5
East South Central	243	−0.3	−0.6	1.0	0.1	0.1	0.8	2.4	2.0
West North Central	311	−0.2	−0.4	0.8	0.0	0.0	0.7	1.5	2.4
West South Central	294	−0.3	−0.6	0.3	0.1	0.1	0.0	3.4	1.8
Mountain	151	−0.1	−0.4	0.2	0.0	0.0	0.1	1.6	2.0
Pacific	112	0.0	−0.4	0.8	0.1	0.1	0.6	2.3	2.7
Puerto Rico	5	−0.7	−0.5	−4.9	0.1	0.1	−5.0	−0.5	−2.8
By Payment Classification:									
Urban hospitals	2,645	0.0	−0.2	−0.1	0.0	0.0	0.0	−0.4	0.2
Large urban areas (populations over 1 million)	1,570	0.1	−0.2	−0.2	0.0	0.0	−0.2	−0.4	−0.2
Other urban areas (populations of 1 million of fewer)	1,075	−0.1	−0.1	0.1	0.0	0.0	0.3	−0.4	0.8
Rural areas	1,656	−0.2	−0.5	0.5	0.1	0.1	0.3	2.4	2.1
Teaching Status:									
Non-teaching	3,195	−0.1	−0.4	0.2	0.1	0.1	0.2	0.3	1.5
Fewer than 100 Residents	872	0.0	−0.1	−0.1	0.0	0.0	0.0	−0.3	0.5
100 or more Residents	234	0.1	−0.2	−0.3	0.0	0.0	−0.3	−0.3	−1.7
Urban DSH:									
Non-DSH	1,565	0.0	−0.1	0.0	0.0	0.0	0.2	0.1	0.7
100 or more beds	1,354	0.0	−0.2	−0.2	0.0	0.0	−0.1	−0.5	0.0
Less than 100 beds	295	0.0	−0.4	0.1	0.1	0.1	0.1	−0.3	1.5

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2003 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Number of hosps.[1] (0)	New labor share[2] (1)	DRG changes.[3] (2)	New wage data[4] (3)	Remove GME & CRNA 80/20[5] (4)	Remove GME & CRNA 100 percent[6] (5)	DRG & WI changes[7] (6)	MCGRB reclassification[8] (7)	All FY 2003 changes[9] (8)
Rural DSH:									
Sole Community (SCH)	470	−0.1	−0.7	0.4	0.0	0.0	−0.1	0.1	2.3
Referral Center (RRC)	156	−0.2	−0.4	0.5	0.1	0.1	0.5	5.1	1.6
Other Rural:									
100 or more beds	78	−0.3	−0.5	0.6	0.1	0.1	0.6	1.2	2.0
Less than 100 beds	383	−0.3	−0.6	0.7	0.1	0.1	0.5	0.8	2.5
Urban teaching and DSH:									
Both teaching and DSH	758	0.0	−0.2	−0.3	0.0	0.0	−0.2	−0.5	−0.6
Teaching and no DSH	278	0.0	0.0	0.0	0.0	0.0	0.2	−0.1	−0.1
No teaching and DSH	891	0.0	−0.4	0.1	0.1	0.1	0.2	−0.4	1.4
No teaching and no DSH	718	0.0	−0.2	0.0	0.0	0.1	0.2	−0.4	1.0
Rural Hospital Types:									
Non special status hospitals	666	−0.3	−0.5	0.7	0.1	0.1	0.6	1.2	2.3
RRC	159	−0.3	−0.3	0.6	0.1	0.1	0.6	6.0	1.2
SCH	540	−0.1	−0.6	0.2	0.0	0.0	−0.2	0.3	2.3
Medicare-dependent hospitals (MDH)	216	−0.2	−0.6	0.7	0.1	0.1	0.3	0.5	2.7
SCH and RRC	75	−0.1	−0.3	0.3	0.0	0.0	0.1	1.8	2.5
Type of Ownership:									
Voluntary	2,473	0.0	−0.2	−0.1	0.0	0.0	0.0	−0.1	0.4
Proprietary	705	0.0	−0.2	−0.2	0.1	0.1	−0.1	−0.1	0.3
Government	910	−0.1	−0.5	0.3	0.1	0.1	0.2	0.2	0.8
Unknown	213	−0.1	−0.3	0.2	0.1	0.1	0.2	−0.4	0.6
Medicare Utilization as a Percent of Inpatient Days:									
0–25	319	0.1	−0.4	−0.3	0.1	0.1	−0.4	−0.3	−0.7
25–50	1,650	0.0	−0.2	−0.1	0.0	0.0	0.0	−0.3	0.0
50–65	1,706	−0.1	−0.2	0.1	0.0	0.0	0.2	0.3	1.1
Over 65	517	−0.1	−0.4	−0.1	0.0	0.0	−0.1	0.5	0.6
Unknown	109	0.2	0.1	−1.1	0.0	0.0	−0.8	−0.7	−0.4
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2003 Reclassifications:									
All Reclassified Hospitals	620	−0.1	−0.3	0.3	0.0	0.1	0.4	4.4	1.0
Standardized Amount Only	29	0.0	−0.4	0.6	0.1	0.1	0.6	0.3	1.6
Wage Index Only	527	−0.1	−0.3	0.3	0.0	0.1	0.3	4.5	0.8
Both	41	−0.2	−0.2	0.4	0.1	0.1	0.6	5.1	1.1
Nonreclassified Hospitals	3,666	0.0	−0.2	−0.1	0.0	0.0	0.0	−0.7	0.3
All Reclassified Urban Hospitals	108	0.1	−0.1	0.1	0.0	0.0	0.4	4.0	−0.4
Standardized Amount Only	1	0.0	−0.1	0.4	−0.1	−0.1	0.4	−0.9	1.6
Wage Index Only	95	0.1	−0.1	0.1	0.0	0.0	0.4	4.1	0.6
Both	12	−0.1	−0.2	0.6	0.1	0.1	0.9	2.9	4.1
Urban Nonreclassified Hospitals	2,471	0.0	−0.2	−0.1	0.0	0.0	0.0	−0.7	0.2
All Reclassified Rural Hospitals	512	−0.2	−0.4	0.4	0.1	0.1	0.4	4.6	1.8
Standardized Amount Only	1	−0.4	0.1	0.1	0.1	0.1	0.6	0.9	3.7
Wage Index Only	502	−0.2	−0.4	0.5	0.1	0.1	0.4	4.6	1.8
Both	9	−0.2	−0.2	0.2	0.1	0.1	0.2	4.7	0.7
Rural Nonreclassified Hospitals	1,175	−0.2	−0.6	0.5	0.1	0.1	0.3	−0.4	2.4
Other Reclassified Hospitals (Section 1886(D)(8)(B))	35	−0.1	−0.6	−0.1	0.0	0.0	−0.5	−1.4	2.8

[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 2001, and hospital cost report data are from reporting periods beginning in FY 1999 and FY 1998.

[2] This column displays impact of the proposed change to the labor share from 71.1 percent to 72.5 percent.

[3] This column displays the payment impact of the recalibration of the DRG weights based on FY 2001 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[4] This column displays the impact of updating the wage index with wage data from hospitals' FY 1999 cost reports.

[5] This column displays the impact of an 80/20 percent blend of removing the labor costs and hours associated with graduate medical education and for the Part A costs of certified registered nurse anesthetists.

[6] This column displays the impact of completely removing the labor costs and hours associated with graduate medical education (GME) and for the Part A costs of certified registered nurse anesthetists (CRNAs).

[7] This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated and revised wage data used to calculate the wage index, the phase-out of GME and CRNA costs and hours, and the budget neutrality adjustment factor for DRG and wage index changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 2, 3, 4 and 5, and the FY 2003 budget neutrality factor of 1.001026.

[8] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2003 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2003. Reclassification for prior years has no bearing on the payment impacts shown here.

[9] This column shows changes in payments from FY 2002 to FY 2003. It incorporates all of the changes displayed in columns 1, 6 and 7 (the changes displayed in columns 2, 3, 4, and 5 are included in column 6). It also displays the impact of the FY 2003 update, changes in hospitals' reclassification status in FY 2003 compared to FY 2002, and the difference in outlier payments from FY 2002 to FY 2003. It also reflects the gradual phase-in for some SCHs of the full 1996 hospital-specific rate. Finally, the impacts of the reduction in IME adjustment payments, and the increase in the DSH adjustment are shown in this column. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effect.

