

*B. Impact of the Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 2)*

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

We compared aggregate payments using the FY 2002 DRG relative weights (GROUPEL version 19.0) to aggregate payments using the FY 2003 DRG relative weights (GROUPEL version 20.0). 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 0.993209 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 making will result in 0.4 percent higher payments to hospitals overall. This effect is largely attributable to the anticipated higher payments after April 1, 2003 for drug-eluting stents, as described in section II.B. of this final rule. Specifically, we created two new DRGs (526 and 527) to be effective April 1, 2003. The relative weights for these new DRGs are 14 and 16 percent higher, respectively, than the weights for current DRGs 516 and 517, the current DRGs for stents. Hospitals that are currently doing these procedures benefit demonstrate positive impacts from this change in this impact analysis.

Another change is to DRGs 14 (retitled, Intracranial Hemorrhage and Stroke with Infarction) and 15 (retitled, Nonspecific Cerebrovascular Accident and Precerebral Occlusion without Infarction), and new DRG 524 (Transient Ischemia). With the new configuration of these DRGs, over 100,000 cases that previously would have been assigned to DRG 14 (with a FY 2003 relative weight of 1.2943) will now be assigned to DRG 15 (with a FY 2003 relative weight of 0.9858).

Urban hospitals with 300 or more beds, and rural hospitals with 200 or more beds benefit from these changes. Rural hospitals with fewer than 50 beds would experience a 0.3 percent decrease due to these changes, and rural hospitals with between 50 and 99 beds would experience a 0.1 percent decrease. Among rural hospitals categorized by region, the East South Central and West South Central would experience a 0.1 percent decrease in payments. Among special rural hospital categories, SCHs would experience a 0.1 percent decrease and MDHs would experience a 0.2 percent decrease.

*C. 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 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 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 5.4 percent decrease). Rural hospitals in the East South Central region experience the next largest impact, a

0.7 percent increase. Among urban hospitals, Puerto Rico and the Middle Atlantic regions would experience a 0.8 and 0.4 percent decreases, respectively. The Mountain region would experience a 0.5 percent increase.

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 have been the fourth year of the phaseout. This would have meant 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 removing 100 percent of GME and CRNA costs from the FY 2003 wage index. To demonstrate the impacts of this provision, 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 0.2 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 no change in payments.

We note that the wage data used for the final wage index are based upon the data available as of July 2002 and, therefore, do not reflect revision requests received and processed by the fiscal intermediaries after that date.

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 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 (343) experience less than a 5-percent change. A total of 11 labor market areas experience an increase of more than 5 percent and less than 10 percent. Three areas experience an increase greater than 10 percent. A total of 15 areas experience decreases of more than 5 percent and less than 10 percent. Finally, 1 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	3
Increase more than 5 percent and less than 10 percent .....	26	11
Increase or decrease less than 5 percent .....	335	343
Decrease more than 5 percent and less than 10 percent .....	10	15
Decrease more than 10 percent .....	1	1

Among urban hospitals, 42 would experience an increase of between 5 and 10 percent and 9 more than 10 percent. A total of 22 rural hospitals have increases greater than 5 percent, but none have greater than

10-percent increases. On the negative side, 55 urban hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. Two urban hospitals have decreases in their wage index values greater

than 10 percent. There are 17 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 .....	9	0
Increase more than 5 percent and less than 10 percent .....	42	22
Increase or decrease less than 5 percent .....	2553	1975
Decrease more than 5 percent and less than 10 percent .....	55	17
Decrease more than 10 percent .....	2	0

*D. 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 final rule, we compared simulated aggregate payments using the FY 2002 DRG relative weights and wage index to simulated aggregate payments using the FY 2003 DRG relative weights and blended wage index. In addition, we are required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. As discussed in section II.D. of this final rule, we are approving one new technology for add-on payments in FY 2003. We estimate the total add-on payments for this new technology will be \$74.8 million.

We computed a wage and recalibration budget neutrality factor of 0.993209. 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.

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.

The changes in this column are the sum of the changes in columns 2, 3, 4, and 5, combined with the budget neutrality factor and the wage index floor for urban areas. There also may be some variation of plus or minus 0.1 percentage point due to rounding.

*E. 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 final 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.

