TABLE 10--Percentage Difference in Wage Indexes for Areas That Qualify for a Wage Index Exception for Excluded Hospitals and Units

Area	1982-1995 Difference	1984-1995 Difference	1988-1995 Difference	1990-1995 Difference	1991-1995 Difference	1992-1995 Difference	1993-1995 Difference	1994-1995 Difference
Wast Palm Beach-Boca Raton, FL		8.0870						
Wilmington-Newark, DE-MD	13.1950	15.6727	9.2931	12.4882	11.4966			
Wilmington, NC		14.5250						
Yakima, WA				9.6066	8.3429			
Yuma, AZ			13.3138	16.1614				

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Appendix A—Regulatory Impact Analysis

I. Introduction

Section 804(2) of Title 5, United States Code (as added by section 251 of Public Law 104–121), specifies that a ''major rule'' is any rule that the Office of Management and Budget finds is likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets.

We estimate that the impact of this final rule will be to decrease payments to hospitals by approximately $530 million in FY 1999. Therefore, this rule is a major rule as defined in Title 5, United States Code, section 804(2).

We have examined the impacts of this final rule as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). The RFA requires agencies to analyze options for regulatory relief for small businesses. For purposes of the RFA, most hospitals, and most other providers, physicians, and health care suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually.

Also, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. 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 prospective payment system, we classify these hospitals as urban hospitals.

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

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

II. Changes in the Final Rule

Since we published the proposed rule, the market basket estimates for hospitals subject to the prospective payment system and hospitals and units excluded from the system have both fallen by 0.2 percentage points. As a result, the updates are 0.2 percent lower than the updates reflected in the impact analysis for the proposed rule.

Also, in the proposed rule, we included discharges to swing beds under the expanded transfer definition. In this final rule we are not including swing beds from the definition of a postacute care setting. The overall payment impact of this change is relatively very small (an increase of approximately $4 million).

With the exception of these two changes, we are generally implementing the policy and statutory changes discussed in the proposed rule.

III. Limitations of Our Analysis

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

We received no comments on the methodology used for the impact analysis in the proposed rule.

IV. GME Payment to Nonhospital Providers

In the past, Medicare only paid hospitals for GME costs. Therefore, FQHCs, RHCs, and Medicare+Choice organizations may have been reluctant to train large numbers of residents since Medicare would not reimburse their incurred training costs. This final rule specifies that Medicare will reimburse the qualified nonhospital provider for Medicare's share of the reasonable costs of the training where the qualified nonhospital provider incurs all or substantially all of the costs of the training at that site. This final rule may facilitate more training of residents in settings where many of those residents will ultimately practice after their training is completed. Additionally, this could result in an increase in the number of physicians practicing in underserved areas.

In addition, hospitals are currently allowed to count residents working in nonhospital sites in their FTE count of residents for determining indirect and direct graduate medical education payments, if the hospital incurs ''all or substantially all of the costs'' of the training at the non-hospital site. The regulation defined the statutory requirement of ''all or substantially all'' to mean at least the residents' salaries and fringe benefits. In this final rule, we are defining ''all or substantially all'' of the costs of training in the nonhospital site to mean residents' salaries and fringe benefits as well as the portion of teaching physicians' salaries and fringe benefits that can be allocated to direct GME. We believe that this definition will not discourage training in nonhospital settings.

Section 4625 of the Balanced Budget Act, which provides for direct graduate medical education payments to nonhospital providers, would have minimal impact in the context of total graduate medical education costs. We believe that the most significant impact resulting from making payment directly to qualified nonhospital providers and the redefinition of ''all or substantially all'' will be that additional nonhospital sites may participate in training residents. We expect that such an impact will result in little if any additional cost to Medicare.

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

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general, short-term, acute care hospitals that participate in the Medicare program. There were 45 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 50 such hospitals in Maryland remain excluded from the prospective payment system under the waiver at section 1814(b)(3) of the Act. Thus, as of July 1998, we have included 4,975 hospitals in our analysis. This represents about 82 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

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

VI. Impact on Excluded Hospitals and Units

As of July 1998, there were 1,077 specialty hospitals excluded from the prospective payment system and instead paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. In addition, there were 2,408 psychiatric and rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also paid in accordance with § 413.40.

As required by section 1886(b)(3)(B) of the Act, the update factor applicable to the rate-of-increase limit for excluded hospitals and units for FY 1999 would be between 0 and 2.4 percent, depending on the hospital's costs in relation to its limit.

The impact on excluded hospitals and units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a

level below the percentage increases in the rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and units receive. Conversely, for excluded hospitals and units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect will be the amount of excess costs that would not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and units to restrain the growth in their spending for patient services.

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

A. Basis and Methodology of Estimates

In this final rule, we are announcing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We have prepared separate impact analyses of the changes to each system. This section deals with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are taken from the FY 1997 MedPAR file and the most current provider-specific file that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not incorporate cost data, the most recently available hospital cost report data were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these final policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

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

The final changes discussed separately below are the following:

- The effects of implementing the expanded transfer definition enacted by section 4407 of the BBA, which counts as a transfer any discharge from one of 10 DRGs if upon discharge the patient is admitted to an excluded hospital or distinct part unit or a skilled nursing facility, or is provided home health care that is related to the hospitalization within 3 days of the date of discharge.
- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of changes in hospitals' wage index values reflecting the wage index update (FY 1995 data).
- The effects of two changes to the wage index for FY 1999: (1) Including the Part A costs associated with physicians under contract; and (2) removing the overhead costs related to departments excluded from the wage data used to calculate the wage index (for example, skilled nursing facilities and distinct part units).
- The effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) that will be effective in FY 1999.
- The total change in payments based on FY 1999 policies relative to payments based on FY 1998 policies.

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

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

Our final comparison illustrates the percent change in payments per case from FY 1998 to FY 1999. Four factors have significant impacts here. First is the update to the standardized amounts. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are updating the large urban and the other areas average standardized amounts for FY 1999 by the most recently forecasted hospital market basket increase for FY 1999 of 2.4 percent minus 1.9 percentage points. Similarly, section 1886(b)(3)(C)(ii) of the Act provides that the update factor applicable to the hospital-specific rates for sole community hospitals (SCHs) and Medicare-dependent, small rural hospitals (MDHs) is equal to the market basket increase of 2.4 percent minus 1.9 percentage points (for an update of 0.5 percent).

A second significant factor impacting changes in hospitals' payments per case from FY 1998 to FY 1999 is a change in MGCRB reclassification status from one year to the next. That is, hospitals reclassified in FY 1998 that are no longer reclassified in FY 1999 may have a negative payment impact going from FY 1998 to FY 1999; conversely, hospitals not reclassified in FY 1998 that are reclassified in FY 1999 may have a positive impact. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage increase in payments for the category may be below the national mean.

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

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

Table I demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 4,975 hospitals included in the analysis. This is 113 fewer hospitals than were included in the impact analysis in the FY 1998 final rule with comment period (62 FR 46119).

The next four rows of Table I contain hospitals categorized according to their geographic location (all urban, which is further divided into large urban and other urban, or rural). There are 2,810 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,611 hospitals located in large urban areas (populations over 1 million), and 1,199 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,165 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 1999 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban,

large urban, other urban, and rural show the numbers of hospitals paid based on these categorizations (after consideration of geographic reclassifications) are 2,894, 1,698, 1,196, and 2,081, respectively.

The next three groupings examine the impacts of the final changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an IME adjustment), receive DSH payments, or some combination of these two adjustments. There are 3,880 nonteaching hospitals in our analysis, 854 teaching hospitals with fewer than 100 residents, and 241 teaching hospitals with 100 or more residents.

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

The next row separately examines hospitals that available data show may qualify under section 4401(b) of the BBA for the special temporary relief provision, which grants an additional 0.3 percent update to the standardized amounts (in addition to the 0.5 percent update other hospitals receive during FY 1999), resulting in a 0.8 percent update for this category of hospitals. To be eligible, a hospital must not be an MDH, nor may it receive either IME or DSH payments. It must also experience a negative margin on its operating prospective payments during FY 1999. We estimated eligible hospitals based on whether they had a negative operating margin on their FY 1995 cost report (latest available data). Finally, to qualify, a hospital must be located in a State where the aggregate FY 1995 operating prospective payments were less than the aggregate associated costs for all of the non-IME, non-DSH, non-MDH hospitals in the State. There are 344 hospitals in this row.

The next four rows examine the impacts of the final changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and MDHs), as well as rural hospitals not receiving a special payment designation. The RRCs (145), SCHs (637), MDHs (352), and SCH and RRCs (59) shown here were not reclassified for purposes of the standardized amount. There are six SCHs that will be reclassified for the standardized amount in FY 1999 that, therefore, are not included in these rows. There are seven hospitals that continue to be paid under the same rules as SCHs, by virtue of their prior designation as essential access community hospitals (EACH). These hospitals are categorized in our analysis as SCHs (there are also three EACH/RRCs).

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 1995 Medicare cost report files, if available (otherwise FY 1994 data are used). Data needed to determine ownership status or Medicare utilization percentages were unavailable for 115 hospitals. For the most part, these are new hospitals.

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

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

[Percent Changes in Payments Per Case]

	Num. of hosps.[1]	Pac tran. provision[2]	DRG recalib.[3]	New wage Data[4]	Contract phys. pt A Costs[5]	Allocated overhead costs[6]	DRG & WI changes[7]	MGCRB reclassification[8]	All FY 99 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
(BY GEOGRAPHIC LOCATION):									
ALL HOSPITALS	4,975	−0.6	0.1	0.0	0.0	0.0	0.0	0.0	−1.0
URBAN HOSPITALS	2,810	−0.7	0.2	−0.1	0.0	−0.1	−0.2	−0.4	−1.3
LARGE URBAN	1,611	−0.7	0.2	−0.4	0.0	−0.1	−0.5	−0.5	−1.7
OTHER URBAN	1,199	−0.6	0.1	0.4	0.0	−0.1	0.3	−0.4	−0.7
RURAL HOSPITALS	2,165	−0.4	0.1	0.7	0.0	0.4	1.0	2.7	1.3
BED SIZE (URBAN):									
0–99 BEDS	704	−0.8	0.1	−0.2	0.0	0.0	−0.2	−0.6	−0.9
100–199 BEDS	937	−0.9	0.2	−0.2	0.0	−0.1	−0.2	−0.5	−1.2
200–299 BEDS	568	−0.7	0.2	−0.2	0.0	−0.1	−0.2	−0.4	−1.2
300–499 BEDS	449	−0.6	0.1	−0.1	0.0	−0.1	−0.2	−0.5	−1.4
500 OR MORE BEDS	152	−0.5	0.1	0.1	0.0	−0.2	0.0	−0.3	−1.6
BED SIZE (RURAL):									
0–49 BEDS	1,137	−0.2	0.0	0.7	0.0	0.5	1.0	0.0	1.0
50–99 BEDS	634	−0.3	0.0	0.6	0.0	0.4	0.8	1.1	0.8
100–149 BEDS	229	−0.5	0.1	0.6	−0.1	0.5	1.0	3.6	1.1
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
150–199 BEDS	91	−0.5	0.1	0.8	0.0	0.4	1.1	4.5	2.5
200 OR MORE BEDS	74	−0.4	0.1	0.8	0.0	0.3	1.1	5.3	1.7
URBAN BY CENSUS DIVISION:									
NEW ENGLAND	152	−0.7	0.1	−1.1	0.2	−0.3	−1.2	−0.2	−2.6
MIDDLE ATLANTIC	425	−0.4	0.2	0.2	0.2	−0.1	0.3	−0.4	−0.9
SOUTH ATLANTIC	414	−0.6	0.2	0.7	−0.2	−0.1	0.5	−0.5	−0.4
EAST NORTH CENTRAL	476	−0.8	0.1	−0.4	−0.2	−0.3	−0.9	−0.4	−2.2
EAST SOUTH CENTRAL	162	−0.5	0.2	0.7	−0.2	−0.3	0.2	−0.5	−0.7
WEST NORTH CENTRAL	189	−0.7	0.1	0.6	0.2	0.2	1.0	−0.5	−0.1
WEST SOUTH CENTRAL	354	−1.0	0.2	−0.7	0.3	−0.1	−0.4	−0.5	−1.6
MOUNTAIN	129	−0.9	0.1	−0.1	0.1	−0.1	−0.2	−0.5	−1.1
PACIFIC	461	−0.8	0.2	−0.9	−0.2	0.1	−0.9	−0.4	−2.0
PUERTO RICO	48	−0.8	0.3	0.9	−0.2	−0.3	0.5	−0.6	−0.3
RURAL BY CENSUS DIVISION:									
NEW ENGLAND	53	−0.4	0.0	1.0	0.0	0.0	0.9	1.4	−0.3
MIDDLE ATLANTIC	80	−0.2	0.0	0.7	0.4	0.2	1.2	1.7	1.3
SOUTH ATLANTIC	286	−0.4	0.1	0.6	−0.2	0.3	0.7	3.8	1.8
EAST NORTH CENTRAL	285	−0.4	0.1	0.8	−0.1	0.3	1.0	2.1	1.3
EAST SOUTH CENTRAL	269	−0.3	0.1	1.3	−0.2	0.4	1.5	2.7	1.7
WEST NORTH CENTRAL	500	−0.3	−0.1	0.9	0.0	0.7	1.5	2.3	1.4
WEST SOUTH CENTRAL	342	−0.5	0.1	0.1	0.1	0.5	0.6	3.5	0.7

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

[Percent Changes in Payments Per Case]