B. Impact of the Proposed Changes to the Labor Share (Column 1)

In Column 1 of Table 1, we present the effects of our proposal to update the labor share from 71.10 percent to 72.49 percent. We estimate the impact of this change by calculating payments using payment rates updated to FY 2003, but using the FY 2002 DRG GROUPER and wage index. The change in this column represents the impact upon various hospital categories of the proposed change to the labor share. This proposed change negatively impacts hospitals with wage indexes less than 1.0, and positively affects those with wage indexes greater than 1.0.

This proposed change has no impact on overall hospital payments. However, there are redistributive impacts generally in the range of plus or minus 0.1 percent or 0.2 percent. The net redistributive impact from those positively and negatively affected is approximately $65 million. Hospitals in large urban areas would experience an increase of 0.1 percent. Hospitals in both ''other'' urban and rural areas would experience −0.1 and −0.2 percent decreases, respectively.

Under the urban by region category, New England, Middle Atlantic and Pacific regions would experience a 0.2 percent increase. The urban East South Central and West South Central regions would experience −0.2 percent decreases. Puerto Rico has a projected decrease of −0.7 percent, due to the low wage indexes in the Puerto Rico MSAs.

All rural regions would experience a negative percent decrease except New England and Pacific regions (at 0.0 percent change). The South Atlantic and West North Central regions would experience a decrease of −0.2 percent. The East South Central and West South Central regions each would experience a −0.3 percent decrease, while Puerto Rico would experience a −0.7 percent decrease. Rural nonspecial status hospitals and RRCs would decline by −0.3. SCH and MDHs also would experience decreases of −0.1 and −0.2 percent, respectively. The relatively smaller negative impact for these hospitals is due to the fact that the hospital-specific rate is not adjusted by the wage index. Therefore, this proposed change would have no effect on hospitals paid on that basis (other than SCHs receiving a blended of their FY 1996 hospital-specific rate and the Federal rate).

C. Impact of the Proposed Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 3)

In column 3 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II. of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us to annually make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 2002 DRG relative weights (GROUPER version 19.0) to aggregate payments using the proposed FY 2003 DRG relative weights (GROUPER version 20.0). Overall payments decrease −0.2 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 changes (combined with the wage index changes) is budget neutral. This budget neutrality factor of 1.001026 is applied to payments in Column 6. Because this is a combined DRG reclassification and recalibration and wage index budget neutrality factor, it is not applied to payments in this column.

The DRG changes we are proposing would result in 0.2 percent lower payments to hospitals overall. This is the reason the budget neutrality factor is greater than 1.0. This change is largely related to the proposed changes we are making to DRGs 14 (proposed to be retitled, Intracranial Hemorrhage and Stroke with Infarction) and 15 (proposed to be retitled, Nonspecific Cerebrovascular and Precerebral Occlusion without Infarction), and new DRG 524 (Transient Ischemia). With the new configuration of these DRGs, over 80,000 cases that previously would have been assigned to DRG 14 (with a FY 2003 proposed relative weight of 1.2742) would now be assigned to DRG 15 (with a FY 2003 proposed relative weight of 0.9844).

This change is evident most dramatically in small and rural hospitals. Rural hospitals with fewer than 50 beds would experience a 0.6 percent decrease, and rural hospitals with between 50 and 99 beds would experience a 0.5 percent decrease. Among rural hospitals categorized by region, the East South Central and West South Central would experience a 0.6 percent decrease in payments. Among special rural hospital categories, SCHs and MDHs both would experience 0.6 percent decreases.

D. Impact of Wage Index Changes (Columns 3, 4, and 5)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for FY 2003 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1998 and before October 1, 1999. As with column 2, the impact of the new data on hospital payments is isolated in columns 3, 4 and 5 by holding the other payment parameters constant in the three simulations. That is, columns 3, 4, and 5 show the percentage changes in payments when going from a model using the FY 2002 wage index (based on FY 1997 wage data before geographic reclassifications to a model using the FY 2003 pre-

reclassification wage index based on FY 1998 wage data).

The wage data collected on the FY 1999 cost reports are similar to the data used in the calculation of the FY 2002 wage index. Also, as described in section III.B of this preamble, the proposed FY 2003 wage index is calculated by removing 100 percent of hospitals' GME and CRNA costs (and hours). The FY 2002 wage index was calculated by blending 60 percent of hospitals' average hourly wages, excluding GME and CRNA data, with 40 percent of average hourly wages including these data.

Column 3 shows the impacts of updating the wage data using FY 1999 cost reports. This column maintains the same 60/40 phase-out of GME and CRNA costs as the FY 2002 wage index, which is the baseline for comparison. Among regions, the largest impact of updating the wage data is seen in rural Puerto Rico (a 4.9 percent decrease). Rural hospitals in the East South Central region experience the next largest impact, a 1.0 percent increase. This is primarily due to a 6 percent increase in the rural Alabama wage index, and a little under a 3 percent increase in the rural Mississippi wage index. Among urban hospitals, the Middle Atlantic region would experience a 0.8 percent decrease, largely due to a 2.4 percent decrease in the New York City wage index and a 2.3 percent decrease in the Philadelphia wage index.

The next two columns show the impacts of removing the GME and CRNA data from the wage index calculation. Under the 5-year phaseout of these data, FY 2003 would be the fourth year of the phaseout. This means that, under the phaseout, the FY 2003 wage index would be calculated with 20 percent of the GME and CRNA data included and 80 percent with these data removed, and FY 2004 would begin the calculation with 100 percent of these data removed. However, we are proposing to remove 100 percent of GME and CRNA costs from the FY 2003 wage index. To demonstrate the impacts of this proposal, we first show the impacts of moving to a wage index with 80 percent of these data removed (Column 4), then show a wage index with 100 percent of these data removed (Column 5). As expected, the impacts in the two columns are similar, with some differences due to rounding. Generally, no group of hospitals is impacted by more than 0.1 percent by this change. Even among the hospital group most likely to be negatively impacted by this change, teaching hospitals with 100 or more residents, the net effect of removing 100 percent of GME and CRNA data is 0.0 percent change in payments.

We note that the wage data used for the proposed wage index are based upon the data available as of February 22, 2001 and, therefore, do not reflect revision requests received and processed by the fiscal intermediaries after that date. To the extent these requests are granted by hospitals' fiscal intermediaries, these revisions will be reflected in the final rule. In addition, we continue to verify the accuracy of the data for hospitals with extraordinary changes in their data from the prior year.

The following chart compares the shifts in wage index values for labor market areas for FY 2002 relative to FY 2003. This chart demonstrates the impact of the proposed changes for the FY 2003 wage index, including updating to FY 1999 wage data and removing 100 percent of GME and CRNA data. The majority of labor market areas (324) experience less than a 5 percent change. A total of 19 labor market areas experience an increase of more than 5 percent and less than 10 percent. One area experiences an increase greater than 10 percent. A total of 26 areas experience decreases of more than 5 percent and less than 10 percent. Finally, 2 areas experience declines of 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 2002	FY 2003
Increase more than 10 percent	2	1
Increase more than 5 percent and less than 10 percent	26	19
Increase or decrease less than 5 percent	335	320
Decrease more than 5 percent and less than 10 percent	10	26
Decrease more than 10 percent	1	2

Among urban hospitals, 24 would experience an increase of between 5 and 10 percent and 2 more than 10 percent. A total of 53 rural hospitals have increases greater than 5 percent, but none greater than 10 percent. On the negative side, 75 urban hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. Six urban hospitals have decreases in their wage index values greater than 10 percent. There are 19 rural hospitals with decreases in their wage index values greater than 5 percent or with increases of more than 10 percent. The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	2	0
Increase more than 5 percent and less than 10 percent	24	53
Increase or decrease less than 5 percent	2506	1616
Decrease more than 5 percent and less than 10 percent	75	19
Decrease more than 10 percent	6	0

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

The impact of DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this proposed rule, we compared simulated aggregate payments using the FY 2002 DRG relative weights and wage index to simulated aggregate payments using the proposed FY 2003 DRG relative weights and blended wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 1.001026. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 6. The 0.0 percent impact for all hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral.

For the most part, the changes in this column are the sum of the changes in columns 2, 3, 4, and 5, plus approximately 0.1 percent attributable to the budget neutrality factor. In addition, section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. This provision is required to be budget neutral. The impact of this provision, which is to increase overall payments by 0.1 percent, is not shown in columns 2, 3, 4, and 5. It is included in the impacts shown in column 6. There also may be some variation of plus or minus 0.1 percent due to rounding.

F. Impact of MGCRB Reclassifications (Column 7)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 6 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2003. These decisions affect hospitals' standardized amount and wage index area assignments.

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 another area's standardized amount, wage index value, or both.