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 0.990672 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this final rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.4 percent in column 7. Payments to urban hospitals decline 0.4 percent. Hospitals in other urban areas see a decrease in payments of 0.4 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 1.1 and 1.6 percent for Mountain and West North Central regions, respectively. The largest increases are in rural South Atlantic and West South Central regions. These regions receive increases of 2.9 and 3.2 percent, respectively.

Among all the hospitals that were reclassified for FY 2003 (including hospitals that received wage index reclassifications in FY 2001 or FY 2002 that extend for 3-years), the MGCRB changes are estimated to provide a 4.5 percent increase in payments. Urban hospitals reclassified for FY 2003 are expected to receive an increase of 4.5 percent, while rural reclassified hospitals are expected to benefit from the MGCRB changes with a 4.5 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 4.7 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 0.6 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 1.3 percent.

*F. 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. 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 2.95 percent update to the standardized amounts and the hospital-specific rates for MDHs and SCHs. It also reflects the 2.1 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 (7.2 percent), as described in the introduction to this Appendix and the Addendum to this final 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. Hospitals in urban areas experience a 0.1 percent increase in payments per case compared to FY 2002. Hospitals in rural areas, meanwhile, experience a 2.1 percent payment increase. Hospitals in large urban areas experience a 0.2 percent decline in payments, largely due to the 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 1.4 percent.

Among urban census divisions, the largest payment increase was 1.7 percent in the Mountain region. Hospitals in urban Middle Atlantic would experience an overall decrease of 1.4 percent and hospitals in the New England region would experience a decrease of 0.3 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 only hospital category experiencing overall payment decreases is Puerto Rico, where payments decrease by 2.7 percent, largely due to the updated wage data. In the East North Central region, payments appear to increase by 2.6 percent. Mountain and West North Central regions also benefited, both with 2.5 percent increases.

Among special categories of rural hospitals, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) experience payment increases of 2.7 percent, 2.5 percent, and 3.1 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 as do hospitals paid based on the national standardized amounts.

Hospitals that were reclassified for FY 2003 are estimated to receive a 1.2 percent increase in payments. Urban hospitals reclassified for FY 2003 are anticipated to receive an increase of 0.1 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 1.9 percent increase in payments. Overall, among hospitals reclassified for purposes of the standardized amount, a payment increase of 1.0 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 2.7 percent.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2003 OPERATING PROSPECTIVE PAYMENT SYSTEM  
[Payments per case]

	Num. of hosps.	Average FY 2002 payment per case <sup>1</sup>	Average FY 2003 payment per case <sup>1</sup>	All FY 2003 changes
	(1)	(2)	(3)	(4)
By Geographic Location:				
All hospitals .....	4,230	7,218	7247.2	0.4
Urban hospitals .....	2,620	7,718	7727.8	0.1
Large urban areas (populations over 1 million) .....	1,519	8,269	8249.2	-0.2
Other urban areas (populations of 1 million of fewer) .....	1,101	7,002	7050.4	0.7
Rural hospitals .....	1,610	5,168	5275.0	2.1
Bed Size (Urban):				
0-99 beds .....	645	5,309	5376.3	1.3
100-199 beds .....	909	6,424	6474.8	0.8
200-299 beds .....	523	7,394	7422.6	0.4
300-499 beds .....	398	8,345	8332.6	-0.1
500 or more beds .....	145	10,007	9943.6	-0.6
Bed Size (Rural):				
0-49 beds .....	747	4,260	4362.7	2.4
50-99 beds .....	501	4,776	4887.0	2.3
100-149 beds .....	215	5,106	5211.2	2.1
150-199 beds .....	78	5,515	5617.2	1.8
200 or more beds .....	69	6,750	6860.1	1.6
Urban by Region:				
New England .....	135	8,224	8203.0	-0.3
Middle Atlantic .....	404	8,789	8667.9	-1.4
South Atlantic .....	384	7,311	7360.5	0.7
East North Central .....	429	7,293	7311.6	0.2
East South Central .....	159	6,956	7000.5	0.6
West North Central .....	178	7,358	7404.2	0.6
West South Central .....	335	7,103	7172.5	1.0
Mountain .....	132	7,417	7546.6	1.7
Pacific .....	417	9,386	9385.9	0.0
Puerto Rico .....	47	3,319	3338.5	0.6
Rural by Region:				
New England .....	40	6,405	6475.6	1.1
Middle Atlantic .....	67	5,267	5338.0	1.3
South Atlantic .....	232	5,245	5330.7	1.6
East North Central .....	215	5,139	5275.2	2.6
East South Central .....	239	4,746	4843.1	2.0
West North Central .....	279	5,223	5354.7	2.5
West South Central .....	285	4,536	4626.7	2.0
Mountain .....	145	5,789	5933.2	2.5
Pacific .....	103	6,652	6803.3	2.3