	Num. of hosps.[1]	Pac tran. provision[2]	DRG recalib.[3]	New wage Data[4]	Contract phys. pt A Costs[5]	Allocated overhead costs[6]	DRG & WI changes[7]	MGCRB reclassification[8]	All FY 99 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
MOUNTAIN	204	−0.2	0.0	0.2	−0.1	0.5	0.5	1.8	0.6
PACIFIC	141	−0.5	0.1	0.3	−0.2	0.5	0.6	2.4	0.7
PUERTO RICO	5	−0.5	0.0	2.3	−0.2	−0.2	1.8	1.7	−0.2
(BY PAYMENT CATEGORIES):									
URBAN HOSPITALS	2,894	−0.7	0.2	−0.1	0.0	−0.1	−0.2	−0.4	−1.3
LARGE URBAN	1,698	−0.7	0.2	−0.4	0.0	−0.1	−0.4	−0.3	−1.6
OTHER URBAN	1,196	−0.6	0.1	0.4	0.0	−0.1	0.3	−0.4	−0.6
RURAL HOSPITALS	2,081	−0.4	0.1	0.7	0.0	0.4	1.0	2.4	1.1
TEACHING STATUS:									
NON-TEACHING	3,880	−0.7	0.1	0.1	−0.1	0.1	0.2	0.3	−0.3
LESS THAN 100 RES	854	−0.7	0.1	−0.1	0.0	−0.1	−0.2	−0.3	−1.1
100+ RESIDENTS	241	−0.5	0.2	−0.1	0.1	−0.2	−0.1	−0.3	−2.0
DISPROPORTIONATE SHARE HOSPITALS (DSH):									
NON-DSH	3,089	−0.6	0.1	0.1	0.0	0.0	0.0	0.3	−0.6
URBAN DSH:									
100 BEDS OR MORE	1,404	−0.7	0.2	−0.1	0.0	−0.1	−0.1	−0.4	−1.4
FEWER THAN 100 BEDS	88	−0.6	0.2	−0.6	−0.1	0.0	−0.7	−0.4	−1.2
RURAL DSH:									
SOLE COMMUNITY (SCH)	162	−0.2	0.0	0.7	−0.1	0.3	0.8	0.0	1.0
REFERRAL CENTERS (RRC)	53	−0.5	0.2	1.1	−0.1	0.4	1.4	5.6	2.5
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
OTHER RURAL DSH HOSP:									
100 BEDS OR MORE	60	−0.6	0.2	0.9	−0.2	0.5	1.3	1.1	0.7
FEWER THAN 100 BEDS	119	−0.2	0.0	1.1	−0.1	0.5	1.4	−0.2	1.3
URBAN TEACHING AND DSH:									
BOTH TEACHING AND DSH	709	−0.7	0.2	−0.1	0.0	−0.1	−0.2	−0.5	−1.6
TEACHING AND NO DSH	331	−0.6	0.1	−0.1	0.0	−0.2	−0.3	−0.1	−1.3
NO TEACHING AND DSH	783	−0.8	0.2	0.0	−0.1	0.0	0.0	−0.2	−0.7
NO TEACHING AND NO DSH	1,071	−0.7	0.1	−0.1	0.0	−0.1	−0.2	−0.4	−0.9
SPECIAL UPDATE HOSPITALS (UNDER SEC. 4401(b) OF PUBLIC LAW 105–33)	344	−0.6	0.1	0.0	−0.1	−0.1	−0.1	−0.2	−0.8
RURAL HOSPITAL TYPES:									
NONSPECIAL STATUS HOSPITALS	888	−0.4	0.1	0.9	−0.1	0.6	1.3	1.2	0.7
RRC	145	−0.6	0.2	0.9	0.0	0.4	1.4	6.4	2.2
SCH	637	−0.1	−0.1	0.3	0.0	0.2	0.4	0.1	0.4
MDH	352	−0.2	0.0	0.8	0.0	0.5	1.2	0.5	1.0
SCH AND RRC	59	−0.2	0.0	0.3	−0.1	0.2	0.3	2.0	1.2
TYPE OF OWNERSHIP:									
VOLUNTARY	2,858	−0.6	0.1	0.0	0.0	−0.1	−0.1	−0.1	−1.0
PROPRIETARY	671	−0.9	0.2	0.1	−0.1	0.0	0.0	0.2	−1.0
GOVERNMENT	1,331	−0.5	0.2	0.1	0.0	0.1	0.2	0.3	−0.5
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
UNKNOWN	115	−0.8	0.2	0.3	−0.2	0.1	0.4	−0.5	−1.0
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:									
0–25	247	−0.6	0.2	−1.0	0.0	0.0	−0.8	−0.2	−2.0
25–50	1,264	−0.7	0.2	−0.2	0.0	−0.1	−0.2	−0.3	−1.5
50–65	1,978	−0.6	0.1	0.2	0.0	−0.1	0.1	0.2	−0.6
OVER 65	1,371	−0.6	0.1	0.2	0.0	0.0	0.3	0.1	−0.2
UNKNOWN	115	−0.8	0.2	0.3	−0.2	0.1	0.4	−0.5	−1.0
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:									
RECLASSIFICATION STATUS DURING FY 98 AND FY 99:									
RECLASSIFIED DURING BOTH FY98 AND FY99	315	−0.5	0.1	0.6	−0.1	0.2	0.7	6.8	−0.5
URBAN	72	−0.4	0.2	0.4	−0.1	−0.2	0.1	4.9	−1.0
RURAL	243	−0.5	0.1	0.7	−0.1	0.4	1.1	8.3	−0.1
RECLASSIFIED DURING FY 99 ONLY	170	−0.5	0.1	0.5	0.0	0.3	0.8	5.0	5.4
URBAN	15	−0.7	0.1	−0.1	0.1	0.1	0.1	4.6	2.3
RURAL	155	−0.5	0.1	0.7	0.0	0.3	1.0	5.1	6.3
RECLASSIFIED DURING FY 98 ONLY	126	−0.7	0.1	0.3	−0.1	−0.1	0.1	−0.6	−3.6
URBAN	53	−0.8	0.1	0.2	−0.1	−0.3	−0.1	−0.7	−2.9
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
RURAL	73	−0.3	0.1	0.6	−0.1	0.4	1.0	−0.5	−5.9
FY 99 RECLASSIFICATIONS:									
ALL RECLASSIFIED HOSP	485	−0.5	0.1	0.6	−0.1	0.2	0.7	6.2	1.4
STAND. AMOUNT ONLY	94	−0.6	0.1	0.5	0.0	−0.2	0.3	1.0	−0.7
WAGE INDEX ONLY	281	−0.5	0.1	0.4	−0.1	0.3	0.6	6.9	−1.2
BOTH	47	−0.6	0.2	0.9	−0.2	−0.3	0.5	3.7	−2.2
NONRECLASSIFIED	4,526	−0.7	0.1	0.0	0.0	−0.1	−0.1	−0.4	−0.9
ALL URBAN RECLASS	87	−0.5	0.2	0.3	−0.1	−0.2	0.1	4.8	−0.3
STAND. AMOUNT ONLY	26	−0.4	0.2	1.3	−0.1	−0.3	0.9	0.8	0.1

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

[Percent Changes in Payments Per Case]

	Num. of hosps.[1]	Pac tran. provision[2]	DRG recalib.[3]	New wage Data[4]	Contract phys. pt A Costs[5]	Allocated overhead costs[6]	DRG & WI changes[7]	MGCRB reclassification[8]	All FY 99 changes[9]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
NONRECLASSIFIED	2,696	−0.7	0.2	−0.1	0.0	−0.1	−0.2	−0.6	1.3
ALL RURAL RECLASS	398	−0.5	0.1	0.7	−0.1	0.4	1.1	7.0	2.4
STAND. AMOUNT ONLY	55	−0.4	0.1	0.9	−0.1	0.4	1.1	4.8	2.7
WAGE INDEX ONLY	314	−0.5	0.1	0.7	0.0	0.4	1.1	6.9	2.2
BOTH	29	−0.5	0.1	0.8	−0.1	0.3	1.1	10.0	3.8
NONRECLASSIFIED	1,767	−0.3	0.0	0.7	0.0	0.4	0.9	−0.4	0.4
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	27	−0.5	0.1	−0.4	0.0	−0.3	−0.6	1.0	1.1

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

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

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

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

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

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

[7] This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated and revised wage data used to calculate the wage index, and the budget neutrality adjustment factor for these two changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 2, 3, 4, and 5, and the FY 1999 budget neutrality factor of 0.999006.

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

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

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

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

Although the expanded definition encompasses only 10 DRGs, they were selected, in accordance with the statute, based upon their large and disproportionate volume of cases receiving postacute care. Therefore, the overall payment impact of this change is significant (a 0.6 percent decrease in payments per case).

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

To simulate the impact of these final policies, we adjusted hospitals' transfer-adjusted discharges and case-mix index values (using version 15 of the GROUPER) to reflect the impact of this expansion in the transfer definition. The transfer-adjusted discharge fraction is calculated one of two ways, depending on the transfer payment methodology. Under our current transfer payment methodology, and for all but the three DRGs receiving special payment consideration, this adjustment is made simply by adding one to the length of stay and dividing that amount by the geometric mean length of stay for the DRG (with the resulting fraction not to exceed 1.0). For example, a transfer after 3 days from a DRG with a geometric mean length of stay of 6 days would have a transfer-adjusted discharge fraction of 0.667 ((3+1)/6).

For transfers from any one of the three DRGs receiving the alternative payment methodology, the transfer-adjusted discharge fraction is 0.5 (to reflect that these cases receive half the full DRG amount the first day), plus one-half of the result of dividing one plus the length of stay prior to transfer by the geometric mean length of stay for the DRG. As with the above adjustment, the result is equal to the lesser of the transfer-adjusted discharge fraction or 1.

The transfer-adjusted case-mix index values are calculated by summing the transfer-adjusted DRG weights and dividing by the transfer-adjusted discharges. The transfer-adjusted DRG weights are calculated by multiplying the DRG weight by the lesser of 1 or the transfer-adjusted discharge fraction for the case, divided by the geometric mean length of stay for the DRG. In this way, simulated payments per case can be compared before and after the change to the transfer policy.

This change has the greatest impact among urban hospitals (0.7 percent decrease). Among urban hospitals, hospitals with up to 99 beds and those with between 100 and 199 beds are most affected, with 0.8 percent and 0.9 percent reductions in payments, respectively. For urban hospitals grouped by census division, the Middle Atlantic division has the smallest negative impact, a 0.4 percent decrease. The Middle Atlantic division has traditionally had the longest average lengths of stay, therefore, it is reasonable that the impact is smallest here. Transfer cases with a length of stay more than the (geometric) mean length of stay minus one day do not experience any payment impact under this provision. (Full payment is reached one day prior to the mean length of stay due to the double per diem paid for the first day under our current transfer payment methodology.)

Rural hospitals experience a smaller payment impact overall, especially the smallest rural hospitals: those with fewer than 50 beds (a 0.2 percent decrease). The smallest impacts among rural census divisions are in the Middle Atlantic and the Mountain. The largest rural impacts are in the West South Central and the Pacific divisions, and Puerto Rico, all with 0.5 percent decreases. This change is consistent with the shorter lengths of stay in these geographic regions.

The largest negative impact is a 1.0 percent decrease in payments observed among urban West South Central hospitals. The smallest negative impact occurs in SCHs (0.1 percent decrease). Those SCHs paid based on their hospital-specific amount would see no impact related to this change, since there is no transfer adjustment made to the hospital-specific amount.

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

In column 2 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II of the preamble to this 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 1998 DRG relative weights (GROUPER version 15) to aggregate payments using the final FY 1999 DRG relative weights (GROUPER version 16). Overall, payments increase by 0.1 percent due to the DRG changes, although this is prior to applying the budget neutrality factor for DRG and wage index changes (see column 6). Consistent with the minor changes reflected in the FY 1999 GROUPER, the redistributional impacts of DRG reclassifications and recalibration across hospital groups are very small (a 0.2 percent increase for large urban hospitals, and a 0.1 percent increase for other urban hospitals as well as for rural hospitals). Within hospital categories, the net effects for urban hospitals are small positive changes for all hospitals (a 0.2 percent increase for hospitals with between 100 and 299 beds, and a 0.1 percent increase for smaller or larger urban hospitals). Rural hospitals with 100 or more beds experience an increase of 0.1 percent, for smaller rural hospitals, there is no impact (0.0 percent change).

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

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

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

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the wage index for FY 1999 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1994 and before October 1, 1995. As with the previous column, the impact of the new data on hospital payments is isolated by holding the other payment parameters constant in the two simulations. That is, column 3 shows the percentage changes in payments when going from a model using the FY 1998 wage index based on FY 1994 wage data before geographic reclassifications to a model using the FY 1999 prereclassification wage index based on FY 1995 wage data.

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

The results indicate that the new wage data have no overall impact in hospital payments. Rural hospitals as a category, however, benefit from the update. Their payments increase by 0.7 percent. These increases are attributable to increases above 5 percent in the wage index values for the rural areas of several States.

Urban hospitals as a group are not significantly affected by the updated wage data (a 0.1 percent decrease). The gains of hospitals in other urban areas (0.4 percent increase) are offset by decreases among hospitals in large urban areas (0.4 percent decrease). The negative impact among large urban areas appears to be largely due to three large urban MSAs with decreases of greater than 6 percent in their wage index values due to the FY 1995 data.