The proposed FY 2003 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2003. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process for MGCRB decisions as of February 28, 2002. Additional changes that result from the Administrator's review of MGCRB decisions or a request by a hospital to withdraw its application will be reflected in the final rule for FY 2003.

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 0.990536 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this proposed rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.5 percent in column 6. Payments to urban hospitals decline 0.5 percent. Hospitals in other urban areas see a decrease in payments of 0.5 percent, while large urban hospitals lose 0.5 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 smallest increases among the rural census divisions are 1.5 and 1.6 percent for West North Central and Mountain regions, respectively. The largest increases are in rural South Atlantic and West South Central regions. These regions receive increases of 3.0 and 3.4 percent, respectively.

Among all the hospitals that were reclassified for FY 2003 (including hospitals that received wage index reclassification in a FY 2001 or FY 2002 that extend for 3-years), the MGCRB changes are estimated to provide a 4.4 percent increase in payments. Urban hospitals reclassified for FY 2003 are expected to receive an increase of 4.0 percent, while rural reclassified hospitals are expected to benefit from the MGCRB changes with a 4.6 percent increase in payments. Overall, among hospitals that were reclassified for purposes of the standardized amount only, a payment increase of 0.3 percent is expected, while those reclassified for purposes of the wage index only show a 4.5 percent increase in payments. Payments to urban and rural hospitals that did not reclassify are expected to decrease slightly due to the MGCRB changes, decreasing by 0.7 for urban hospitals and 0.4 for rural hospitals. Those hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive a decrease in payments of 1.4 percent.

The foregoing analysis was based on MGCRB and CMS Administrator decisions made by February 28, 2002. As previously noted, there may be changes to some MGCRB decisions through the appeals, review, and applicant withdrawal process. The outcome of these cases will be reflected in the analysis presented in the final rule.

G. All Changes (Column 8)

Column 8 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2003 (including statutory changes), to our estimate of payments per case in FY 2002. This column includes all of the policy changes to date, including the proposed new labor share shown in column 1, and the combined DRG and wage index changes from column 6. Because the reclassifications shown in column 7 do not reflect FY 2002 reclassifications, the impacts of FY 2003 reclassifications only affect the impacts from FY 2002 to FY 2003 if the reclassification impacts for any group of hospitals are different in FY 2003 compared to FY 2002.

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 1.7 percentage point difference between the projected outlier payments in FY 2002 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2002 (6.8 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule.

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 2003, eligible SCHs that rebase receive a hospital-specific rate comprised of 25 percent of the higher of their FY 1982 or FY 1987 hospital-specific rate or their Federal rate, and 75 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 8 as well.

Under section 1886(d)(5)(B)(ii) of the Act, the formula for IME is reduced beginning in FY 2003. The reduction is from approximately a 6.5 percent increase for every 10 percent increase in the resident-to-bed ratio during FY 2002 to approximately a 5.5 percent increase. We estimate the impact of this change to be a 0.9 percent reduction in hospitals' overall FY 2003 payments. The impact upon teaching hospitals would be larger.

Finally, the DSH adjustment increases in FY 2003 compared with FY 2002. In accordance with section 1886(d)(5)(F)(ix) of the Act, during FY 2002, DSH payments that the hospital would otherwise receive were reduced by 3 percent. This reduction is no longer applicable beginning with FY 2003. The estimated impact of this change is to increase overall hospital payments by 0.2 percent.

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

The overall change in payments per case for hospitals in FY 2003 increases by 0.4 percent. This reflects the update of 2.75 percent, the 1.7 percent higher outlier payments in FY 2002 than projected for FY 2003, a 0.9 percent reduction in payments for IME, and a 0.2 percent increase in payments due to higher DSH payments in FY 2003. Hospitals in urban areas experience a 0.1 percent increase in payments per case compared to FY 2002, although hospitals in large urban areas experience a 0.3 percent decline in payments, largely due to reduction in IME payments. The impact of the reduction in IME payments is most evident among teaching hospitals with 100 or more residents, who would experience a decrease in payments per case of 1.7 percent. Hospitals in rural areas, meanwhile, experience a 2.1 percent payment increase.

Among urban census divisions, the largest payment increase was 0.9 percent in South Atlantic, East South Central, and West North Central. Hospitals in urban Middle Atlantic would experience an overall decrease of 1.8 percent. This is primarily due to the combination of the negative impact on these hospitals of reducing IME and the lower outlier payments during FY 2003. The rural census division experiencing the smallest increase in payments were New England and the Middle Atlantic regions (1.0 and 1.6 percent, respectively). The only decreases by rural hospitals are in Puerto Rico, where payments appear to decrease by 2.8 percent, largely due to the updated wage data. In the Pacific, payments appear to increase by 2.7 percent. Rural East and West North Central regions also benefited, with 2.5 and 2.4 percent increases, 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 2.3 percent, 2.7 percent, and 2.5 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there are no outlier payments. Therefore, these hospitals do not experience negative payment impacts from the decline in outlier payments from FY 2002 to FY 2003 (from 6.8 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 2003, hospitals overall are estimated to receive a 1.0 percent increase in payments. Urban hospitals reclassified for FY 2003 are anticipated to receive a decrease of −0.4 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 1.8 percent increase in payments. Overall, among hospitals reclassified for purposes of the standardized amount, a payment increase of 1.6 percent is expected, while those hospitals reclassified for purposes of the wage index only show an expected 0.8 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 2.8 percent.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2003 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per Case]

	Number of hosps. (1)	Average FY 2002 payment per case [1] (2)	Average FY 2003 payment per case [1] (3)	All FY 2003 changes (4)
By Geographic Location:				
All hospitals	4,301	7,194	7,224	0.4
Urban hospitals	2,613	7,707	7,718	0.1
Large urban areas (populations over 1 million)	1,511	8,269	8,245	–0.3
Other urban areas (populations of 1 million of fewer)	1,102	6,977	7,034	0.8
Rural hospitals	1,688	5,108	5,213	2.1
Bed Size (Urban):				
0–99 beds	647	5,299	5,380	1.5
100–199 beds	904	6,436	6,498	1.0
200–299 beds	528	7,391	7,425	0.5
300–499 beds	387	8,276	8,280	0.1
500 or more beds	147	10,046	9,932	–1.1
Bed Size (Rural):				
0–49 beds	819	4,204	4,313	2.6
50–99 beds	507	4,754	4,866	2.4
100–149 beds	216	5,052	5,154	2.0
150–199 beds	78	5,494	5,600	1.9
200 or more beds	68	6,651	6,742	1.4
Urban by Region:				
New England	134	8,228	8,225	0.0
Middle Atlantic	402	8,832	8,675	–1.8
South Atlantic	380	7,287	7,353	0.9
East North Central	431	7,269	7,296	0.4

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2003 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per Case]

	Number of hosps. (1)	Average FY 2002 payment per case [1] (2)	Average FY 2003 payment per case [1] (3)	All FY 2003 changes (4)
East South Central	158	6,919	6,984	0.9
West North Central	180	7,330	7,399	0.9
West South Central	334	7,089	7,121	0.4
Mountain	132	7,505	7,553	0.6
Pacific	416	9,319	9,383	0.7
Puerto Rico	46	3,310	3,311	0.0
Rural by Region:				
New England	40	6,227	6,290	1.0
Middle Atlantic	68	5,345	5,430	1.6
South Atlantic	239	5,221	5,319	1.9
East North Central	225	5,059	5,185	2.5
East South Central	243	4,723	4,819	2.0
West North Central	311	5,093	5,214	2.4
West South Central	294	4,547	4,627	1.8
Mountain	151	5,424	5,531	2.0
Pacific	112	6,592	6,772	2.7
Puerto Rico	5	2,754	2,677	–2.8
By Payment Classification:				
Urban hospitals	2,645	7,691	7,703	0.2
Large urban areas (populations over 1 million)	1,570	8,194	8,175	–0.2
Other urban areas (populations of 1 million of fewer)	1,075	7,003	7,057	0.8
Rural areas	1,656	5,094	5,199	2.1
Teaching Status:				
Non-teaching	3,195	5,866	5,952	1.5
Fewer than 100 Residents	872	7,479	7,515	0.5
100 or more Residents	234	11,431	11,239	–1.7
Urban DSH:				
Non-DSH	1,565	6,538	6,581	0.7
100 or more beds	1,354	8,299	8,299	0.0
Less than 100 beds	295	5,235	5,312	1.5
Rural DSH:	470	4,938	5,053	2.3
Sole Community (SCH).				
Referral Center (RRC)	156	5,906	6,001	1.6
Other Rural:				
100 or more beds	78	4,509	4,598	2.0
Less than 100 beds	383	4,076	4,179	2.5
Urban teaching and DSH:				
Both teaching and DSH	758	9,185	9,134	–0.6
Teaching and no DSH	278	7,724	7,717	–0.1
No teaching and DSH	891	6,510	6,600	1.4
No teaching and no DSH	718	6,066	6,124	1.0
Rural Hospital Types:				
Non special status hospitals	666	4,247	4,345	2.3
RRC	159	5,667	5,737	1.2
SCH	540	5,223	5,344	2.3
Medicare-dependent hospitals (MDH)	216	4,032	4,142	2.7
SCH and RRC	75	6,429	6,589	2.5
Type of Ownership:				
Voluntary	2,473	7,322	7,349	0.4
Proprietary	705	6,907	6,929	0.3
Government	910	6,764	6,815	0.8
Unknown	213	7,281	7,326	0.6
Medicare Utilization as a Percent of Inpatient Days:				
0–25	319	9,820	9,755	–0.7
25–50	1,650	8,252	8,252	0.0
50–65	1,706	6,225	6,293	1.1
Over 65	517	5,645	5,679	0.6
Unknown	109	8,871	8,832	–0.4
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
FY 2002 Reclassifications:				
All Reclassified Hospitals	620	6,513	6,579	1.0
Standardized Amount Only	29	5,918	6,016	1.6
Wage Index Only	527	6,678	6,728	0.8
Both	41	5,874	5,936	1.1
All Nonreclassified Hospitals	3,666	7,310	7,335	0.3
All Urban Reclassified Hospitals	108	8,752	8,720	–0.4