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2003 OPERATING PROSPECTIVE PAYMENT SYSTEM  
[Payments per case]

	Num. of hosps.	Average FY 2002 payment per case <sup>1</sup>	Average FY 2003 payment per case <sup>1</sup>	All FY 2003 changes
	(1)	(2)	(3)	(4)
Puerto Rico .....	5	2,753	2677.6	-2.7
By Payment Classification:				
Urban hospitals .....	2,650	7,703	7713.5	0.1
Large urban areas (populations over 1 million) .....	1,576	8,196	8180.0	-0.2
Other urban areas (populations of 1 million of fewer) .....	1,074	7,027	7075.0	0.7
Rural areas .....	1,580	5,155	5261.6	2.1
Teaching Status:				
Non-teaching .....	3,119	5,890	5965.9	1.3
Fewer than 100 Residents .....	870	7,475	7511.1	0.5
100 or more Residents .....	241	11,352	11196.8	-1.4
Urban DSH:				
Non-DSH .....	1,549	6,567	6604.7	0.6
100 or more beds .....	1,361	8,296	8299.2	0.0
Less than 100 beds .....	286	5,168	5232.1	1.2
Rural DSH:				
Sole Community (SCH) .....	470	4,942	5067.0	2.5
Referral Center (RRC) .....	156	5,974	6067.9	1.6
Other Rural:				
100 or more beds .....	76	4,517	4589.9	1.6
Less than 100 beds .....	332	4,089	4172.8	2.0
Urban teaching and DSH:				
Both teaching and DSH .....	757	9,177	9140.8	-0.4
Teaching and no DSH .....	284	7,773	7763.4	-0.1
No teaching and DSH .....	890	6,535	6608.4	1.1
No teaching and no DSH .....	719	6,041	6086.3	0.7
Rural Hospital Types:				
Non special status hospitals .....	577	4,261	4341.7	1.9
RRC .....	160	5,677	5737.5	1.1
SCH .....	526	5,280	5420.1	2.7
Medicare-dependent hospitals (MDH) .....	241	4,048	4150.6	2.5
SCH and RRC .....	76	6,626	6829.3	3.1
Type of Ownership:				
Voluntary .....	2,461	7,342	7369.6	0.4
Proprietary .....	723	6,945	6969.7	0.4
Government .....	869	6,809	6851.5	0.6
Unknown .....	177	7,302	7318.9	0.2
Medicare Utilization as a Percent of Inpatient Days:				
0-25 .....	310	9,845	9786.3	-0.6
25-50 .....	1,613	8,267	8268.6	0.0
50-65 .....	1,677	6,257	6318.9	1.0
Over 65 .....	504	5,647	5684.7	0.7
Unknown .....	126	8,992	9011.1	0.2
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2002 Reclassifications:				
All Reclassified Hospitals .....	628	6,530	6609.5	1.2
Standardized Amount Only .....	28	5,971	6029.0	1.0
Wage Index Only .....	521	6,749	6805.1	0.8
Both .....	38	5,901	5947.1	0.8
All Nonreclassified Hospitals .....	3,605	7,327	7351.4	0.3
All Urban Reclassified Hospitals .....	113	8,610	8615.0	0.1
Urban Nonreclassified Hospitals .....	11	5,794	5804.7	0.2
Standardized Amount Only .....	87	9,211	9195.4	-0.2
Wage Index Only .....	15	5,870	6047.1	3.0
Both .....	2,473	7,690	7699.1	0.1
All Reclassified Rural Hospitals .....	515	5,721	5829.0	1.9
Standardized Amount Only .....	11	4,848	5000.7	3.1
Wage Index Only .....	485	5,728	5835.5	1.9
Both .....	19	5,875	5981.2	1.8
Rural Nonreclassified Hospitals .....	1,094	4,516	4621.1	2.3
Other Reclassified Hospitals (Section 1886(D)(8)(B)) .....	35	4,894	5026.9	2.7