Among urban census divisions, New England experiences the largest decline, 1.1 percent. This is primarily attributable to a 2.0 percent decline in the Boston MSA's wage index. The negative impact in the Pacific division is associated with three MSAs that have a 7 percent decline in their wage index. On the other hand, in urban Puerto Rico, two MSAs had increases of more than 10 percent.

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

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

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

Column 4 shows the payment impacts of including these data. Although only two States currently maintain the prohibition against hospitals directly employing physicians (Texas and California), many hospitals in other States reported these costs as well. Thus, the impacts of this final change extend well beyond Texas and California.

In general, most hospital categories experience either no changes due to this final policy, or small (0.1 percent) increases or decreases. Urban hospitals in the West South Central census division (which includes Texas) have a 0.3 percent increase. Hospitals in the Pacific division (which includes California) have a decrease of 0.2 percent overall in their wage index.

The MSA with the greatest increase due to this change is Galveston-Texas City, TX. Although hospitals in this MSA experience a drop in their wage index due to the use of FY 1995 data, much of that decrease is recovered by a 12 percent increase resulting from the inclusion of contract physician Part A costs. Two California MSAs experience increases in their wage indexes of at least 1.0 percent: Stockton-Lodi and Fresno.

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

Prior years' wage index calculations have removed the direct wages and hours associated with certain subprovider components excluded from the prospective payment system; however, the overhead costs associated with these excluded components have not been removed. We revised the FY 1995 cost report to allow hospitals to report separately overhead salaries and hours, and for the FY 1999 wage index we are removing the overhead costs and hours allocated to areas of the hospital excluded from the wage index calculation.

Column 5 displays the impacts on FY 1999 payments per case of implementing this change. The overall payment impact is 0.0 percent; however, the impact diverges along urban and rural lines. Urban hospitals lose 0.1 percent as a result of removing these overhead costs, while rural hospitals gain 0.4 percent.

Hospitals in the rural West North Central census division experience the largest percentage increase (0.7 percent). All the rural Statewide wage indexes increased in this census division, led by Minnesota (3.2 percent) and South Dakota (2.4 percent).

The combined wage index changes in Table I are determined by summing the individual impacts in columns 3, 4, and 5. For example, the rural West North Central census division gains 0.9 percent from the new wage data, and 0.7 percent from removing the overhead costs allocated to

excluded areas. Therefore, the combined impact of the FY 1999 wage index for these hospitals is a 1.6 percent increase.

The following chart compares the shifts in wage index values for labor market areas for FY 1999 relative to FY 1998. This chart demonstrates the impact of the changes for the FY 1999 wage index relative to the FY 1998 wage index. The majority of labor market areas (305) experience less than a 5 percent change. A total of 38 labor market areas experience an increase of more than 5 percent, with 9 having an increase greater than 10 percent. A total of 28 areas (all urban) experience decreases of more than 5 percent, although, of those, all decline by less than 10 percent.

Percentage change in area wage index values	Number of labor market areas	
	FY 1998	FY 1999
Increase more than 10 percent	2	9
Increase more than 5 percent and less than 10 percent	24	29
Increase or decrease less than 5 percent	334	305
Decrease more than 5 percent and less than 10 percent	9	28
Decrease more than 10 percent	1	0

Among urban hospitals, 129 would experience an increase of more than 5 percent and 23 more than 10 percent. More rural hospitals have increases greater than 5 percent (355), but none greater than 10 percent. On the negative side, 186 urban hospitals but no rural hospitals have decreases in their wage index values of at least 5 percent (none have decreases greater than 10 percent). The following chart shows the impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	23	0
Increase more than 5 percent and less than 10 percent	129	355
Increase or decrease less than 5 percent	2472	1810
Decrease more than 5 percent and less than 10 percent	186	0
Decrease more than 10 percent	0	0

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

The impact of DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this final rule, we compared aggregate payments using the FY 1998 DRG relative weights and wage index to aggregate payments using the FY 1999 DRG relative weights and wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.999006. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 6. The 0.0 percent impact for All Hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral.

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

H. Impact of MGCRB Reclassifications (Column 7)

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

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

The FY 1999 final wage index values incorporate all of the MGCRB's reclassification decisions for FY 1999. The wage index values also reflect all decisions made by the HCFA 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 0.993433 to ensure that the effects of reclassification are budget neutral. (See section II.A.4 of the Addendum to this final rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.7 percent, while 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 all rural hospital groups except the smallest hospitals (under 50 beds), which experience no payment impact overall. The smallest increase among the rural census divisions is 1.4 percent for New England. The largest increase is in rural South Atlantic, with an increase of 3.8 percent.

Among rural hospitals designated as RRCs, 116 hospitals are reclassified for purposes of the wage index only, leading to the 6.4 percent increase in payments among RRCs overall. This positive impact on RRCs is also reflected in the category of rural hospitals with 200 or more beds, which has a 5.3 percent increase in payments.

Rural hospitals reclassified for FY 1998 and FY 1999 experience a 8.3 percent increase in payments. This may be due to the fact that these hospitals have the most to gain from reclassification and have been reclassified for a period of years. Rural hospitals reclassified for FY 1999 only experience a 5.1 percent increase in payments, while rural hospitals reclassified for FY 1998 only experience a 0.5 percent decrease in payments. Urban hospitals reclassified for FY 1998 but not FY 1999 experience a 0.7 percent decline in payments overall. Urban hospitals reclassified for FY 1999 but not for FY 1998 experience a 4.6 percent increase in payments.

The FY 1999 Reclassification rows of Table I show the changes in payments per case for all FY 1999 reclassified and nonreclassified hospitals in urban and rural locations for each of the three reclassification categories (standardized amount only, wage index only, or both). The table illustrates that the largest impact for reclassified rural hospitals is for those hospitals reclassified for both the standardized amount and the wage index. These hospitals receive a 10.0 percent increase in payments. In addition, rural hospitals reclassified just for the wage index receive a 6.9 percent payment increase. The overall impact on reclassified hospitals is to increase their payments per case by an average of 6.2 percent for FY 1999.

Among the 27 rural hospitals deemed to be urban under section 1886(d)(8)(B) of the Act, payments increase 1.0 percent due to MGCRB reclassification. This is because, although these hospitals are treated as being attached to an urban area in our baseline (their redesignation is ongoing, rather than annual like the MGCRB reclassifications), they are eligible for MGCRB reclassification. For FY 1999, one hospital in this category reclassified to a large urban area.

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

The number of reclassifications for purposes of the standardized amount, or for

both the standardized amount and the wage index, has decreased from 149 in FY 1998 to 141 in FY 1999. The number of wage index only reclassifications decreased from 284 in FY 1998 to 281 in FY 1999.

I. All Changes (Column 8)

Column 8 compares our estimate of payments per case, incorporating all changes reflected in this final rule for FY 1999 (including statutory changes), to our estimate of payments per case in FY 1998. It includes the effects of the 0.5 percent update to the standardized amounts and the hospital-specific rates for SCHs and MDHs. It also reflects the 0.3 percentage point difference between the projected outlier payments in FY 1999 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 1998 (5.4 percent), as described in the introduction to this Appendix and the Addendum to this final rule.

Additional changes affecting the difference between FY 1998 and FY 1999 payments are the reductions to the IME and DSH adjustments enacted by the BBA. These changes initially went into effect during FY 1998 and include additional decreases in payment for each of several succeeding years. As noted in the introduction to this impact analysis, for FY 1999, IME is reduced to approximately a 6.5 percent rate of increase, and DSH is reduced by 2 percent from what hospitals otherwise would receive. We estimate the overall effect of these statutory changes to be a 0.5 percent reduction in FY 1999 payments relative to FY 1998. For hospitals receiving both IME and DSH, the impact is estimated to be a 0.9 percent reduction in payments per case.

Column 8 also includes the impacts of FY 1999 MGCRB reclassifications compared to the payment impacts of FY 1998 reclassifications. Therefore, when comparing FY 1999 payments to FY 1998, the percent changes due to FY 1999 reclassifications shown in column 7 need to be offset by the effects of reclassification on hospitals' FY 1998 payments (column 7 of Table 1, August 29, 1997 final rule with comment period; 62 FR 46119). For example, the impact of MGCRB reclassifications on rural hospitals' FY 1998 payments was approximately a 2.2 percent increase, offsetting much of the 2.7 percent increase in column 7 for FY 1999. Therefore, the net change in FY 1999 payments due to reclassification for rural hospitals is actually closer to an increase of 0.5 percent relative to FY 1998. However, last year's analysis contained a somewhat different set of hospitals, so this might affect the numbers slightly.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 8 may not equal the sum of the changes in columns 1, 6, and 7, plus the other impacts that we are able to identify.

The overall payment change from FY 1998 to FY 1999 for all hospitals is a 1.0 percent decrease. This reflects the 0.6 percent net change in total payments due to the postacute transfer change for FY 1999 shown in column 1; the 0.5 percent update for FY 1999, the 0.3 percent lower outlier payments in FY 1999 compared to FY 1998 (5.1 percent compared to 5.4 percent); and the 0.5 percent reduction due to lower IME and DSH payments.

Hospitals in urban areas experience a 1.3 percent drop in payments per case compared to FY 1998. Urban hospitals lose 0.9 percent due to the combined effects of the expanded transfer definition and the DRG and wage index changes. The 0.4 percent negative impact due to reclassification is offset by an identical negative impact for FY 1998. The impact of reducing IME and DSH is a 0.5 percent reduction in FY 1999 payments per case. Most of this negative impact is incurred by hospitals in large urban areas, where payments are expected to fall 1.7 percent per case compared to 0.7 percent per case for hospitals in other urban areas.

Hospitals in rural areas, meanwhile, experience a 1.3 percent payment increase. As discussed previously, this is primarily due to a smaller negative impact due to the expanded transfer definition (0.4 percent decrease compared to 0.6 percent nationally) and the positive effect due to the wage index and DRG changes (1.0 percent increase).

Among census divisions, urban New England displays the largest negative impact, 2.6 percent. This outcome is primarily related to the 1.1 percent decrease due to the new wage data. Similarly, urban East North Central experiences a 2.2 percent drop in payments per case, due to a 0.9 percent drop due to the combined wage index and DRG changes. The urban Pacific and the urban West South Central also experience overall larger payment declines, with 2.0 and 1.6 percent decreases, respectively. The urban West North Central has the smallest negative change among urban census divisions (0.1 percent), stemming primarily from a 1.0 percent increase due to the DRG and wage index changes. Hospitals in this census division also are less reliant on IME and DSH funding, and are, therefore, impacted less by these reductions.

The only rural census division to experience a negative payment impact is New England (0.3 percent decrease). This appears to result from a much smaller reclassification effect for rural New England hospitals in FY 1999. For FY 1998, the impact of MGCRB reclassification for these hospitals was a 2.1 percent increase (see 62 FR 46119). For FY 1999, the increase is only 1.4 percent. The largest increases by a rural census division are in the South Atlantic and the East South Central, with 1.8 and 1.7 percent increases, respectively. In the South Atlantic, this is primarily due to a larger FY 1999 benefit from MGCRB reclassifications. For the East South Central, it is largely due to a 1.3 percent increase from the FY 1995 wage data.

Among special categories of rural hospitals, RRCs have the largest increase, 2.2 percent. This carries over to other categories as well: rural hospitals with between 150 and 200 beds have a 2.5 percent rise in payments (there are 37 RRCs in this category); and RRCs receiving DSH see a 2.5 percent increase.

The largest negative payment impacts from FY 1998 to FY 1999 are among hospitals that were reclassified for FY 1998 and are not reclassified for FY 1999. Overall, these hospitals lose 3.6 percent. The urban hospitals in this category lose 2.9 percent, while the rural hospitals lose 5.9 percent. On the other hand, hospitals reclassified for FY 1999 that were not reclassified for FY 1998 would experience the greatest payment increases: 5.4 percent overall; 6.3 percent for 155 rural hospitals; and 2.3 percent for 15 urban hospitals.