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2003 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per Case]

	Number of hosps. (1)	Average FY 2002 payment per case [1] (2)	Average FY 2003 payment per case [1] (3)	All FY 2003 changes (4)
Urban Nonreclassified Hospitals	1	5,484	5,569	1.6
Standardized Amount Only	95	9,003	8,951	–0.6
Wage Index Only	12	5,680	5,911	4.1
Both	2,471	7,672	7,685	0.2
All Reclassified Rural Hospitals	512	5,666	5,768	1.8
Standardized Amount Only	1	5,408	5,605	3.7
Wage Index Only	502	5,650	5,754	1.8
Both	9	6,370	6,415	0.7
Rural Nonreclassified Hospitals	1,175	4,478	4,585	2.4
Other Reclassified Hospitals (Section 1886(D)(8)(B))	35	4,892	5,031	2.8

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

Table II presents the projected impact of the proposed changes for FY 2003 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 2002 with the average estimated per case payments for FY 2003, 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.

VII. Impact of Specific Proposed Policy Changes

A. Impact of Proposed Policy Changes Relating to Hospital Bed Counts

As discussed in section V.E.3. of the preamble of this proposed rule, we are proposing that if a hospital's reported bed count results in an occupancy rate below 35 percent, the applicable bed count for that hospital would be the number of beds that would result in an occupancy rate of 35 percent.

We have calculated an estimated impact on the Medicare program for FY 2003 as a result of this policy. We first identified urban hospitals receiving DSH with bed counts above 100, but with occupancy rates below 35 percent. Then, we determined the amount of DSH payments made to these hospitals in FY 1999. Next, we simulated what these hospitals' DSH payments would have been had their bed counts been less than 100. We compared the difference between actual DSH payments using 100 or more beds to simulated DSH payments using fewer than 100 beds, and determined that the reductions in DSH payments to these hospitals, inflated to FY 2003 using the update to the average standardized amount, would be approximately $38.9 million.

B. Impact of Proposed Changes Relating to EMTALA Provisions

In section V.J. of the preamble to this proposed rule, we discuss our proposed changes to our policies relating to the responsibilities of Medicare-participating hospitals under the patient antidumping statute (EMTALA) to medically screen all patients seeking emergency services and provide stabilizing medical treatment as necessary to patients whose conditions warrant it. In summary, to help promote consistent application of our regulations concerning EMTALA, we are proposing to clarify certain policies in areas where issues have arisen and at the same time address concerns about EMTALA raised by the Secretary's Regulatory Reform Task Force, including the following:

- We are proposing to change the requirements relating to emergency patients presenting at those off-campus outpatient clinics that do not routinely provide emergency services. We believe these changes would enhance the quality and promptness of emergency care by permitting individuals to be referred to appropriately equipped emergency facilities close to such clinics.
- We are proposing to clarify when EMTALA applies to both inpatients and outpatients. We believe these clarifications would enhance overall patient access to emergency services by helping to relieve administrative burdens on frequently overcrowded emergency departments.
- We are proposing to clarify the circumstances in which physicians, particularly specialty physicians, must serve on hospital medical staff ''on-call'' lists. We expect these clarifications would help improve access to physician services for all hospital patients by permitting hospitals local flexibility to determine how best to maximize their available physician resources. We are currently aware of reports of physicians, particularly specialty physicians, severing their relationships with hospitals, especially when those physicians belong to more than one hospital medical staff. Physician attrition from these medical staffs could result in hospitals having no specialty physician service coverage for their patients. Our proposed clarification of the on-call list requirement would permit hospitals to continue to attract physicians to serve on their medical staffs and thereby continue to provide services to emergency room patients.
- We are proposing to clarify the responsibilities of hospital-owned ambulances so that these ambulances can be more fully integrated with citywide and local community EMS procedures for responding to medical emergencies and thus use these resources more efficiently for the benefit of these communities.

We believe it would be difficult to quantify the impact of these changes and are soliciting comments on these issues.

C. Impact of Proposed Policy Changes Relating to Provider-Based Entity

In section V.K. of the preamble of this proposed rule, we discuss our proposed Medicare payment policy changes relating to determinations of provider-based status for entities of main providers. These changes are intended to focus mainly on issues raised by the hospital industry surrounding the provider-based regulations and to allow for a orderly and uniform implementation strategy once the

grandfathering provision for these entities expires on September 30, 2002.

We believe it would be difficult to quantify the impact of these changes and are soliciting comments on these issues.

VIII. Impact of Proposed Policies Affecting Rural Hospitals

A. Raising the Threshold To Qualify for the CRNA Pass-Through Payments

In section V. of the preamble of this proposed rule, we are proposing to raise the maximum number of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services that a rural hospital may perform to qualify for pass-through payments for the costs of CRNAs to 800 from 500. Currently, we have identified 622 hospitals that qualify under this provision.

To measure the impact of this provision, we determined that approximately half of the hospitals that would appear to be eligible based on the current number of procedures appear to receive this adjustment. In order to be eligible, hospitals must employ the CRNA and the CRNA must agree not to bill for services under Part B. We estimate approximately 90 rural hospitals would qualify under the increased maximum volume threshold. If one-half of these hospitals then met the other criteria, 45 additional hospitals would be eligible for these pass-through payments under this proposed change.

B. Removal of Requirement for CAHs To Use State Resident Assessment Instrument

In section VII. of the preamble of this proposed rule, we are proposing to eliminate the requirement that CAHs use the State resident assessment instrument (RAI) to conduct patient assessments. There are approximately 600 CAHs. The overwhelming majority of CAHs, 95 percent, provide SNF level care. The elimination of the requirement to use the State RAI would greatly reduce the burden on CAHs because facilities would no longer be required to complete an RAI document for each SNF patient (which would involve approximately 12,000 admissions based on the most recent claims data). Facilities would have the flexibility to document the assessment data in the medical record in a manner appropriate for their facility. The elimination of the requirement for use of the State RAI would reduce the amount of time required to perform patient assessments and allow more time for direct patient care.

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

A. General Considerations

Fiscal year 2001 was the last year of the 10-year transition period established to phase in the prospective payment system for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the Federal rate and their hospital-specific rate (see § 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a proportion of the Federal rate (see § 412.344). As we state in section VI.A. of the preamble of this proposed rule, the end of the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), capital prospective payment system payments for most hospitals are based solely on the Federal rate in FY 2003. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

In accordance with section § 412.312, the basic methodology for determining a capital prospective payment system payment is:

(Standard Federal Rate) × (DRG weight) × (Geographic Adjustment Factor(GAF)) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share (DSH) Adjustment Factor + Indirect Medical Education (IME) Adjustment Factor, if applicable).

In addition, hospitals may also receive outlier payments for those cases that qualify under the proposed threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the December 2001 update of the FY 2001 MedPAR file and the December 2001 update of the Provider Specific File that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the December 2001 update of the most recently available hospital cost report data (FY 1999) to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, 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. However, for individual hospitals, some miscategorizations are possible.