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

Table II presents the projected impact of the 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 Policy Changes**

*A. Impact of Changes Relating to Payment for the Clinical Training Portion of Clinical Psychology Training Programs*

In section V.I.5. of the preamble to this final rule, we have revised our policy on Medicare payment for approved nursing and allied health education programs to permit payment for the costs incurred by a provider for the clinical training portion of clinical psychology training programs.

Our actuarial estimates indicate that there will be a fiscal impact of \$40 million the first year after payments begin, growing to \$50 million by the 5th year (\$220 million over 5 years). Costs are expected to increase because we believe that Medicare's support through its education regulations will encourage hospitals to report more costs for clinical psychology training programs than are reported today. This estimate is based on assumptions as to how much Medicare could pay for additional educational programs and how quickly other providers with clinical training portions would begin seeking those payments.

The following chart shows projected costs to the Medicare program for the next 5 years:

Fiscal year	Medicare program costs (in millions)
2003 .....	\$40
2004 .....	40
2005 .....	40
2006 .....	50
2007 .....	50

*B. Impact of Changes Relating to EMTALA Provisions*

We are addressing proposed changes related to the EMTALA provisions in a separate final rule to be published at a later date.

*C. Impact of 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.

Because we believed it would be difficult to quantify the impact of these changes, in the May 9, 2002 proposed rule, we solicited comments on these issues. However, we received no comments that would assist us in developing a quantitative analysis of impact. Therefore, we are not able to prepare such an analysis.

**VIII. Impact of Policies Affecting Rural Hospitals**

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

In section V. of the preamble of this final rule, we are raising 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 change.

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

In section VII. of the preamble of this final rule, we are eliminating 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, or approximately 270 CAHs, provide SNF level care. The elimination of the requirement to use the State RAI will greatly reduce the burden on CAHs because facilities will 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 will reduce the amount of time required to perform patient assessments and allow more time for direct patient care.

**IX. Impact of 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 final 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 § 412.312, the basic methodology for determining a capital prospective payment system payment is: (Standard Federal Rate) x (DRG weight) x (Geographic Adjustment Factor(GAF)) x (Large Urban Add-on, if applicable) x (COLA adjustment for hospitals located in Alaska and Hawaii) x (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 threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the March 2002 update of the FY 2001 MedPAR file and the March 2002 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 June 2002 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 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 March 2002 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 final rule, payments will no longer be made under the regular

exceptions provision under §§ 412.348(b) through (e). Therefore, we are no longer using the actuarial capital cost model (described in Appendix B of August 1, 2001 final rule (66 FR 40099)). We modeled payments for each hospital by multiplying the 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 FY 2003 update is 1.1 percent (see section III.A.1.a. of the Addendum to this final rule).

- In addition to the FY 2003 update factor, the FY 2003 Federal rate was calculated based on a GAF/DRG budget neutrality factor of 0.9957, an outlier adjustment factor of 0.9469, an exceptions adjustment factor of 0.9970, and a special adjustment for FY 2003 of 1.0255 (see section III.A. of the Addendum of this final 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 § 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

changes for FY 2003 on total capital payments per case, using a universe of 4,230 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the March 2002 update of the FY 2001 MedPAR file, the March 2002 update to the Provider-Specific File, and the most recent cost report data from the June 2002 update of HCRIS. In Table III, we present a comparison of total payments per case for FY 2002 compared to FY 2003 based on 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 update to 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 3.8 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 (3.6 percent and 4.8 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 final rule). Changes by region vary from a minimum increase of 2.7 percent (Pacific urban region) to a maximum increase of 5.3 percent (East North Central rural region). Hospitals located in Puerto Rico are expected

to experience an increase in total capital payments per case of 4.4 percent.