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

[Payments per case]

	Number of hospitals (1)	Average FY 1998 payment per case (2) [1]	Average FY 1999 payment per case (3) [1]	All changes (4)
(BY GEOGRAPHIC LOCATION):				
ALL HOSPITALS	4,975	6,773	6,707	−1.0
URBAN HOSPITALS	2,810	7,342	7,246	−1.3
LARGE URBAN AREAS	1,611	7,891	7,758	−1.7
OTHER URBAN AREAS	1,199	6,589	6,544	−0.7
RURAL AREAS	2,165	4,460	4,517	1.3
BED SIZE (URBAN):				
0–99 BEDS	704	4,931	4,889	−0.9
100–199 BEDS	937	6,128	6,056	−1.2
200–299 BEDS	568	6,934	6,851	−1.2

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

[Payments per case]

	Number of hospitals	Average FY 1998 payment per case	Average FY 1999 payment per case	All changes
	(1)	(2) [1]	(3) [1]	(4)
300–499 BEDS	449	7,846	7,738	−1.4
500 OR MORE BEDS	152	9,743	9,592	−1.6
BED SIZE (RURAL):				
0–49 BEDS	1,137	3,665	3,701	1.0
50–99 BEDS	634	4,176	4,207	0.8
100–149 BEDS	229	4,613	4,662	1.1
150–199 BEDS	91	4,776	4,895	2.5
200 OR MORE BEDS	74	5,610	5,704	1.7
URBAN BY CENSUS DIV:				
NEW ENGLAND	152	7,887	7,682	−2.6
MIDDLE ATLANTIC	425	8,181	8,107	−0.9
SOUTH ATLANTIC	414	6,978	6,948	−0.4
EAST NORTH CENTRAL	476	7,029	6,873	−2.2
EAST SOUTH CENTRAL	162	6,569	6,524	−0.7
	(1)	(2) [1]	(3) [1]	(4)
WEST NORTH CENTRAL	189	7,001	6,996	−0.1
WEST SOUTH CENTRAL	354	6,830	6,720	−1.6
MOUNTAIN	129	7,046	6,971	−1.1
PACIFIC	461	8,409	8,245	−2.0
PUERTO RICO	48	3,065	3,056	−0.3
RURAL BY CENSUS DIV:				
NEW ENGLAND	53	5,305	5,287	−0.3
MIDDLE ATLANTIC	80	4,818	4,881	1.3
SOUTH ATLANTIC	286	4,610	4,694	1.8
EAST NORTH CENTRAL	285	4,496	4,553	1.3
EAST SOUTH CENTRAL	269	4,162	4,235	1.7
WEST NORTH CENTRAL	500	4,178	4,236	1.4
WEST SOUTH CENTRAL	342	3,991	4,017	0.7
MOUNTAIN	204	4,750	4,779	0.6
PACIFIC	141	5,608	5,647	0.7
PUERTO RICO	5	2,374	2,370	−0.2
(BY PAYMENT CATEGORIES):				
URBAN HOSPITALS	2,894	7,299	7,207	−1.3
LARGE URBAN AREAS	1,698	7,798	7,670	−1.6
OTHER URBAN AREAS	1,196	6,570	6,530	−0.6
RURAL AREAS	2,081	4,444	4,494	1.1
TEACHING STATUS:				
NON-TEACHING	3,880	5,468	5,450	−0.3
FEWER THAN 100 RESIDENTS	854	7,228	7,145	−1.1
100 OR MORE RESIDENTS	241	10,974	10,755	−2.0
DISPROPORTIONATE SHARE HOSPITALS (DSH):				
NON-DSH	3,089	5,837	5,799	−0.6
URBAN DSH:				
100 BEDS OR MORE	1,404	7,951	7,843	−1.4
FEWER THAN 100 BEDS	88	5,068	5,007	−1.2
	(1)	(2) [1]	(3) [1]	(4)
RURAL DSH:				
SOLE COMMUNITY (SCH)	162	4,211	4,251	1.0
REFERRAL CENTERS (RRC)	53	5,294	5,428	2.5
OTHER RURAL DSH HOSP:				
100 BEDS OR MORE	60	4,134	4,162	0.7
FEWER THAN 100 BEDS	119	3,553	3,600	1.3
URBAN TEACHING AND DSH:				
BOTH TEACHING AND DSH	709	8,975	8,828	−1.6
TEACHING AND NO DSH	331	7,384	7,291	−1.3
NO TEACHING AND DSH	783	6,318	6,271	−0.7
NO TEACHING AND NO DSH	1,071	5,664	5,612	−0.9
SPECIAL UPDATE HOSPITALS (UNDER SEC. 4401(b) OF PUBLIC LAW 105–33	344	5,276	5,236	−0.8
RURAL HOSPITAL TYPES:				
NONSPECIAL STATUS HOSPITALS	888	3,920	3,947	0.7
RRC	145	5,170	5,286	2.2
SCH	637	4,484	4,502	0.4

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

[Payments per case]

	Number of hospitals	Average FY 1998 payment per case	Average FY 1999 payment per case	All changes
	(1)	(2) [1]	(3) [1]	(4)
MDH	352	3,715	3,753	1.0
SCH AND RRC	59	5,339	5,402	1.2
TYPE OF OWNERSHIP:				
VOLUNTARY	2,858	6,956	6,884	−1.0
PROPRIETARY	671	6,160	6,096	−1.0
GOVERNMENT	1,331	6,243	6,209	−0.5
UNKNOWN	115	7,894	7,811	−1.0
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:				
0–25	247	8,931	8,755	−2.0
25–50	1,264	8,254	8,127	−1.5
50–65	1,978	6,170	6,134	−0.6
OVER 65	1,371	5,253	5,241	−0.2
UNKNOWN	115	7,894	7,811	−1.0
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:				
RECLASSIFICATION STATUS DURING FY98 AND FY99:				
RECLASSIFIED DURING BOTH FY98 AND FY99	315	5,971	5,944	−0.5
URBAN	72	7,376	7,302	−1.0
RURAL	243	5,258	5,254	−0.1
RECLASSIFIED DURING FY99 ONLY	170	5,149	5,427	5.4
URBAN	15	8,019	8,207	2.3
RURAL	155	4,668	4,960	6.3
RECLASSIFIED DURING FY98 ONLY	126	6,310	6,084	−3.6
URBAN	53	7,218	7,011	−2.9
RURAL	73	4,453	4,188	−5.9
FY 99 RECLASSIFICATIONS:				
ALL RECLASSIFIED HOSP	485	5,683	5,763	1.4
STAND. AMT. ONLY	94	5,940	5,899	−0.7
WAGE INDEX ONLY	281	6,007	5,935	−1.2
BOTH	47	6,407	6,264	−2.2
NONRECLASS	4,526	6,851	6,786	−0.9
ALL URBAN RECLASS	87	7,497	7,472	−0.3
STAND. AMT. ONLY	26	5,630	5,635	0.1
WAGE INDEX ONLY	40	8,874	8,872	0.0
BOTH	21	6,810	6,725	−1.3
NONRECLASS	2,696	7,348	7,249	−1.3
ALL RURAL RECLASS	398	5,016	5,134	2.4
STAND. AMT. ONLY	55	4,374	4,494	2.7
WAGE INDEX ONLY	314	5,083	5,194	2.2
BOTH	29	5,039	5,231	3.8
NONRECLASS	1,767	4,109	4,127	0.4
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	27	4,765	4,714	−1.1

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

Table II presents the projected impact on payments per case of the final changes for FY 1999 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the projected payments per case for FY 1999 with the average estimated per case payments for FY 1998, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 8 of Table I.

VIII. Impact of Changes in the Capital Prospective Payment System

A. General Considerations

We now have data that were unavailable in previous impact analyses for the capital prospective payment system. Specifically, we have cost report data available for the fourth year of the capital prospective payment system (cost reports beginning in FY 1995) available through the March 1998 update of the Health Care Provider Cost Report Information System (HCRIS). We also have updated information on the projected aggregate amount of obligated capital approved by the fiscal intermediaries. However, our impact analysis of payment changes for capital-related costs is still limited by the lack of hospital-specific data on several items. These are the hospital's projected new capital costs for each year, its projected old capital costs for each year, and the actual amounts of obligated capital that will be put in use for patient care and recognized as Medicare old capital costs in each year. The lack of this information affects our impact analysis in the following ways:

- Major investment in hospital capital assets (for example in building and major fixed equipment) occurs at irregular intervals. As a result, there can be significant variation in the growth rates of Medicare capital-related costs per case among hospitals. We do not have the necessary hospital-specific budget data to project the hospital capital growth rate for individual hospitals.
- Moreover, our policy of recognizing certain obligated capital as old capital makes it difficult to project future capital-related costs for individual hospitals. Under § 412.302(c), a hospital is required to notify

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

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

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

1. Assumptions

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

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

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

AVERAGE PERCENTAGE CHANGE IN CAPITAL COSTS PER DISCHARGE

Fiscal year	Percentage change
1997	−3.02
1998	−0.46
1999	0.61

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

- The Medicare case-mix index will increase by 1.0 percent in FY 1998 and FY 1999.
- The Federal capital rate and hospital-specific rate were updated in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs, and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The final FY 1999 update for inflation is 0.10 percent (see section IV of the Addendum).

2. Results

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

CAPITAL TRANSITION PAYMENT METHODOLOGY FOR FY 1999

Type of hospital	Percent of hospitals	Percent of discharges	Percent of capital costs	Percent of capital payments
Low Cost Hospital	66	62	53	58
High Cost Hospital	34	38	47	42

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

Assuming no behavioral changes in capital expenditures, Table III displays the percentage change in payments from FY 1998 to FY 1999 using the above described actuarial model. With the final Federal rate, we estimate aggregate Medicare capital payments will increase by 2.78 percent in FY 1999.

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

	Number of hospitals	Discharges	Adjusted Federal payment	Average Federal percent	Hospital specific payment	Hold harmless payment	Exceptions payment	Total payment	Percent change over FY 1998
FY 1998 Payments per Discharge:									
Low Cost Hospitals	3,258	6,777,970	$458.00	72.42	$86.30	$3.85	$8.89	$557.04	.....
Fully Prospective	3,024	6,149,617	441.23	70.00	95.12	.....	7.61	543.95	.....
100% Federal Rate	204	554,222	650.05	100.00	.....	17.77	667.82	.....	
Hold Harmless	30	74,130	413.10	61.17	.....	351.63	49.36	814.09	.....
High Cost Hospitals	1,643	4,203,327	635.31	95.72	.....	37.11	15.30	687.72	.....
100% Federal Rate	1,415	3,748,353	660.94	100.00	.....	.....	10.62	671.56	.....
Hold Harmless	228	454,974	424.09	61.78	.....	342.86	53.86	820.81	.....
Total Hospitals	4,901	10,981,297	525.87	81.61	53.27	16.58	11.35	607.06	.....
FY 1999 Payments per Discharge:									
Low Cost Hospitals	3,258	6,626,732	527.01	81.53	58.33	3.13	9.57	598.04	7.36
Fully Prospective	3,024	6,012,484	515.37	80.00	64.29	.....	8.28	587.94	8.09
100% Federal Rate	207	545,059	663.77	100.00	.....	.....	17.97	681.75	2.09
Hold Harmless	27	69,188	460.62	66.21	.....	300.02	55.73	816.37	0.28
High Cost Hospitals	1,643	4,107,081	656.33	96.98	.....	26.89	20.02	703.24	2.26
100% Federal Rate	1,438	3,730,929	674.49	100.00	.....	.....	14.16	688.65	2.54
Hold Harmless	205	376,151	476.26	68.09	.....	293.59	78.14	847.99	3.31
Total Hospitals	4,901	10,733,812	576.49	87.61	36.01	12.22	13.57	638.29	5.15

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 7.36 percent, and high capital cost hospitals will experience an average increase of 2.26 percent.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 70 percent to 80 percent and the hospital-specific rate payment percentage will decrease from 30 to 20 percent in FY 1999. The Federal rate payment percentage for hospitals paid under the hold-harmless payment methodology is based on the hospital's ratio of new capital costs to total capital costs. The average Federal rate payment percentage for high cost hospitals receiving a hold-harmless payment for old capital will increase from 61.78 percent to 68.09 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 86.3 percent to 87.6 percent. We estimate that high cost hold-harmless hospitals will experience an increase in payments of 3.31 per cent from FY 1998 to FY 1999. This is different from our projection in the proposed rule, which projected a decrease in payments. This change is a result of lower projected capital costs, which means some hospitals who otherwise would have been paid hold-harmless will now receive 100 percent of the federal rate. Since these are the lowest cost hospitals in the hold-harmless grouping, removing these hospitals from the mix increased the average projected hold-harmless payment and, consequently, the average projected total payment.

We expect that the average hospital-specific rate payment per discharge will decrease from $53.27 in FY 1998 to $36.01 in FY 1999. This is partly due to the decrease in the hospital-specific rate payment percentage from 30 percent in FY 1998 to 20 percent in FY 1999.

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

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

We estimate that exceptions payments will be 2.13 percent of the total capital payments in FY 1999. Since the August 29, 1997 final rule with comment period, we have reduced our estimates of capital cost per case based on more recent data. Although we still estimate that more hospitals will receive exceptions payment in FY 1999 than in FY 1998 fewer hospitals will have costs over the exceptions threshold then we previously estimated. The projected distribution of the eligible hospitals and exception payments is shown in the table below:

ESTIMATED FY 1999 EXCEPTIONS PAYMENTS

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	185	44
High Capital Cost	215	56
Total	400	100

C. Cross-Sectional Comparison of Capital Prospective Payment Methodologies

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

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

	(1) Total No. of Hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
By Geographic Location:				
All hospitals	4,901	4.7	33.6	61.7
Large urban areas (populations over 1 million)	1,574	5.4	41.1	53.5
Other urban areas (populations of 1 million of fewer)	1,178	5.4	41.6	53.0