Using cases from the December 2001 update of the FY 2001 MedPAR file, we simulated payments under the capital prospective payment system for FY 2002 and FY 2003 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general hospital inpatient prospective payment systems (Indian Health Service Hospitals and hospitals in Maryland) are excluded from the simulations.

As we explain in section III.A.4. of the Addendum of this proposed rule, payments will no longer be made under the regular exceptions provision under §§ 412.348(b) through (e). Therefore, we are no longer using the actuarial capital cost model (described in Appendix B of August 1, 2001 final rule (66 FR 40099)). We modeled payments for each hospital by multiplying the Federal rate by the GAF and the hospital's case-mix. We then added estimated payments for indirect medical education, disproportionate share, large urban add-on, and outliers, if applicable. For purposes of this impact analysis, the model includes the following assumptions:

- We estimate that the Medicare case-mix index will increase by 0.99800 percent in FY 2002 and will increase by 1.01505 percent in FY 2003.
- We estimate that the Medicare discharges will be 13,398,000 in FY 2002 and 13,658,000 in FY 2003 for a 1.9 percent increase from FY 2002 to FY 2003.
- The Federal capital rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The proposed FY 2003 update is 1.1 percent (see section III.A.1.a. of the Addendum to this proposed rule).

• In addition to the proposed FY 2003 update factor, the proposed FY 2003 Federal rate was calculated based on a proposed GAF/DRG budget neutrality factor of 1.0224, a proposed outlier adjustment factor of 0.9460, a proposed exceptions adjustment factor of 0.9960, and a proposed special adjustment for FY 2003 of 1.0255 (see section III.A. of the Addendum of this proposed rule).

2. Results

In the past, in this impact section we presented the redistributive effects that were expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals and a cross-sectional summary of hospital groupings by the capital prospective payment system transition period payment methodology. We are no longer including this information since all hospitals (except new hospitals under § 412.324(b) and under proposed § 412.32(c)(2)) are paid 100 percent of the Federal rate in FY 2003.

We used the actuarial model described above to estimate the potential impact of our proposed changes for FY 2003 on total capital payments per case, using a universe of 4,300 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the December 2001 update of the MedPAR file, the December 2001 update to the Provider-Specific File, and the most recent cost report data. In Table III, we present a comparison of total payments per case for FY 2002 compared to FY 2003 based on proposed FY 2003 payment policies. Column 3 shows estimates of payments per case under our model for FY 2002. Column 4 shows estimates of payments per case under our model for FY 2003. Column 5 shows the total percentage change in payments from FY 2002 to FY 2003. The change represented in Column 5 includes the 1.1 percent increase in the Federal rate, a 1.01505 percent increase in case-mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB, as well as changes in special exception payments. The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 3.7 percent in FY 2003. 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 (3.5 percent and 5.1 percent, respectively). This difference is due to a projection that urban hospitals will experience a larger decrease in outlier payments from FY 2002 to FY 2003 compared to rural hospitals.

All regions are estimated to receive an increase in total capital payments per case, partly due to the elimination of the 2.1 percent reduction to the Federal rate for FY 2003 (see section VI.D. of the preamble of this proposed rule). Changes by region vary from a minimum increase of 2.1 percent (Middle Atlantic urban region) to a maximum increase of 5.7 percent (West North Central rural region). Hospitals located in Puerto Rico are expected to experience an increase in total capital payments per case of 4.3 percent.

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (4.4 percent). Similarly, payments to voluntary hospitals will increase 3.9 percent, while payments to proprietary hospitals will increase 2.0 percent.

Section 1886(d)(10) of the Act established the MGCRB. Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both. Although the 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 2003 compared to the effects of reclassification for FY 2002, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 2003 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 2003 as a whole are projected to experience a 4.2 percent increase in payments. Payments to nonreclassified hospitals will increase slightly less (3.6 percent) than reclassified hospitals, overall. Hospitals reclassified during both FY 2002 and FY 2003 are projected to receive an increase in payments of 3.9 percent. Hospitals reclassified during FY 2003 only are projected to receive an increase in payments of 9.0 percent. This increase is primarily due to changes in the GAF (wage index).

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2002 Payments Compared To FY 2003 Payments]

	Number of hospitals	Average FY 2002 payments/ case	Average FY 2003 payments/ case	Change
By Geographic Location:				
All hospitals	4,300	667	692	3.7
Large urban areas (populations over 1 million)	1,511	773	798	3.1
Other urban areas (populations of 1 million of fewer)	1,102	652	678	4.0
Rural areas	1,687	448	471	5.1
Urban hospitals	2,613	721	746	3.5
0–99 beds	647	511	533	4.3
100–199 beds	904	611	634	3.7
200–299 beds	528	692	717	3.6
300–499 beds	387	762	790	3.7
500 or more beds	147	935	961	2.8
Rural hospitals	1,687	448	471	5.1
0–49 beds	818	370	393	6.0

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 2002 Payments Compared To FY 2003 Payments]

	Number of hospitals	Average FY 2002 payments/ case	Average FY 2003 payments/ case	Change
50–99 beds	507	412	435	5.6
100–149 beds	216	454	477	5.1
150–199 beds	78	493	517	4.9
200 or more beds	68	566	589	4.1
By Region:				
Urban by Region	2,613	721	746	3.5
New England	134	771	804	4.3
Middle Atlantic	402	817	834	2.1
South Atlantic	380	690	716	3.7
East North Central	431	687	718	4.5
East South Central	158	649	675	4.0
West North Central	180	703	735	4.6
West South Central	334	666	685	2.9
Mountain	132	695	724	4.2
Pacific	416	841	866	2.9
Puerto Rico	46	305	319	4.3
Rural by Region	1,687	448	471	5.1
New England	40	549	575	4.6
Middle Atlantic	68	472	497	5.4
South Atlantic	239	467	489	4.8
East North Central	225	456	481	5.5
East South Central	243	414	435	5.0
West North Central	311	440	465	5.7
West South Central	294	403	423	5.0
Mountain	150	460	483	5.0
Pacific	112	528	557	5.5
By Payment Classification:				
All hospitals	4,300	667	692	3.7
Large urban areas (populations over 1 million)	1,570	767	791	3.2
Other urban areas (populations of 1 million of fewer)	1,075	654	680	4.0
Rural areas	1,655	447	469	5.1
Teaching Status:				
Non-teaching	3,194	545	568	4.2
Fewer than 100 Residents	872	699	726	3.8
100 or more Residents	234	1,041	1,069	2.7
Urban DSH:				
100 or more beds	1,354	759	784	3.3
Less than 100 beds	295	492	512	4.2
Rural DSH:				
Sole Community (SCH/EACH)	469	392	414	5.6
Referral Center (RRC/EACH)	156	518	540	4.3
Other Rural:				
100 or more beds	78	418	439	5.0
Less than 100 beds	383	378	400	5.8
Urban teaching and DSH:				
Both teaching and DSH	758	838	864	3.1
Teaching and no DSH	278	746	776	4.0
No teaching and DSH	891	600	623	3.8
No teaching and no DSH	718	600	623	3.8
Rural Hospital Types:				
Non special status hospitals	666	398	420	5.5
RRC/EACH	159	526	548	4.2
SCH/EACH	539	415	438	5.5
Medicare-dependent hospitals (MDH)	216	368	391	6.3
SCH, RRC and EACH	75	503	530	5.3
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
Reclassification Status During FY2002 and FY2003:				
Reclassified During Both FY2002 and FY2003	567	588	611	3.9
Reclassified During FY2003 Only	53	516	563	9.0
Reclassified During FY2002 Only	77	623	651	4.4
FY2003 Reclassifications:				
All Reclassified Hospitals	620	583	607	4.2
All Nonreclassified Hospitals	3,645	683	708	3.6
All Urban Reclassified Hospitals	108	799	826	3.4
Urban Nonreclassified Hospitals	2,471	718	743	3.5
All Reclassified Rural Hospitals	512	500	524	4.7
Rural Nonreclassified Hospitals	1,174	389	411	5.7
Other Reclassified Hospitals (Section 1886(D)(8)(B))	35	454	484	6.4

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 2002 Payments Compared To FY 2003 Payments]

	Number of hospitals	Average FY 2002 payments/ case	Average FY 2003 payments/ case	Change
Type of Ownership:				
Voluntary	2,473	680	707	3.9
Proprietary	705	658	671	2.0
Government	909	600	627	4.4
Medicare Utilization as a Percent of Inpatient Days:				
0–25	318	859	885	3.0
25–50	1,650	767	792	3.3
50–65	1,706	582	606	4.2
Over 65	517	525	547	4.3

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Appendix B—Report to Congress

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

MAR 2 2 2002

The Honorable Richard B. Cheney
President of the Senate
Washington, DC 20510

Dear Mr. President:

I am pleased to submit to Congress this letter containing my recommendation for the applicable percentage increase in Medicare's hospital inpatient prospective payment system (IPPS) rates for Federal fiscal year (FY) 2003. Also included are my recommendations for updates to the payment limits for hospitals and hospital units excluded from IPPS, and for adjustments to the diagnosis-related group (DRG) weighting factors.