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (4.2 percent). Similarly, payments to voluntary hospitals will increase 4.1 percent, while payments to proprietary hospitals will increase 2.1 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 4.5 percent increase in payments. Payments to nonreclassified hospitals will increase slightly less (3.7 percent) than reclassified hospitals, overall. Hospitals reclassified during both FY 2002 and FY 2003 are projected to receive an increase in payments of 4.1 percent. Hospitals reclassified during FY 2003 only are projected to receive an increase in payments of 8.6 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 .....	4,230	668	693	3.8
Large urban areas (populations over 1 million) .....	1,519	772	798	3.4
Other urban areas (populations of 1 million or fewer) .....	1,101	653	679	4.0
Rural areas .....	1,610	451	472	4.8
Urban hospitals .....	2,620	720	746	3.6
0–99 beds .....	645	511	532	4.2
100–199 beds .....	909	607	630	3.7
200–299 beds .....	523	692	718	3.7
300–499 beds .....	398	767	794	3.6
500 or more beds .....	145	933	964	3.4
Rural hospitals .....	1,610	451	472	4.8
0–49 beds .....	747	371	392	5.5
50–99 beds .....	501	412	434	5.3
100–149 beds .....	215	456	478	4.8

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
150–199 beds .....	78	494	517	4.7
200 or more beds .....	69	569	591	3.8
By Region:				
Urban by Region .....	2,620	720	746	3.6
New England .....	135	771	805	4.4
Middle Atlantic .....	404	807	829	2.8
South Atlantic .....	384	692	717	3.6
East North Central .....	429	688	720	4.6
East South Central .....	159	654	677	3.6
West North Central .....	178	706	736	4.3
West South Central .....	335	671	693	3.4
Mountain .....	132	694	728	4.8
Pacific .....	417	840	862	2.7
Puerto Rico .....	47	306	320	4.4
Rural by Region .....	1,610	451	472	4.8
New England .....	40	549	574	4.6
Middle Atlantic .....	67	473	496	4.9
South Atlantic .....	232	469	490	4.3
East North Central .....	215	457	482	5.3
East South Central .....	239	415	434	4.8
West North Central .....	279	443	466	5.2
West South Central .....	285	405	424	4.7
Mountain .....	145	467	490	5.0
Pacific .....	103	531	556	4.7
By Payment Classification:				
All hospitals .....	4,230	668	693	3.8
Large urban areas (populations over 1 million) .....	1,576	765	792	3.4
Other urban areas (populations of 1 million or fewer) .....	1,074	655	681	4.0
Rural areas .....	1,580	449	470	4.8
Teaching Status:				
Non-teaching .....	3,119	546	568	4.0
Fewer than 100 Residents .....	870	698	725	3.8
100 or more Residents .....	241	1,030	1,064	3.3
Urban DSH:				
100 or more beds .....	1,361	758	784	3.4
Less than 100 beds .....	286	482	502	4.2
Rural DSH:				
Sole Community (SCH/EACH) .....	470	394	414	5.1
Referral Center (RRC/EACH) .....	156	516	537	4.1
Other Rural:				
100 or more beds .....	76	419	438	4.6
Less than 100 beds .....	332	379	399	5.2
Urban teaching and DSH:				
Both teaching and DSH .....	757	836	864	3.4
Teaching and no DSH .....	284	750	781	4.2
No teaching and DSH .....	890	602	624	3.6
No teaching and no DSH .....	719	596	619	3.8
Rural Hospital Types:				
Non special status hospitals .....	577	399	419	5.0
RRC/EACH .....	160	528	549	4.0
SCH/EACH .....	526	417	438	5.1
Medicare-dependent hospitals (MDH) .....	241	372	394	5.9
SCH, RRC and EACH .....	76	507	532	5.0
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
Reclassification Status During FY2002 and FY2003:				
Reclassified During Both FY2002 and FY2003 .....	573	585	610	4.1
Reclassified During FY2003 Only .....	54	525	570	8.6
Reclassified During FY2002 Only .....	77	764	758	-0.7
FY2003 Reclassifications:				
All Reclassified Hospitals .....	628	581	606	4.5
All Nonreclassified Hospitals .....	3,567	684	709	3.7
All Urban Reclassified Hospitals .....	113	780	814	4.4
Urban Nonreclassified Hospitals .....	2,473	719	745	3.6
All Reclassified Rural Hospitals .....	515	503	525	4.5
Rural Nonreclassified Hospitals .....	1,094	389	409	5.2
Other Reclassified Hospitals (Section 1886(D)(8)(B)) .....	35	455	483	6.2
Type of Ownership:				
Voluntary .....	2,461	680	708	4.0
Proprietary .....	723	659	673	2.1