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

	(1) Total No. of Hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
Rural areas	2,149	3.9	23.6	72.5
Urban hospitals	2,752	5.4	41.3	53.3
0–99 beds	656	5.3	34.8	59.9
100–199 beds	929	7.3	47.0	45.6
200–299 beds	567	5.5	41.4	53.1
300–499 beds	448	1.8	40.8	57.4
500 or more beds	152	4.6	35.5	59.9
Rural hospitals	2,149	3.9	23.6	72.5
0–49 beds	1,124	3.6	15.7	80.6
50–99 beds	632	4.6	28.5	66.9
100–149 beds	229	3.1	39.7	57.2
150–199 beds	90	5.6	26.7	67.8
200 or more beds	74	1.4	48.6	50.0
By Region:				
Urban by Region	2,752	5.4	41.3	53.3
New England	151	0.0	27.8	72.2
Middle Atlantic	421	5.0	33.3	61.8
South Atlantic	409	5.1	53.8	41.1
East North Central	472	4.7	31.4	64.0
East South Central	157	7.0	52.2	40.8
West North Central	183	6.6	36.1	57.4
West South Central	334	12.0	57.2	30.8
Mountain	125	4.8	52.0	43.2
Pacific	452	3.3	37.6	59.1
Puerto Rico	48	2.1	27.1	70.8
Rural by Region	2,149	3.9	23.6	72.5
New England	53	0.0	22.6	77.4
Middle Atlantic	79	5.1	24.1	70.9
South Atlantic	282	2.5	33.0	64.5
East North Central	283	3.2	19.1	77.7
East South Central	267	0.7	35.2	64.0
West North Central	498	3.4	16.3	80.3
West South Central	339	3.5	28.0	68.4
Mountain	203	11.3	14.3	74.4
Pacific	140	6.4	22.1	71.4
Large urban areas (populations over 1 million)	1,661	5.5	40.9	53.6
Other urban areas (populations of 1 million of fewer)	1,175	5.1	41.8	53.1
Rural areas	2,065	3.9	23.0	73.1
Teaching Status:				
Non-teaching	3,809	4.8	33.1	62.1
Fewer than 100 Residents	852	4.9	35.7	59.4
100 or more Residents	240	2.9	32.9	64.2
Disproportionate share hospitals (DSH):				
Non-DSH	3,030	5.1	29.2	65.6
Urban DSH:				
100 or more beds	1,398	4.6	44.1	51.3
Less than 100 beds	82	2.4	26.8	70.7
Rural DSH:				
Sole Community (SCH/EACH)	162	4.3	22.8	72.8
Referral Center (RRC/EACH)	53	3.8	49.1	47.2
Other Rural:				
100 or more beds	60	1.7	40.0	58.3
Less than 100 beds	116	0.0	28.4	71.6
Urban teaching and DSH:.				
Both teaching and DSH	707	3.8	36.8	59.4
Teaching and no DSH	330	6.1	32.1	61.8
No teaching and DSH	773	5.0	49.0	45.9
No teaching and no DSH	1,026	6.3	41.5	52.1
Rural Hospital Types:				
Non special status hospitals	875	1.7	24.2	74.1
RRC/EACH	145	1.4	39.3	59.3
SCH/EACH	636	8.8	19.5	71.7
Medicare-dependent hospitals (MDH)	350	0.9	18.0	81.1

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

	(1) Total No. of Hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
SCH, RRC and EACH	59	8.5	30.5	61.0
Type of Ownership:				
Voluntary	2,848	4.7	33.1	62.2
Proprietary	658	8.2	60.2	31.6
Government	1,329	3.2	21.1	75.6
Medicare Utilization as a Percent of Inpatient Days:				
0–25	237	3.8	32.1	64.1
25–50	1,259	5.3	41.5	53.1
50–65	1,972	5.3	33.4	61.4
Over 65	1,367	3.7	26.5	69.8

As we explain in Appendix B, we were not able to determine a hospital-specific rate for 74 of the 4,975 hospitals in our database. Consequently, the payment methodology distribution is based on 4,901 hospitals. These data should be fully representative of the payment methodologies that will be applicable to hospitals.

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

The percentage of hospitals paid fully Federal (100 percent of the Federal rate) as hold-harmless hospitals is expected to increase to 33.6 percent in FY 1999. We note that the number of hospitals paid fully Federal as hold-harmless hospitals has not increased as quickly as we predicted in the August 29, 1997 final rule with comment period because of revised estimates.

Table IV indicates that 61.7 percent of hospitals will be paid under the fully prospective payment methodology. (This figure, unlike the figure of 66 percent for low cost capital hospitals in the previous section, takes account of the effects of redeterminations. In other words, this figure does not include low cost hospitals that, following a hospital-specific rate redetermination, are now paid under the hold-harmless methodology.) As expected, a relatively higher percentage of rural and governmental hospitals (72.5 percent and 75.6 percent, respectively by payment classification) are being paid under the fully prospective methodology. This is a reflection of their lower than average capital costs per case. In contrast, only 31.6 percent of proprietary hospitals are being paid under the fully prospective methodology. This is a reflection of their higher than average capital costs per case. (We found at the time of the August 30, 1991 final rule (56 FR 43430) that 62.7 percent of proprietary hospitals had a capital cost per case above the national average cost per case.)

D. Cross-Sectional Analysis of Changes in Aggregate Payments

We used our FY 1999 actuarial model to estimate the potential impact of our final changes for FY 1999 on total capital payments per case, using a universe of 4,901 hospitals. The individual hospital payment parameters are taken from the best available data, including: the April 1, 1998 update to the provider-specific file, cost report data, and audit information supplied by intermediaries. In Table V we present the results of the cross-sectional analysis using the results of our actuarial model and the aggregate impact of the FY 1999 payment policies. Columns 3 and 4 show estimates of payments per case under our model for FY 1998 and FY 1999. Column 5 shows the total percentage change in payments from FY 1998 to FY 1999. Column 6 presents the percentage change in payments that can be attributed to Federal rate changes alone.

Federal rate changes represented in Column 6 include the 1.8 percent increase in the Federal rate, a 1.0 percent increase in case mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB. Column 5 includes the effects of the Federal rate changes represented in Column 6. Column 5 also reflects the effects of all other changes, including: the change from 70 percent to 80 percent in the portion of the Federal rate for fully prospective hospitals, the hospital-specific rate update, changes in the proportion of new to total capital for hold-harmless hospitals, changes in old capital (for example, obligated capital put in use), hospital-specific rate redeterminations, and exceptions. The comparisons are provided by: (1) Geographic location, (2) region, and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 5.1 percent in FY 1999. The results show that the effect of the Federal rate changes alone is to increase payments by 1.8 percent. In addition to the increase attributable to the Federal rate changes, a 3.3 percent increase is attributable to the effects of all other changes.

Our comparison by geographic location shows that urban and rural hospitals will experience slightly different rates of increase in capital payments per case (4.9 percent and 6.7 percent, respectively). This difference is due to the lower rate of increase for urban hospitals relative to rural hospitals (1.6 percent and 3.4 percent, respectively) from the Federal rate changes alone. Urban hospitals will gain approximately the same as rural hospitals (3.3 percent for both) from the effects of all other changes.

All regions are estimated to receive increases in total capital payments per case, partly due to the increased share of payments that are based on the Federal rate (from 70 to 80 percent). Changes by region vary from a low of 4.0 percent increase (West South Central urban region) to a high of 8.6 percent increase (Middle Atlantinc Rural Region).

By type of ownership, government hospitals are projected to have the largest rate of increase (6.6 percent, 2.2 percent due to Federal rate changes and 4.4 percent from the effects of all other changes). Payments to voluntary hospitals will increase 5.2 percent (a 1.8 percent increase due to Federal rate changes and a 3.4 percent increase from the effects of all other changes) and payments to proprietary hospitals will increase 3.1 percent (a 1.5 percent increase due to Federal rate changes and a 1.6 percent increase from the effects of all other changes).

Section 1886(d)(10) of the Act established the MGCRB. Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both and for purposes of DSH, for FY 1999–2001. Although the Federal capital rate is not affected, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. Reclassification for wage index purposes affects the geographic adjustment factor since that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 1999 compared to the effects of reclassification for FY 1998, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 1999 reclassifications, we indicate those hospitals reclassified for standardized amount purposes only, for wage index purposes only, and for both purposes. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 1999 as a whole are projected to experience a 7.1 percent increase in payments (a 3.8 percent increase attributable to Federal rate changes and a 3.3 percent increase attributable to the effects of all other changes). Payments to nonreclassified hospitals will increase slightly less (6.2 percent) than reclassified hospitals (7.1 percent) overall. Payments to nonreclassified hospitals will increase less than reclassified hospitals from the Federal rate changes (1.9 percent compared to 3.8 percent), but they will gain about the same from the effects of all other changes (3.3 percent for both).

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 1998 Payments Compared to FY 1999 Payments]

	Number of hospitals	Average FY 1998 payments/case	Average FY 1999 payments/case	All changes	Portion attributable to Federal rate change
By Geographic Location:					
All hospitals	4,901	607	638	5.1	1.8
Large urban areas (populations over 1 million)	1,574	700	733	4.7	1.4
Other urban areas (populations of 1 million or fewer).	1,178	596	628	5.3	1.9
Rural areas	2,149	406	433	6.7	3.4
Urban hospitals	2,752	656	688	4.9	1.6
0–99 beds	656	482	502	4.3	1.5
100–199 beds	929	581	606	4.4	1.5
200–299 beds	567	626	655	4.8	1.6
300–499 beds	448	682	718	5.4	1.6
500 or more beds	152	830	872	5.1	1.6
Rural hospitals	2,149	406	433	6.7	3.4
0–49 beds	1,124	323	346	7.2	3.0
50–99 beds	632	389	413	6.2	2.8
100–149 beds	229	423	450	6.4	3.2
150–199 beds	90	437	468	7.2	4.2
200 or more beds	74	499	534	7.0	4.1
By Region:					
Urban by Region	2,752	656	688	4.9	1.6
New England	151	663	700	5.7	0.9
Middle Atlantic	421	711	747	5.1	2.0
South Atlantic	409	642	674	5.0	2.3
East North Central	472	615	646	4.9	0.9
East South Central	157	602	626	4.0	1.4
West North Central	183	638	677	6.1	2.6
West South Central	334	664	691	4.0	1.2
Mountain	125	684	715	4.6	1.5
Pacific	452	717	752	4.9	1.1
Puerto Rico	48	272	286	5.5	2.6
Rural by Region	2,149	406	433	6.7	3.4
New England	53	474	505	6.3	2.4
Middle Atlantic	79	427	463	8.6	3.9
South Atlantic	282	437	467	7.0	3.7
East North Central	283	402	431	7.2	3.5
East South Central	267	376	400	6.3	3.5
West North Central	498	387	410	6.0	3.4
West South Central	339	372	394	6.1	2.8
Mountain	203	421	442	4.9	2.3
Pacific	140	466	501	7.3	3.0
By Payment Classification:					
All hospitals	4,901	607	638	5.1	1.8
Large urban areas (populations over 1 million)	1,661	693	725	4.7	1.4
Other urban areas (populations of 1 million or fewer).	1,175	594	626	5.4	2.0
Rural areas	2,065	404	430	6.5	3.2
Teaching Status:					
Non-teaching	3,809	513	538	4.9	2.0
Fewer than 100 Residents	852	643	678	5.5	1.7
100 or more Residents	240	897	944	5.2	1.5
Urban DSH:					
100 or more beds	1,398	690	725	5.0	1.6
Less than 100 beds	82	457	475	3.9	1.0
Rural DSH:					
Sole Community (SCH/EACH)	162	362	379	4.7	2.7
Referral Center (RRC/EACH)	53	472	507	7.4	4.6
Other Rural:					
100 or more beds	60	378	397	5.1	2.8
Less than 100 beds	116	318	339	6.5	3.4

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

[FY 1998 Payments Compared to FY 1999 Payments]

	Number of hospitals	Average FY 1998 payments/case	Average FY 1999 payments/case	All changes	Portion attributable to Federal rate change
Urban teaching and DSH:					
Both teaching and DSH	707	759	799	5.2	1.6
Teaching and no DSH	330	662	701	5.8	1.6
No teaching and DSH	773	580	607	4.7	1.8
No teaching and no DSH	1,026	554	576	3.9	1.6
Rural Hospital Types:					
Nonspecial status hospitals	875	368	391	6.1	2.7
RRC/EACH	145	469	503	7.3	4.3
SCH/EACH	636	390	412	5.9	2.3
Medicare-dependent hospitals (MDH)	350	323	352	9.0	3.7
SCH, RRC and EACH	59	499	526	5.5	3.2
Hospitals Reclassified by the Medicare Geographic Classification:					
Review Board:					
Reclassification Status During FY98 and FY99:					
Reclassified During Both FY98 and FY99	315	541	568	5.0	1.9
Reclassified During FY99 Only	170	466	521	11.8	7.8
Reclassified During FY98 Only	106	598	607	1.6	−1.4
FY99 Reclassifications:					
All Reclassified Hospitals	485	515	551	7.1	3.8
All Nonreclassified Hospitals	4,453	613	645	5.2	1.9
All Urban Reclassified Hospitals	87	651	695	6.7	2.3
Urban Nonreclassified Hospitals	2,638	657	689	4.9	1.6
All Reclassified Rural Hospitals	398	464	498	7.4	4.5
Rural Nonreclassified Hospitals	1,751	369	392	6.1	2.4
Other Reclassified Hospitals (Section 1886(D)(8)(B))	27	470	492	4.6	1.3
Type of Ownership:					
Voluntary	2,848	621	654	5.2	1.8
Proprietary	658	612	631	3.1	1.5
Government	1,329	530	566	6.6	2.2
Medicare Utilization as a Percent of Inpatient Days:					
0–25	237	687	736	7.2	1.2
25–50	1,259	726	761	4.7	1.5
50–65	1,972	561	591	5.3	2.0

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

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

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

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

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

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

Source	Number of hospitals
Provider-Specific File Only	118
Provider-Specific and Audit File	4,857
Total	4,975

Ninety-seven of the 4,975 hospitals had unusable or missing data or had no cost reports available. We determined from the cost reports that 23 of the 97 hospitals were paid under the hold-harmless methodology. Since the hospital-specific amount is not used to determine payments for these hospitals, we were able to include these 23 hospitals in the analysis. We used the cost report data of 4,901 hospitals for the analysis. Seventy-four hospitals could not be used in the analysis because of insufficient information. These hospitals account for approximately 0.3 percent of admissions, therefore, any effects from the elimination of their cost report data should be minimal.