Section 1886(e)(3) of the Social Security Act (the Act) directs the Secretary of the Department of Health and Human Services to report to the Congress his initial estimate of his recommendation (required by section 1886(e)(4) of the Act) of an appropriate payment update for inpatient hospital services for the upcoming FY. Consistent with current law, the President's FY 2003 budget includes an update to the standardized amounts (the base dollar amounts for IPPS payments) equal to the market basket (an index of inflation in goods and services used by hospitals) minus 0.55 percentage points. The President's FY 2003 budget estimated the IPPS market basket rate of increase for FY 2003 to be 2.8 percent. Based on this estimate, I am recommending an update to the standardized amounts for hospitals in both large urban and other areas of 2.25 percent. Payments to hospitals under IPPS are projected to increase by $2.1 billion, from $86.0 billion in FY 2002 to $88.1 billion in FY 2003.

Although payments for most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid the higher of a hospital-specific rate based on their costs in a base year (the higher of either 1982, 1987, or 1996) or the IPPS rate based on the standardized amount. Consistent with current law and the President's FY 2003 budget, I am recommending an update equal to 2.25 percent to the hospital-specific rate for both sole community hospitals and Medicare-dependent, small rural hospitals.

I am also submitting, consistent with Section 1886(e)(3) of the Act, my recommendation for updating payments for hospitals and distinct-part hospital units that are excluded from IPPS.

The excluded hospital types are: psychiatric hospitals; rehabilitation hospitals; children's hospitals; long-term care hospitals; and cancer hospitals. The types of excluded distinct-part hospital units are psychiatric and rehabilitation. Hospitals and units excluded from the IPPS have in the past been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

Page 2 — The Honorable Richard B. Cheney

Psychiatric hospitals and units, and children's and cancer hospitals continue to be paid based on their reasonable costs subject to TEFRA limits. For these hospitals, the President's FY 2003 budget incorporates an increase to the TEFRA limit using 2.8 percent for the excluded hospital market basket increase.

Inpatient rehabilitation facilities (IRF) are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning on or after October 1, 2002, the IRF prospective payment is based on 100 percent of the adjusted Federal IRF PPS amount, updated annually.

Effective for cost reporting periods beginning on or after October 1, 2002, we are proposing that long-term care hospitals will be paid under a PPS based on a 5-year transition period (hospitals may elect to receive full PPS rather than transition payments.) For purposes of the update factor, the portion of the proposed PPS transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the long term care hospital's TEFRA limit by 2.8 percent.

My recommendation for the updates is based on cost projections used in the President's FY 2003 budget. A final recommendation on the appropriate percentage increases for FY 2003 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projection available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including recommendations by the Medicare Payment Advisory Commission (MedPAC).

Section 1886(d)(4)(C)(iv) of the Act also requires that I include in my report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time I do not anticipate recommending any across-the-board adjustment to the DRG weighting factors for FY 2003.

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

Sincerely,

Tommy G. Thompson

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

MAR 2 2 2002

The Honorable J. Dennis Hastert
Speaker of the House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

I am pleased to submit to Congress this letter containing my recommendation for the applicable percentage increase in Medicare's hospital inpatient prospective payment system (IPPS) rates for Federal fiscal year (FY) 2003. Also included are my recommendations for updates to the payment limits for hospitals and hospital units excluded from IPPS, and for adjustments to the diagnosis-related group (DRG) weighting factors.

Section 1886(e)(3) of the Social Security Act (the Act) directs the Secretary of the Department of Health and Human Services to report to the Congress his initial estimate of his recommendation (required by section 1886(e)(4) of the Act) of an appropriate payment update for inpatient hospital services for the upcoming FY. Consistent with current law, the President's FY 2003 budget includes an update to the standardized amounts (the base dollar amounts for IPPS payments) equal to the market basket (an index of inflation in goods and services used by hospitals) minus 0.55 percentage points. The President's FY 2003 budget estimated the IPPS market basket rate of increase for FY 2003 to be 2.8 percent. Based on this estimate, I am recommending an update to the standardized amounts for hospitals in both large urban and other areas of 2.25 percent. Payments to hospitals under IPPS are projected to increase by $2.1 billion, from $86.0 billion in FY 2002 to $88.1 billion in FY 2003.

Although payments for most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid the higher of a hospital-specific rate based on their costs in a base year (the higher of either 1982, 1987, or 1996) or the IPPS rate based on the standardized amount. Consistent with current law and the President's FY 2003 budget, I am recommending an update equal to 2.25 percent to the hospital-specific rate for both sole community hospitals and Medicare-dependent, small rural hospitals.

I am also submitting, consistent with Section 1886(e)(3) of the Act, my recommendation for updating payments for hospitals and distinct-part hospital units that are excluded from IPPS.

The excluded hospital types are: psychiatric hospitals; rehabilitation hospitals; children's hospitals; long-term care hospitals; and cancer hospitals. The types of excluded distinct-part hospital units are psychiatric and rehabilitation. Hospitals and units excluded from the IPPS have in the past been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

Page 2 — The Honorable J. Dennis Hastert

Psychiatric hospitals and units, and children's' and cancer hospitals continue to be paid based on their reasonable costs subject to TEFRA limits. For these hospitals, the President's FY 2003 budget incorporates an increase to the TEFRA limit using 2.8 percent for the excluded hospital market basket increase.

Inpatient rehabilitation facilities (IRF) are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning on or after October 1, 2002, the IRF prospective payment is based on 100 percent of the adjusted Federal IRF PPS amount, updated annually.

Effective for cost reporting periods beginning on or after October 1, 2002, we are proposing that long-term care hospitals will be paid under a PPS based on a 5-year transition period (hospitals may elect to receive full PPS rather than transition payments.) For purposes of the update factor, the portion of the proposed PPS transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the long term care hospital's TEFRA limit by 2.8 percent.

My recommendation for the updates is based on cost projections used in the President's FY 2003 budget. A final recommendation on the appropriate percentage increases for FY 2003 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projection available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including recommendations by the Medicare Payment Advisory Commission (MedPAC).

Section 1886(d)(4)(C)(iv) of the Act also requires that I include in my report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time I do not anticipate recommending any across-the-board adjustment to the DRG weighting factors for FY 2003.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the President of the Senate.

Sincerely,

Tommy G. Thompson

ATTACHMENT

Discussion of Two Market Basket Estimates

Section 1886(b)(3)(B)(iii) of the Act defines the "market basket percentage increase" as "the percentage, estimated by the Secretary" by which the cost of goods and services comprising inpatient hospital services "will exceed the cost of such goods and services for the preceding period. The estimate is based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services."

With the implementation of the Inpatient Prospective Payment System in Fiscal Year 1984, the Office of the Actuary (OACT) developed the market basket methodology and determined the official input price index from which the update percentage is calculated. OACT also forecasts the percentage increases for all of the Medicare payment categories that are updated by health-specific market baskets and other price indexes, including skilled nursing facility PPS, home health care PPS, and noninpatient hospital PPSs (capital, outpatient, rehabilitation facility, and hospice). To help ensure consistency among the many economic and price factors comprising the market baskets and other indexes, OACT contracts with a well-known and widely-respected independent forecasting firm, Global Insights/*DRI-WEFA*, to assist in making their forecasts.

In addition, each year for the President's Budget, the Office of Management and Budget forecasts the market basket by applying future assumptions of economy-wide wage and Consumer Price Index growth to the historical relationship between these factors and the market basket. This forecast does not attempt to capture the interrelationships among market basket factors that should be reflected in the actual update. OACT is in a stronger position to forecast the percentage increase in the market basket to be used in the actual update because they possess the detailed knowledge of the factors that affect the market basket, having developed these indexes for nearly two decades.

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

I. Background

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 inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish the update factors recommended under section 1886(e)(4) of the Act. Accordingly, this Appendix provides the recommendations of appropriate update factors and the analysis underlying our recommendations. We also respond to MedPAC's recommendations concerning the update factors.

Section 1886(b)(3)(B)(i)(XVIII) of the Act, as amended by Section 301 Public Law 106–554, sets the FY 2003 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 0.55 percent for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 2003 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 acute care hospital inpatient 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 2003 percentage increase in the rate-of-increase limits for hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system is the market basket percentage increase.