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
Government .....	869	604	629	4.2
Medicare Utilization as a Percent of Inpatient Days:				
0–25 .....	310	864	892	3.3
25–50 .....	1,613	766	792	3.5
50–65 .....	1,677	583	607	4.1
Over 65 .....	504	523	546	4.3

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

### I. Background

Consistent with section 1886(e)(5)(B) of the Act, in this final rule we are publishing our final recommendations for updating hospital payments for FY 2003. In accordance with section 1886(d)(3)(A) and section 1886(b)(3)(B)(i)(XVIII) of the Act, we are updating the standardized amounts for FY 2003 equal to the rate of increase in the hospital market basket minus 0.55 percentage points for acute inpatient prospective payments to 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 of increase in the market basket minus 0.55 percentage points.

Based on the revised and rebased second quarter 2002 forecast of the FY 2003 market basket increase of 3.5 percent, the update to the standardized amounts for hospitals subject to the acute inpatient prospective payment system is 2.95 percent (that is, the market basket rate of increase minus 0.55 percentage points) for hospitals in both large urban and other areas. The update to the hospital-specific rate applicable to SCHs and MDHs is also 2.95 percent. In the proposed rule, the market basket was 3.3 percent, for proposed update factors of 2.75 percent.

Under section 1886(b)(3)(B)(ii)(VIII) of the Act, the FY 2003 percentage increase in the rate-of-increase limits for hospitals and hospital units excluded from the acute inpatient prospective payment system is equal to the market basket percentage increase. Facilities excluded from the acute 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 acute 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 update is the percentage increase in the excluded hospital market basket (currently estimated at 3.5 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 have proposed that long-term care hospitals would be paid under a prospective payment system based on a 5-year transition period (see the March 22, 2002 proposed rule (67 FR 13416)). We also proposed that a long-term care hospital may elect to be paid on 100 percent of the Federal prospective payment 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 3.5 percent).

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for 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, we published the FY 2003 update factors recommended by the Secretary as Appendix C in the May 9, 2002 proposed rule (67 FR 31685). In that appendix, we discussed the recommendations of appropriate update factors and the analysis underlying our recommendations. We also responded to MedPAC's recommendations concerning the update factors.

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

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

adequate reimbursement to health care providers.

*Comment:* Numerous commenters pointed out the negative impact of reducing the market basket estimate by 0.55 percentage points. However, the commenters acknowledged that the statute requires an update to payments for FY 2002 of the market basket percentage increase minus 0.55 percentage points. One commenter stated that another year of "market basket minus" update was unsustainable.

*Response:* The commenters are correct that the 0.55 percentage point reduction from the market basket in calculating the update factor is required by statute.

Our final recommendation of the update is market basket minus 0.55 percentage points, which is consistent with current law, and does not differ from the proposed recommendation. However, the second quarter forecast of the market basket percentage increase is 3.5 for prospective payment hospitals (up from 3.3 percent estimated in the proposed rule). Thus, the Secretary's final recommendation is that the update to the prospective payment system standardized amounts for both large urban and other urban areas is 2.95 percentage points. The update to the hospital-specific rate applicable to SCHs and MDHs is also 2.95 percent (or consistent with current law, market basket percentage increase minus 0.55 percentage points).

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

We received no comments concerning our proposed recommendation for updating the rate-of-increase for excluded hospitals and hospital units. Our final recommendation does not differ from the proposed recommendation. However, the second quarter forecast of the market basket percentage increase is 3.5 for excluded hospitals and hospital units (up from 3.4 percent estimated in the proposed rule).

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.

For purposes of the proposed long-term care hospital prospective payment system update factor, the portion of the 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 3.5 percent).

Thus, the Secretary's final recommendation is that the update for the remaining hospitals and hospital units

excluded from the acute inpatient prospective payment system is 3.5 percent.  
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