We analyzed changes in capital-related costs (depreciation, interest, rent, leases, insurance, and taxes) reported in the cost reports. We found a wide variance among hospitals in the growth of these costs. For hospitals with more than 100 beds, the distribution and mean of these cost increases were different for large changes in bed-size

(greater than +20 percent). We also analyzed changes in the growth in old capital and new capital for cost reports that provided this information. For old capital, we limited the analysis to decreases in old capital. We did this since the opportunity for most hospitals to treat ''obligated'' capital put into service as old capital has expired. Old capital costs should, therefore, decrease as assets become fully depreciated, and as interest costs decrease as the loan is amortized.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

To determine the factors for FY 1999, we first determined the portions of the Federal national and Puerto Rico rates that would be paid for each hospital in FY 1999 based on its applicable payment methodology. Using our model, we then compared, separately for the national rate and the Puerto Rico rate, estimated aggregate Federal rate payments based on the FY 1998 DRG relative weights and the FY 1998 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 1998 relative weights and the FY 1999 geographic adjustment factor. In making the comparison, we held the FY 1999 Federal rate portion constant and set the other budget neutrality adjustment factor and the exceptions reduction factor to 1.00. We determined that, to achieve budget neutrality for the changes in the national geographic adjustment factor, an incremental budget neutrality adjustment of 0.99930 for FY 1999 should be applied to the previous cumulative FY 1998 adjustment of 1.00015, yielding a cumulative adjustment of 0.99945 through FY 1999. Since this is the first adjustment for Puerto Rico, the incremental and cumulative adjustment for Puerto Rico would be 0.99883 through FY

1999. We apply these new adjustments, then compare estimated aggregate Federal rate payments based on the FY 1998 DRG relative weights and the FY 1999 geographic adjustment factors to estimated aggregate Federal rate payments based on the FY 1999 DRG relative weights and the FY 1999 geographic adjustment factors. The incremental adjustment for DRG classifications and changes in relative weights would be 1.00336 nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the geographic adjustment factors through 1999 would be 1.00281 nationally, and 1.00219 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

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

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG reclassifications and recalibration	Combined	
1992	.....	.....	.....	1.00000	.....	.....	.....	.....
1993	.....	.....	0.99800	0.99800	.....	.....	.....	.....
1994	.....	.....	1.00531	1.00330	.....	.....	.....	.....
1995	.....	.....	0.99980	1.00310	.....	.....	.....	.....
1996	.....	.....	0.99940	1.00250	.....	.....	.....	.....
1997	.....	.....	0.99873	1.00123	.....	.....	.....	.....
1998	.....	.....	0.99892	1.00015	.....	.....	.....	1.00000
1999	0.99930	1.00336	1.00266	1.00281	0.99883	1.00336	1.00219	1.00219

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

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

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

In the August 30, 1991 final rule (56 FR 43517), we indicated that we would publish each year the estimated payment factors generated by the model to determine payments for the next 5 years. The table below provides the actual factors for fiscal years 1992 through 1999, and the estimated factors that would be applicable through FY 2003. We caution that these are estimates for fiscal years 2000 and later, and are subject to revisions resulting from continued methodological refinements, receipt of additional data, and changes in payment policy changes. We note that in making these projections, we have assumed that the cumulative national DRG/GAF budget neutrality adjustment factor will remain at 1.00281 (1.00219 for Puerto Rico) for FY 1999 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 1999.

The projections are as follows:

Fiscal year	Update factor	Exceptions reduction factor	Budget neutrality factor	DRG/GAF adjustment factor [1]	Outlier adjustment factor	Federal rate adjustment	Federal rate (after outlier reduction)
1992	N/A	0.9813	0.9602		.9497		415.59
1993	6.07	.9756	.9162	.9980	.9496		417.29
1994	3.04	.9485	.8947	1.0053	.9454	[2] .9260	378.34
1995	3.44	.9734	.8432	.9998	.9414		376.83
1996	1.20	.9849	N/A	.9994	.9536	[3] .9972	461.96
1997	0.70	.9358	N/A	.9987	.9481		438.92
1998	0.90	.9659	N/A	.9989	.9382	[4] .8222	371.51
1999	0.10	.9783	N/A	1.0027	.9392		378.05
2000	0.70	.9763	N/A	[5] 1.0000	[5] .9392		379.92
2001	0.70	.9735	N/A	1.0000	.9392		381.48
2002	0.70	[6] 1.0000	N/A	1.0000	.9392		394.61
2003	0.80	[6] 1.0000	N/A	1.0000	.9392	[4] 1.0255	407.92

[1] Note: The incremental change over the previous year.
[2] Note: OBRA 1993 adjustment.

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

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

I. Background

Several provisions of the Act address the setting of update factors for inpatient services furnished in FY 1999 by hospitals subject to the prospective payment system and those excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XIV) of the Act sets the FY 1999 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 1.9 percent for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 1999 percentage increase in the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act, that is, the same update factor as all other hospitals subject to the prospective payment system, or the rate of increase in the market basket minus 1.9 percentage points. Under section 1886(b)(3)(B)(ii)(VII) of the Act, the FY 1999 percentage increase in the rate of increase limits for hospitals excluded from the prospective payment system can range from the rate of increase in the excluded hospital market basket to zero, depending on the hospital's costs in relation to its limit for the most recent cost reporting period for which information is available.

In accordance with section 1886(d)(3)(A) of the Act, we are updating the standardized amounts, the hospital-specific rates, and the rate-of-increase limits for hospitals excluded from the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the second quarter 1998 forecast of the FY 1999 market basket increase of 2.4 percent for hospitals subject to the prospective payment system, the updates in the standardized amounts are 0.5 percent for hospitals in both large urban and other areas. The update in the hospital-specific rate applicable to sole community and Medicare-dependent, small rural hospitals is also 0.5 percent. The update for hospitals excluded from the prospective payment system can be as high as the percentage increase in the excluded hospital market basket (currently estimated at 2.4 percent) or as low as zero, depending on the hospital's costs in relation to its rate-of-increase limit. (See section V of the addendum to this final rule.)

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In its March 1, 1998 report, MedPAC stated that, although a somewhat lower update could be justified in light of changes in the utilization and provision of hospital inpatient care, the legislated update of the market basket increase minus 1.9 percentage points will provide a reasonable level of payments to hospitals.

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 1999 update factors recommended by the Secretary as Appendix D of the May 8, 1998 proposed rule (63 FR 25704).

II. Secretary's Final Recommendations

We received two comments concerning our proposed recommendations, neither of which took issue with the update recommendation itself. Therefore, our final recommendations for the operating update for both prospective and excluded hospitals do not differ from the proposed, except that the forecast of the market basket percentage increase has been revised from 2.6 to 2.4 percent for prospective payment hospitals and from 2.5 to 2.4 percent for excluded hospitals.

Comment: The commenters suggested that HCFA's update framework take into account the impact of ''Year 2000'' (Y2K) systems'' conversions on hospital expenditures.

Response: The purpose of the hospital input price indexes in the hospital market basket is to measure the price escalation associated with the inputs needed to provide hospital services, not to measure changes in the quantity and quality of inputs used to provide these services. The increased costs associated with Y2K systems conversions are in the form of 3 factors: (1) Increased quantities (such as more workers), (2) increased price levels for higher quality workers (with higher wage levels) or other inputs, and (3) increased price escalation, holding constant the quantity and quality of inputs (such as faster wage and input price escalation rates). The third factor of increased escalation for wages and prices should be picked up by the hospital input price indexes.

Since the input price indexes measure the ''pure price'' changes associated with the inputs needed to provide hospital services, they would reflect the potentially faster rate of price escalation faced by hospitals from Y2K. An example would be higher market prices paid by hospitals for goods and services purchased from suppliers that also incurred higher production costs due to the Y2K conversion. We believe that the price proxies used in the hospital input price indexes, such as CPIs, PPIs, and ECIs, will reflect any escalating prices since all sectors of the economy are faced with additional costs of Y2K. This escalation will show up in the monthly or quarterly updates of the price proxies from the Bureau of Labor Statistics.

Any change in the mix of inputs caused by Y2K would not be picked up in the index until it is rebased. Such a change would cause a modification of the weights in the input price index. However, any changes in the weights are likely to have a minimal effect on the overall percent change in the index. For example, we did a sensitivity analysis of this effect by increasing the weight for professional and technical wages and benefits by 10 percent with a corresponding 10 percent decrease in the non-professional and technical wages and benefits. Altering the weights in this manner had no impact on the overall percent change in the index.

Comment: MedPAC commented that HCFA's recommendations differed from those of MedPAC in the proposed rule because HCFA did not separately account for hospital product change. Hospital product change reflects the dramatic change in recent years in the role of the hospital inpatient setting in the continuum of care. More patients are receiving postacute care after a hospital stay, and the average length of acute care stays has declined sharply.

Response: HCFA recognizes the changes in hospital inpatient care delivery noted by MedPAC and for FY 1999, accounted for them in the determination of the intensity factor. To the extent that there is a mismatch in component designation between HCFA and MedPAC, HCFA is willing to work with MedPAC to set more clearly defined and mutually agreeable categories for future update recommendations.

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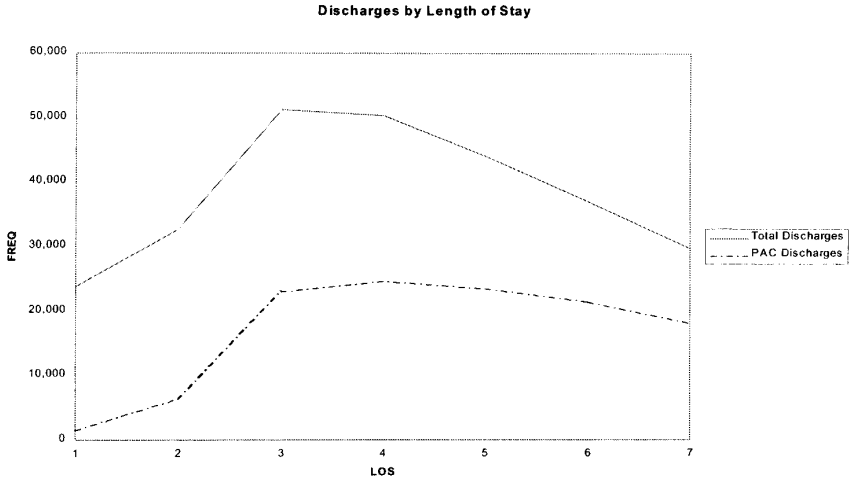
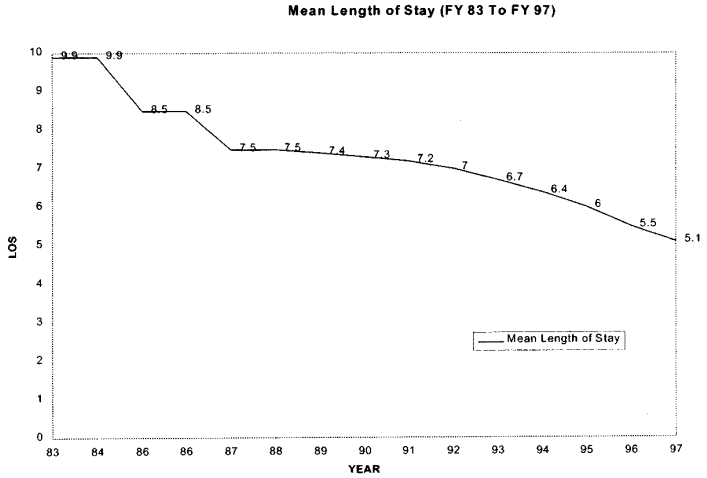
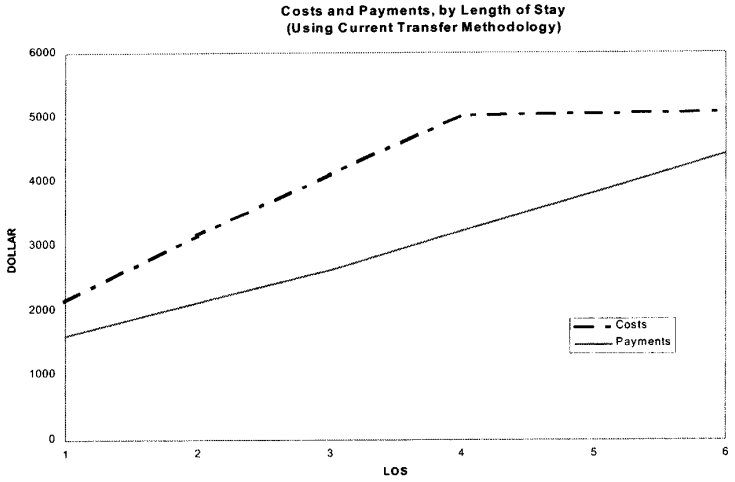
APPENDIX D: DRG Charts

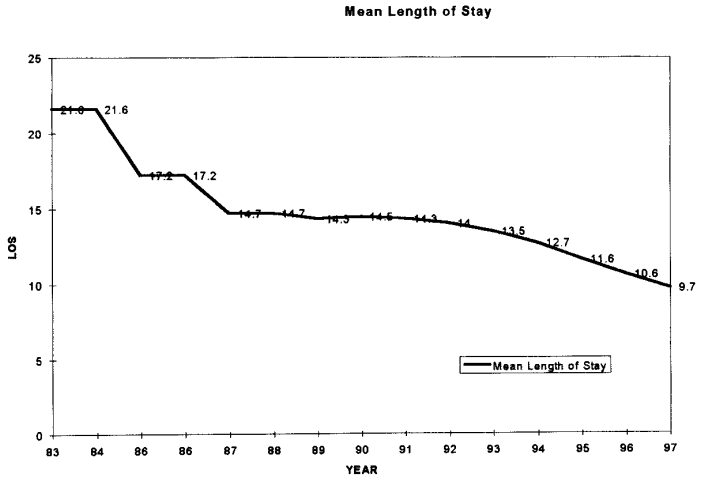
DRG 14
SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA (MEDICAL)