In accordance with section 1886(d)(3)(A) of the Act, we are proposing to update the standardized amounts, the hospital-specific rates, and the rate-of-increase limits for hospitals and hospital units excluded from the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the proposed revised and rebased first quarter 2002 forecast of the FY 2003 market basket increase of 3.3 percent for hospitals subject to the acute care hospital inpatient prospective payment system, the proposed update to the standardized amounts is 2.75 percent (that is, the market basket rate of increase minus 0.55 percent percentage points) for hospitals in both large urban and other areas. The proposed update to the hospital-specific rate applicable to SCHs and MDHs is also 2.75 percent.

Consistent with section 1886(e)(3) of the Act, we are proposing a recommendation for updating payments for hospitals and distinct-part hospital units that are excluded from the hospital inpatient prospective payment system. Facilities excluded from the hospital inpatient prospective payment system include psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, cancer hospitals, and children's hospitals.

In the past, hospitals and hospital units excluded from the hospital inpatient prospective payment system have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid based on their reasonable costs are subject to TEFRA limits for FY 2003. For these hospitals, the proposed update is the percentage increase in the excluded hospital market basket (currently estimated at 3.4 percent).

Inpatient rehabilitation facilities (IRFs) are paid under the IRF prospective payment system for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2003, the Federal prospective payment for IRFs is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually (see the August 7, 2001 final rule (66 FR 41316)).

Effective for cost reporting periods beginning during FY 2003, we are proposing that long-term care hospitals would be paid under a prospective payment system under which long-term care hospitals receive payment based on a 5-year transition period (see the March 22, 2002 proposed rule (67 FR 13416)). We are also proposing that long-term care hospitals may elect to be paid on 100 percent of the Federal prospective rate at the beginning of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor, the portion of the proposed prospective payment system transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the long-term care hospital's TEFRA limit by the current estimate of the excluded hospital market basket (or 3.4 percent).

In its March 1, 2002 Report to the Congress, MedPAC recommended that the base payment rates for Medicare covered services under the hospital inpatient prospective payment system be increased by the market basket percentage increase minus 0.55 percent for hospitals located in large urban areas, and by the full market basket percentage increase for hospitals located in all other areas (page 66). MedPAC did not make a separate recommendation for the hospital-specific rate applicable to SCHs and MDHs. MedPAC also presented a new approach for updating the hospital inpatient prospective system payment rates, which assesses the adequacy of current payments and accounts for the increase in efficient providers' costs in the upcoming year. While this approach is not fundamentally different from what MedPAC has done in the past, it no longer produces a detailed update framework for direct comparison with the Secretary's framework. We discuss MedPAC's recommendations concerning the update factors and our responses to these recommendations in section III. of this Appendix C. Below we describe the basis of our FY 2003 update recommendation (as shown in Table 1).

II. Secretary's Recommendations

Under section 1886(e)(4) of the Act, we are recommending that an appropriate update factor for the standardized amounts is the market basket percentage increase minus 0.55 percentage points for hospitals located in large urban and other areas. We are also recommending an update factor of the market basket percentage increase minus 0.55 percentage points for the hospital-specific rate for SCHs and MDHs. We believe these recommended update factors for FY 2003 would ensure that Medicare acts as a prudent purchaser and provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund.

Rehabilitation hospitals and units are now paid under the IRF prospective payment system. For cost reporting periods beginning on or after October 1, 2002, the IRF prospective payment is based on 100 percent of the adjusted Federal IRF prospective payment system amount updated annually.

Effective for cost reporting periods beginning during FY 2003, we have proposed that long-term care hospitals be paid under a prospective payment system (67 FR 13416). For purposes of the update factor, the portion of the proposed prospective payment system transition blend payment based on reasonable costs for inpatient operating services for FY 2003 would be determined by updating the TEFRA target amount for long-term care hospitals by the most recent available estimate of the increase in the excluded hospital operating market basket (or 3.4 percent).

We recommend that the remaining excluded hospitals and units (which are excluded from the acute care hospital inpatient prospective payment system and will continue to be paid on a reasonable cost basis in FY 2003) receive an update of 3.4 percent. The update for excluded hospitals and hospital units is equal to the most recent available estimate of the increase in the excluded hospital operating market basket. Based on the proposed revised and rebased first quarter 2002 forecast for FY 2003, the proposed market basket rate of increase for excluded hospitals and hospital units is 3.4 percent.

As required by section 1886(e)(4) of the Act, we have taken into consideration the recommendations of MedPAC in setting these recommended update factors. Our responses to the MedPAC recommendations concerning the update factors are discussed below. Consistent with current law, we are proposing an update recommendation of the market basket percentage increase minus 0.55 percentage points for the hospital inpatient prospective payment system operating cost standardized amounts for FY 2003. This proposed update recommendation is supported by the following analyses that measure changes in hospital productivity, scientific and technological advances, practice pattern changes, changes in case-mix, the effect of reclassification on recalibration, and forecast error correction.

A. Productivity

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

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

1989 or 1.2 percent annually. At the same time, ProPAC estimated total output growth at 3.4 percent annually, implying a ratio of service productivity growth to output growth of 0.35.

Absent a productivity measure specific to Medicare patients, we examined productivity (output per hour) and output (gross domestic product) for the economy. Depending on the exact time period, annual changes in productivity range from 0.3 to 0.35 percent of the change in output (that is, a 1.0 percent increase in output would be correlated with a 0.3 to 0.35 percent change in output per hour).

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

The expected change in total hospital service output is the product of projected growth in total admissions (adjusted for outpatient usage), projected real case-mix growth, expected quality-enhancing intensity growth, and net of expected decline in intensity due to reduction of cost-ineffective practice. Case-mix growth and intensity numbers for Medicare are used as proxies for those of the total hospital, since case-mix increases (used in the intensity measure as well) are unavailable for non-Medicare patients. Thus, expected FY 2003 hospital output growth is simply the sum of the expected change in intensity (1.0 percent), projected admissions change (1.9 percent), and projected real case-mix growth (1.0 percent), or 3.9 percent. The share of direct labor services in the market basket (consisting of wages, salaries, and employee benefits) is 61.7 percent (based on the proposed revised and rebased hospital market basket discussed in section IV. of the preamble of this proposed rule).

Multiplying the expected change in total hospital service output (3.9 percent) by the ratio of historical service productivity change to total service growth of 0.30 to 0.35 and by the direct labor share percentage 61.6, provides our productivity standard of 0.9 to 0.7 percent. Because productivity gains hold down the rate of increase in hospitals' costs, this factor is applied as a negative offset to the market basket increase.

B. Intensity

We base our intensity standard on the combined effect of three separate factors: changes in the use of quality enhancing services, changes in the use of services due to shifts in within-DRG severity, and changes in the use of services due to reductions of cost-ineffective practices. For FY 2003, we recommend an adjustment of 1.0 percent. The basis of this recommendation is discussed below.

Following methods developed by CMS' Office of the Actuary for deriving hospital output estimates from total hospital charges, we have developed Medicare-specific intensity measures based on a 5-year average using FYs 1997 through 2001 MedPAR billing data. Case-mix constant intensity is calculated as the change in total Medicare charges per discharge adjusted for changes in the average charge per unit of service as measured by the Consumer Price Index (CPI) for hospital and related services and changes in real case-mix. [1] The 5-year average percentage change in charge per discharge was 6.3 percent, the 5-year average annual change in the CPI for hospital and related services was 4.5 percent, and the 5-year average annual change in case-mix was −0.3 percent. Dividing the change in charge per discharge by the product of the real case-mix index change and the CPI for hospital and related services yields a 5-year average annual change in intensity of 2.0 percent. To account for the proportions of the overall annual intensity increases due to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume that one-half of the annual increase is due to each of these factors. Our recommended adjustment excludes the estimated amount of the overall intensity increase due to ineffective practice patterns. Thus, we are recommending an intensity adjustment for FY 2003 of 1.0 percent.

C. Change in Case-Mix

Our analysis takes into account projected changes in case-mix, adjusted for changes attributable to improved coding practices. For our FY 2003 update recommendation, we are projecting a 1.0 percent increase in the case-mix index. We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs, but do not reflect greater resource requirements. We do not believe changes in coding behavior will impact the overall case-mix in FY 2003. As such, for FY 2003, we estimate that real case-mix is equal to projected change in case-mix. Thus, we are recommending a 0.0 percent adjustment for case-mix.