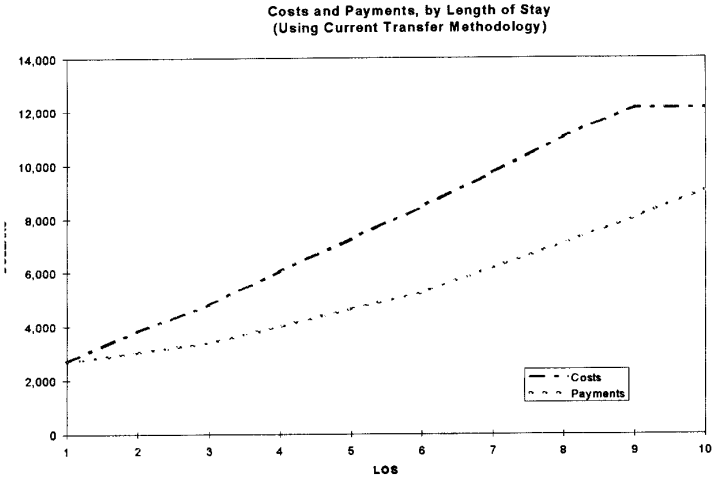






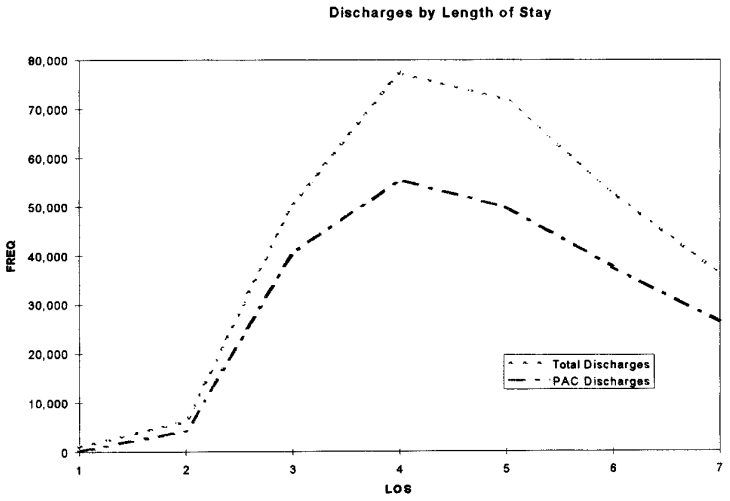
DRG 113
AMPUTATION FOR CIRCULATORY SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE (SURGICAL)

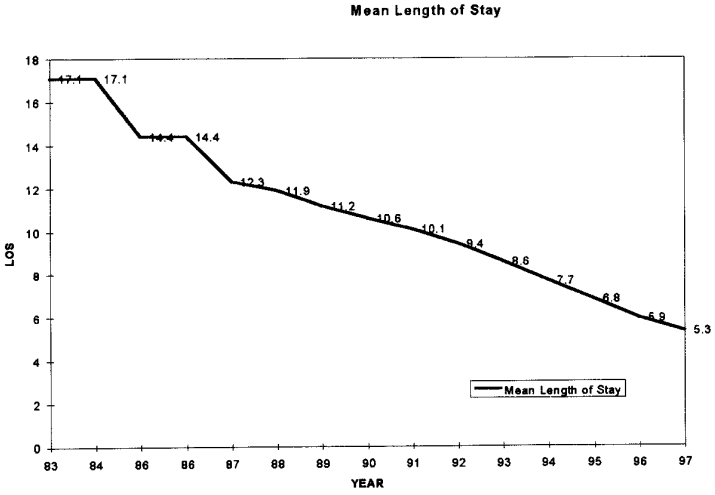


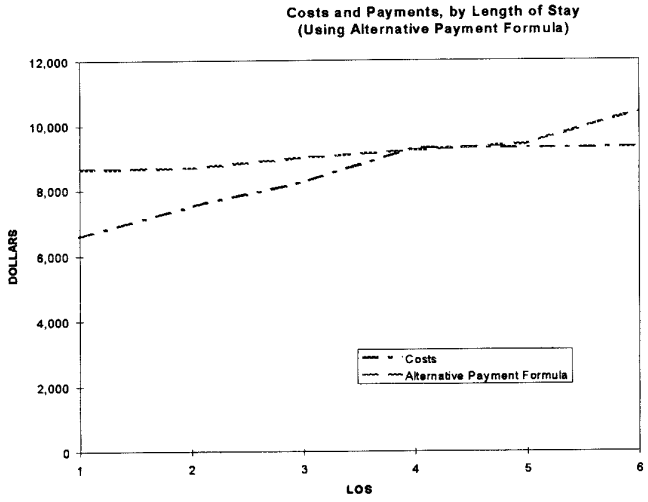


DRG 209

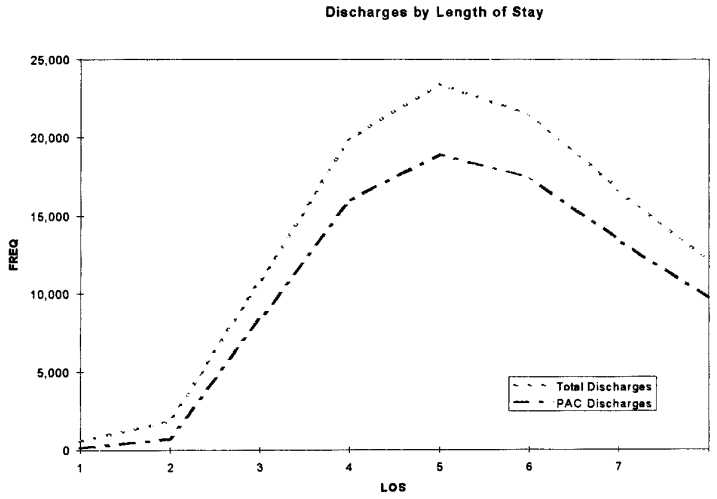
MAJOR JOINT LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY (SURGICAL)

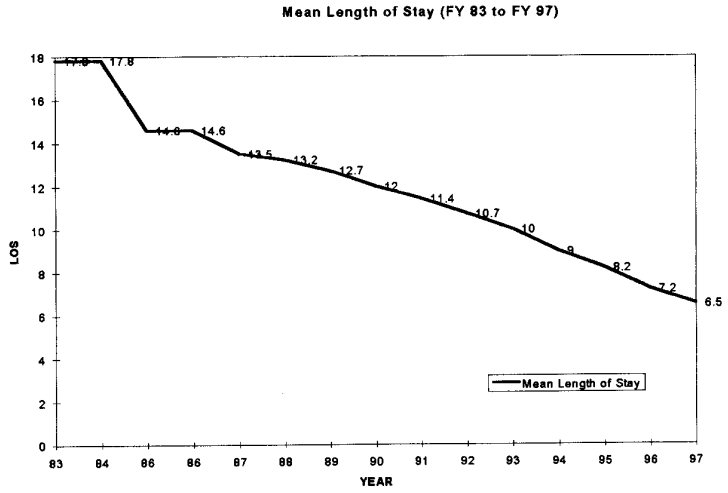


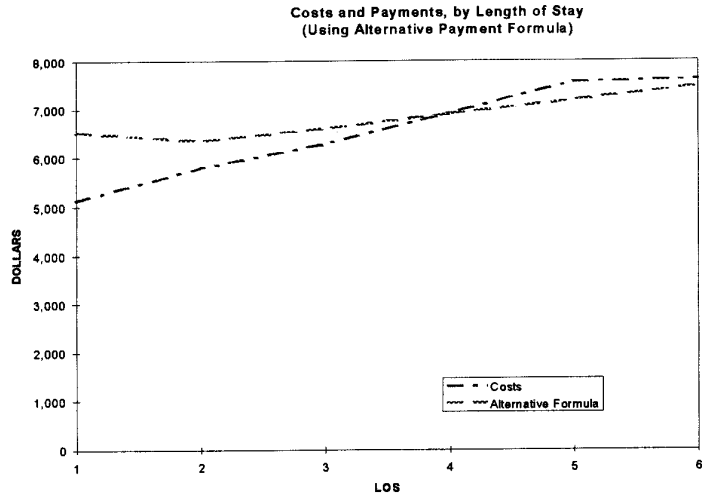




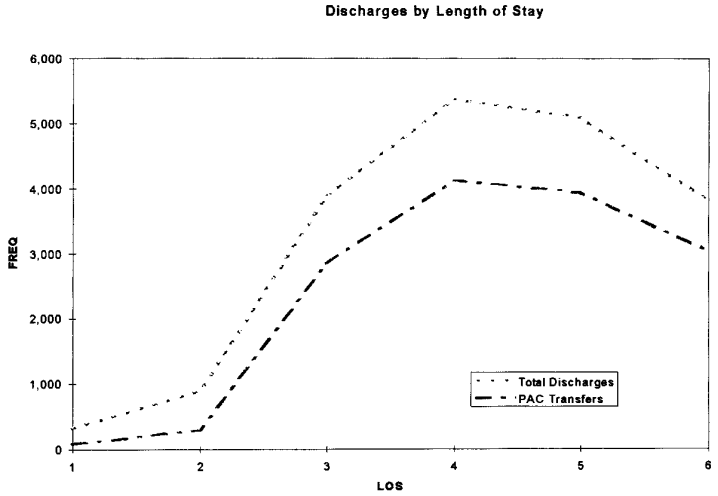
DRG 210
HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 WITH CC (SURGICAL)

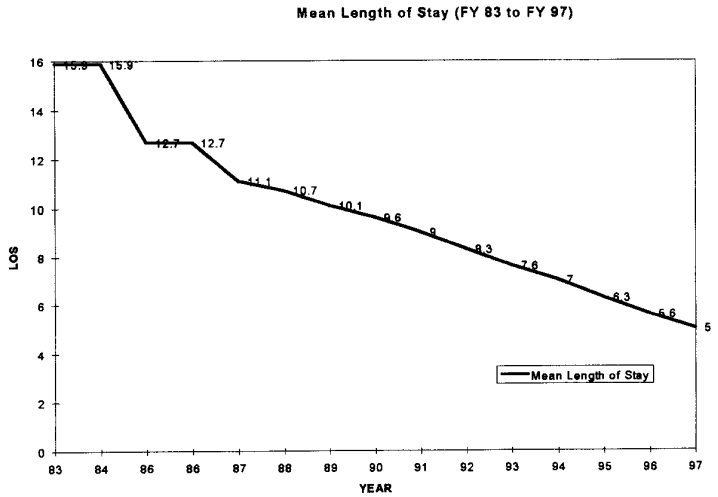


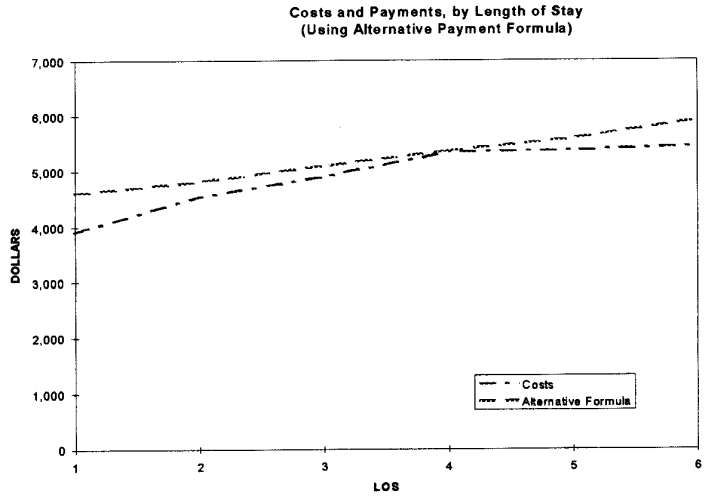




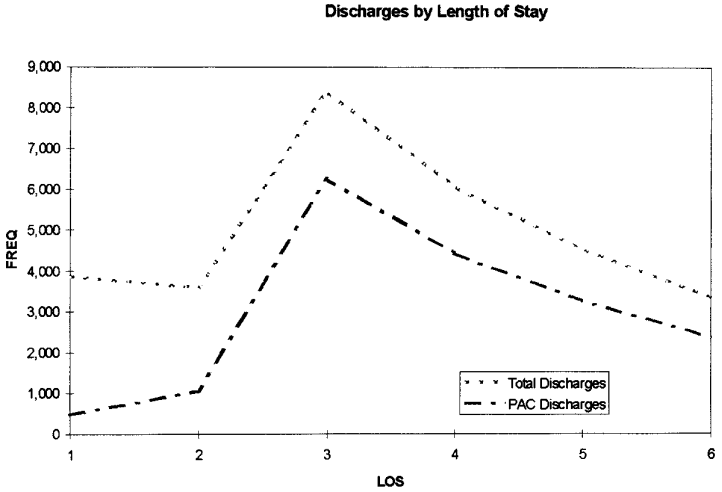
DRG 211
HIP FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC (SURGICAL)