D. Effect of FY 2001 DRG Reclassification and Recalibration

We estimate that DRG reclassification and recalibration for FY 2001 resulted in a 0.3 percent change in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPER. Therefore, we are recommending a −0.3 percent adjustment for the effect of FY 2001 DRG reclassification and recalibration.

E. Forecast Error Correction

We make a forecast error correction if the actual market basket changes differ from the forecasted market basket by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of forecast error. The estimated market basket percentage increase used to update the FY 2001 payment rates was 3.4 percent. Our most recent data indicates the actual FY 2001 increase was 4.1 percent. The resulting forecast error in the FY 2001 market basket rate of increase is 0.7 percentage points. This forecast error is a result of prices for wages, benefits, and utilities increasing more rapidly than expected. The effects of a labor shortage within the health services industry caused hospitals to increase wages greater than initially projected. Increases in actual benefits were faster than projected due to a greater than expected increase in health insurance premiums. Finally, market conditions for natural gas and electricity caused

[1] In the past, we have considered the upper bound of real case mix to be from 1.0 to 1.4 percent annually, with any increase beyond this bound assumed to be due to changes in coding practices. Because none of the annual changes in observed case mix change during the 5-year period from FY 1997 through FY 2001 exceeded 1.0 percent, it is all assumed to be real case mix change.

prices for those products to increase more rapidly than expected.

The following is a summary of the update range supported by our analyses:

HHS'S FY 2003 UPDATE RECOMMENDATION

Market basket	MB
Policy Adjustment Factors:	
Productivity	−0.9 to −0.7
Intensity	1.0
Subtotal	0.1 to 0.3
Case-Mix Adjustment Factors:	
Projected Case-Mix Change	1.0
Real Across DRG Change	−1.0
Subtotal	0.0
Effect of FY 2001 DRG Reclassification and Recalibration	−0.3
Forecast Error Correction	0.7
Total Recommendation Update	MB + 0.5 to MB + 0.7

While the above analysis would suggest an update between market basket plus 0.5 percentage points and the market basket plus 0.7 percentage points, the Secretary is recommending, consistent with current law, an update of the market basket percentage increase minus 0.55 percentage points (or 2.75 percent) for hospitals in all areas.

We believe that a 2.75 percent update factor for FY 2003 will appropriately reflect current trends in health care delivery, including the recent decreases in the use of hospital inpatient services and the corresponding increase in the use of hospital outpatient and postacute care services. Also, consistent with current law, we are recommending that the hospital-specific rates applicable to SCHs and MDHs be increased by the same update, 2.75 percentage points.

Since the inception of the acute care hospital inpatient prospective payment system, hospitals have received a full market basket update only once, in FY 2001. The stabilization of overall hospital margins in recent years suggests that the restrictions on market basket increases have not resulted in inadequate hospital payments. Modest limits below full market basket updates could be linked to continued careful review of Medicare hospital margin data to ensure that margins do not worsen among certain hospital types with negative and declining Medicare margins.

III. MedPAC Recommendations for Assessing Payment Adequacy and Updating Payments in Traditional Medicare

In its FY 2002 Report to Congress, MedPAC developed a new approach for updating fee-for-service payments that breaks the process into two basic parts: assessing the adequacy of current payments; and accounting for the increase in efficient providers' costs in the coming year. MedPAC points out this new approach ''is not fundamentally different from what the Commission has done in the past, but we expect formalizing the two parts of our process will lead to greater emphasis on the broad question of whether the amount of money in the system currently is right and less emphasis on the role of specific cost-influencing factors'' (page 39).

In assessing payment adequacy, MedPAC reviews the relationship between costs and payments (conventionally expressed as a margin). On the payment side, MedPAC applied the annual payment updates specified in law through FY 2002 and then modeled the effects of other policy changes that have affected the level of payments. On the cost side, MedPAC estimated the increases in costs per unit of output over the same period using the change in cost per adjusted admission in the American Hospital Association's annual survey of hospitals for FY 2000, and the CMS projected increase in the FYs 2001 and 2002 market baskets (page 58). MedPAC estimated that the inpatient Medicare margin would be 10.8 percent in FY 2002 (with FY 2003 payment rules). This amount is down slightly from MedPAC's estimate of 11.9 percent in FY 1999. In addition to the inpatient Medicare margin, MedPAC measured the overall Medicare margin, incorporating almost all Medicare-related payments and costs to hospitals. This overall Medicare margin was estimated to be 3.8 percent. The report notes that ''the Commission does not plan to specify a 'standard margin,' although we will take the need for a small positive margin into account as we assess the adequacy of various fee-for-service payments'' (page 43).

In addition to considering the relationship between estimated payments and costs, MedPAC also considered the following three factors to assess whether current payments are adequate (page 43):

- Changes in access to or quality of care;
- Changes in the volume of services or number of providers; and
- Changes in providers access to capital.

MedPAC found no evidence that the hospital cost base is inappropriate and concluded that Medicare payment is adequate and no payment adequacy adjustment is needed for FY 2003.

MedPAC recommends gradually eliminating the differential in the standardized amounts for hospitals in large urban and other areas. MedPAC's data on margins and its analysis of costs suggest that a different standardized amount (the large urban standardized amount is 1.6 percent higher than the amount for other areas) is unwarranted. MedPAC estimates the FY 2002 Medicare inpatient margins will range from 5 percent for rural hospitals to 14 percent for hospitals in large urban areas. Because much of this difference is due to the greater proportion of IME and DSH payments going to hospitals in large urban areas, MedPAC removed DSH payments and the portion of the IME payment above the measured cost relationship between IME and hospitals' costs, and found that hospitals in large urban areas still have Medicare margins that are about 4 percentage points higher than other urban and rural hospitals (page 64).

MedPAC believes that ''(e)liminating the differential would improve payment equity across geographic areas and also help to simplify the payment system'' (page 63). For example, eliminating the standardized amount differential would also eliminate the need for hospitals to reclassify for a higher standardized amount through the MGCRB. Therefore, MedPAC recommends holding the update for hospitals in large urban areas to the legislated level of the market

basket percentage increase minus 0.55 percent for FY 2003, while updating the other areas standardized amount by the full market basket percentage increase.

MedPAC accounts for providers' cost changes in the coming payment year primarily through a forecast of input price inflation, which estimates how much providers' costs would rise in the coming year if the quality and mix of inputs they use to furnish care and the types of patients they treat remain constant. MedPAC relies on CMS' market basket estimate to forecast input price inflation, but considers other factors that may affect providers' costs. These other factors are scientific and technological advances, changes in DRG case-mix complexity, site-of-service substitution, and other one-time factors.

In the past, MedPAC recommended specific adjustments to its update recommendation for each of these factors. In its March 2002 Report to Congress, MedPAC did not provide specific estimates for these factors, but stated ''(a)fter considering all factors that might potentially affect the rate of growth in efficient providers' costs, we conclude that the appropriate adjustment for cost growth in fiscal year 2003 is the forecasted increase in the market basket, or 2.9 percent'' (page 66). This market basket forecast was based on the December 2001 market basket estimated by CMS' Office of the Actuary, and does not reflect the proposed revisions and rebasing discussed in section IV. of the preamble of this proposed rule.

MedPAC's second recommendation related to updating payments under the hospital inpatient prospective payment system is that the Congress should increase the base rate for inpatient services covered by Medicare's prospective payment system in FY 2003 by the market basket percentage increase minus 0.55 percent for hospitals in large urban areas and by the market basket percentage increase for hospitals in all other areas. MedPAC focused on the operating update only because it applies to 92 percent of hospitals' Medicare costs. The report noted that, in its March 2000 report to Congress, MedPAC recommended combining the operating and capital payment systems into a single prospective payment system.

Response: As described above, we continue to use our detailed update framework to develop our recommended update for FY 2003. However, we believe MedPAC's new approach will be useful to focusing the policy discussion more directly on the overall adequacy of hospital payments. We look forward to continuing to work with MedPAC to refine and utilize both methodologies in an effort to produce analyses that provide the most helpful information for setting the annual updates.

We agree with MedPAC's recommendation that the current law update for FY 2003 of the market basket percentage increase minus 0.55 percentage points is appropriate for the operating system update. However, we are not recommending differential updates to gradually eliminate the higher standardized amount for hospitals in large urban areas, as recommended by MedPAC. We believe the stabilization of overall hospital margins in recent years suggests that modest limits below full market basket updates provide adequate payments. We agree, however, that certain hospital types that show clear evidence of negative and declining Medicare margins should be monitored closely.

Because the operating and capital prospective payment systems remain separate, CMS continues to use separate updates for operating and capital payments. The proposed update to the capital payment rate is discussed in section III. of the Addendum of this proposed rule.

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