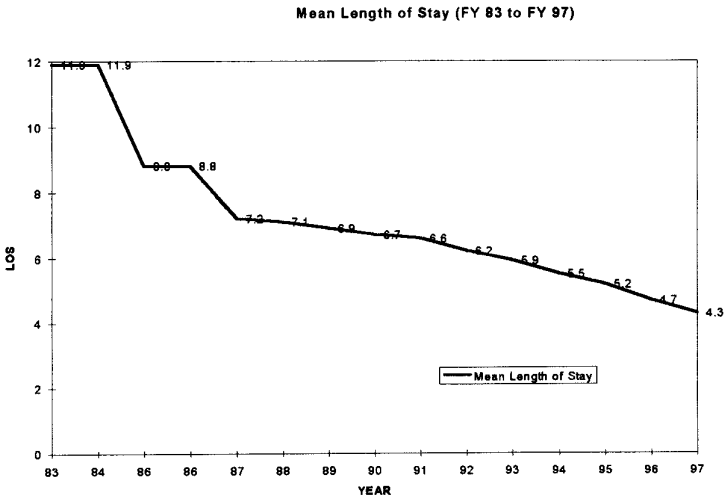


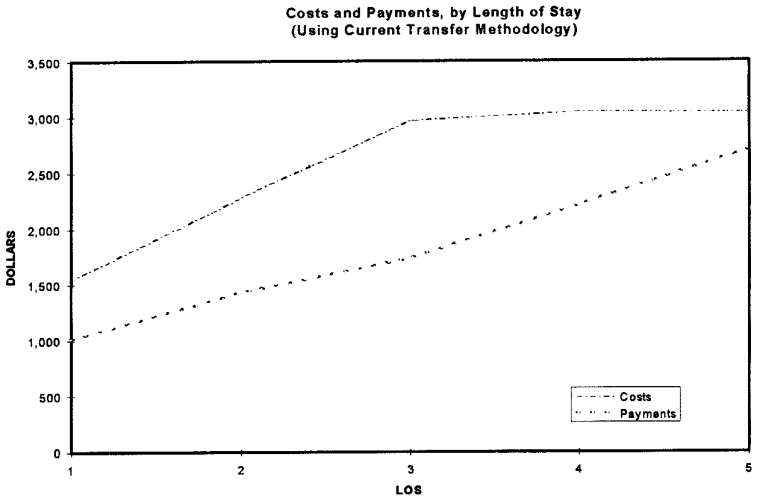




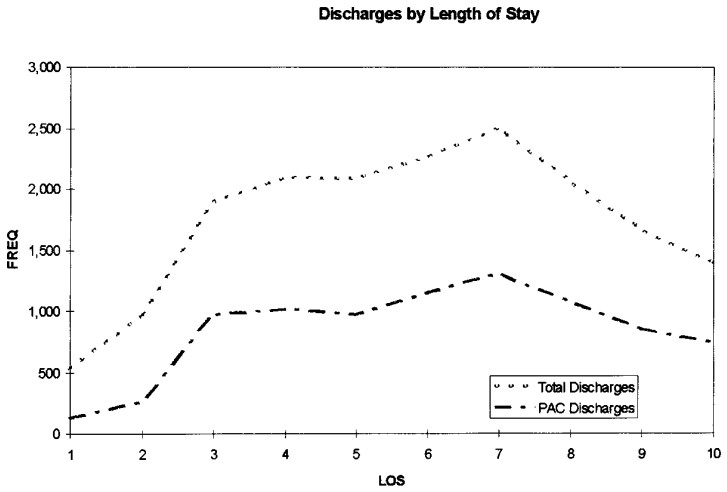
DRG 236
FRACTURE OF HIP PELVIS (MEDICAL)

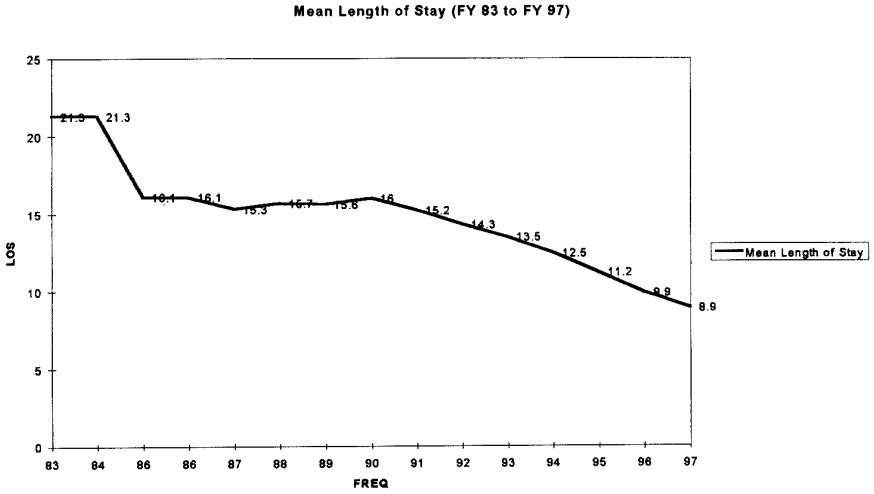


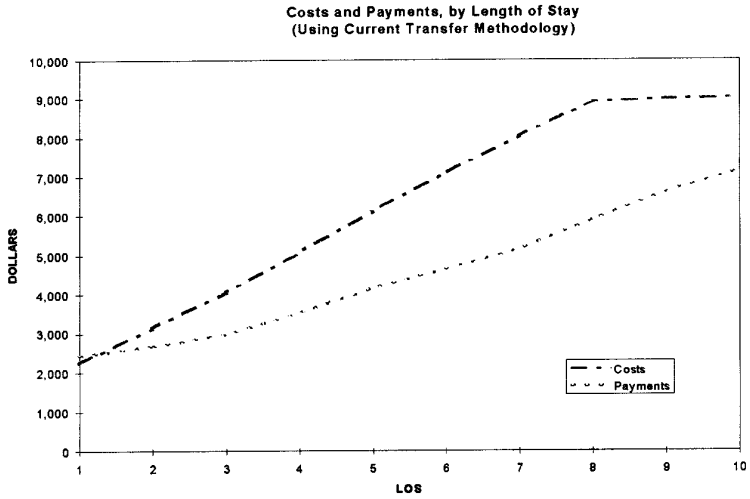




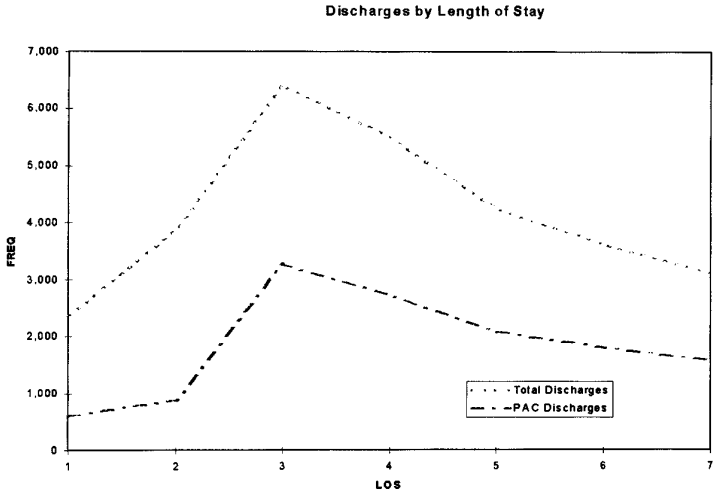
DRG 263
SKIN GRAFT AND/OR DEBRIDEMENT FOR SKIN ULCER OR CELLULITIS WITH CC (SURGICAL)

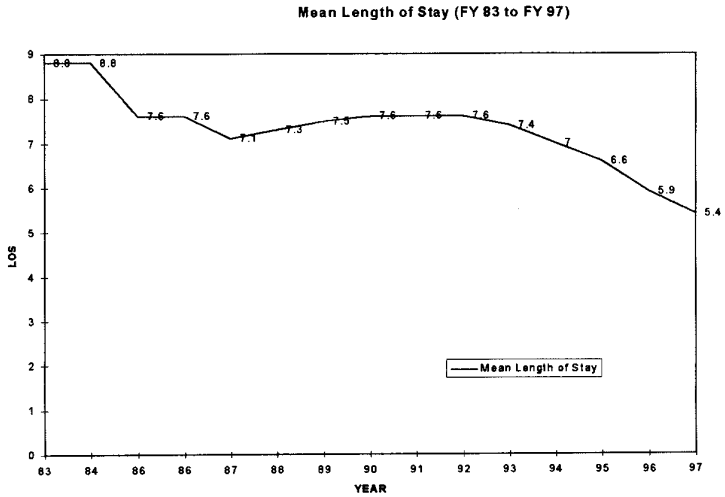


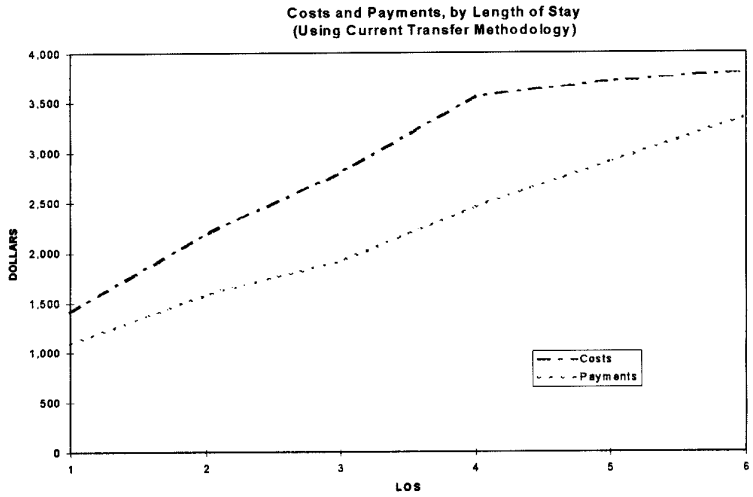




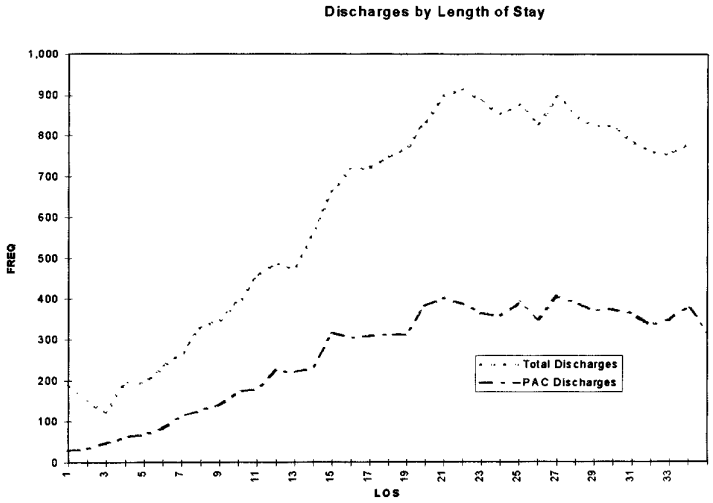
DRG 429
ORGANIC DISTURBANCES MENTAL RETARDATION (MEDICAL)

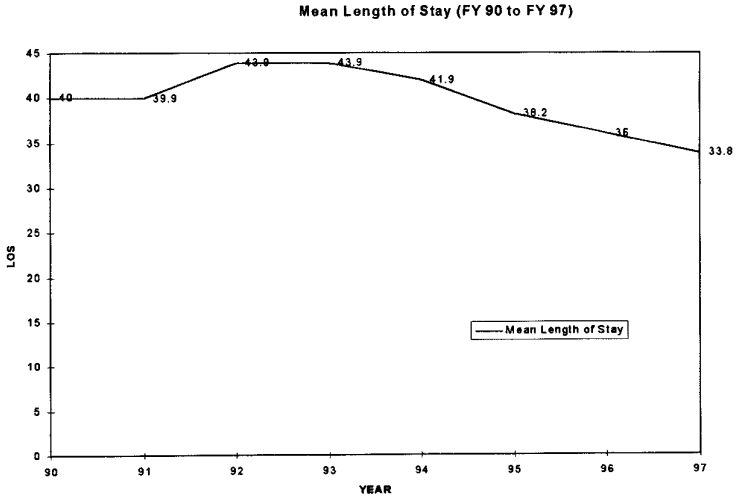


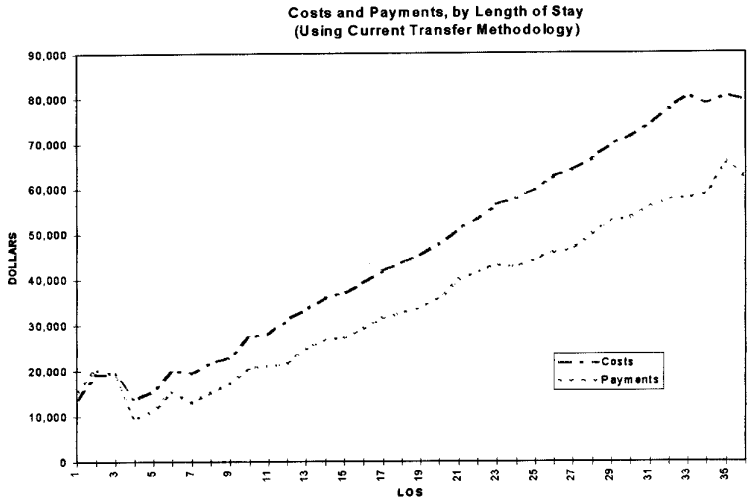




DRG 483
TRACHEOSTOMY EXCEPT FOR FACE, MOUTH, NECK DIAGNOSES (SURGICAL)







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