

consists of HCPCS codes previously assigned to other APCs, the copayment amount is calculated as the product of the APC payment rate and the lowest coinsurance percentage of the codes comprising the new APC.

3. If no codes are added to or removed from an APC and, after recalibration of its relative payment weight, the new payment rate is equal to or *greater than* the prior year's rate, the copayment amount remains constant (unless the resulting coinsurance rate is less than 20 percent).

4. If no codes are added to or removed from an APC and, after recalibration of its relative payment weight, the new payment rate is *less than* the prior year's rate, the copayment amount is calculated as the product of the new payment rate and the prior year's coinsurance percentage.

5. If HCPCS codes are added to or deleted from an APC, and, after recalibrating its relative payment weight, holding its unadjusted copayment amount constant results in a decrease in the coinsurance percentage for the reconfigured APC, the copayment amount would not change (unless retaining the copayment amount would result in a coinsurance rate less than 20 percent).

6. If HCPCS codes are added to an APC, and, after recalibrating its relative payment weight, holding its unadjusted copayment amount constant results in an increase in the coinsurance percentage for the reconfigured APC, the copayment amount would be calculated as the product of the payment rate of the reconfigured APC and the lowest coinsurance rate of the codes being added to the reconfigured APC.

This methodology would, in general, reduce the beneficiary coinsurance rate and copayment amount for APCs for which the payment rate changes as the result of the reconfiguration of APCs and/or the recalibration of relative payment weights.

IX. Conversion Factor Update for CY 2004

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPSS on an annual basis. Section 1833(t)(3)(C)(iv) of the Act provides that for 2004, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

The forecast of the hospital market basket increase for FY 2004 published in the inpatient PPS proposed rule on May 19, 2003 is 3.5 percent. To set the proposed OPSS conversion factor for

2004, we increased the 2003 conversion factor of \$52.151 (the figure from the November 1, 2002 final rule (67 FR 66788) by 3.5 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the proposed conversion factor for 2004 to ensure that the revisions we are proposing to update by means of the wage index are made on a budget-neutral basis. We calculated a budget neutrality factor of 1.003 for wage index changes by comparing total payments from our simulation model using the proposed FY 2004 hospital inpatient PPS wage index values to those payments using the current (FY 2003) wage index values. In addition, for CY 2004, allowed pass-through payments have decreased to 2 percent of total OPSS payments, down from 2.3 percent in CY 2003. The 0.3 percent was also used to adjust the conversion factor.

The increase factor of 3.5 percent for 2004, the required wage index budget neutrality adjustment of approximately 1.003, and the 0.3 percent adjustment to the pass-through estimate, result in a proposed conversion factor for 2004 of 54.289.

X. Proposed Outlier Policy and Elimination of Transitional Corridor Payments for CY 2004

A. Proposed Outlier Policy for CY 2004

For OPSS services furnished between August 1, 2000 and April 1, 2002, we calculated outlier payments in the aggregate for all OPSS services that appear on a bill in accordance with section 1833(t)(5)(D) of the Act. In the November 30, 2001 final rule (66 FR 59856, 59888), we specified that beginning with 2002, we will calculate outlier payments based on each individual OPSS service. We revised the aggregate method that we had used to calculate outlier payments and began to determine outliers on a service-by-service basis.

As explained in the April 7, 2000 final rule (65 FR 18498), we set a target for outlier payments at 2.0 percent of total payments. For purposes of simulating payments to calculate outlier thresholds, we propose to continue to set the target for outlier payments at 2.0 percent, as we did for CYs 2001, 2002, and 2003. For 2003, the outlier threshold is met when costs of furnishing a service or procedure exceed 2.75 times the APC payment amount, and the current outlier payment percentage is 45 percent of the amount of costs in excess of the threshold. For the reasons discussed in detail in section XI.E of this preamble, we are proposing to establish two separate

outlier thresholds, one for community mental health centers (CMHCs) and one for hospitals. For CY 2004, we propose to continue to set the target for outlier payments at 2.0 percent of total OPSS payments (a portion of that 2.0 percent, 0.36 percent, would be allocated to CMHCs for PHP services). Based on our simulations for 2004, we propose to set the hospital threshold for 2004 at 2.75 times the APC payment amount, and the proposed 2004 payment percentage applicable to costs over the threshold at 50 percent. We propose to set the threshold for CMHCs for 2004 at 11.75 times the APC payment amount and the 2004 outlier payment percentage applicable to costs over the threshold at 50 percent.

B. Elimination of Transitional Corridor Payments for CY 2004

Since the inception of the OPSS, providers have been eligible to receive additional transitional payments if the payments they received under the OPSS were less than the payments they would have received for the same services under the payment system in effect before the OPSS. Under 1833(t)(7) of the Act, most hospitals that realize lower payments under the OPSS received transitional corridor payments based on a percent of the decrease in payments. However, rural hospitals having 100 or fewer beds, as well as cancer hospitals and children's hospitals described in section 1886(d)(1)(B)(iii) and (v) of the Act, were held harmless under this provision and paid the full amount of the decrease in payments under the OPSS. Transitional corridor payments were intended to be temporary payments to ease providers' transition from the prior cost-based payment system to the prospective payment system. Beginning January 1, 2004, in accordance with section 1833(t)(7) of the Act, transitional corridor payments will no longer be paid to providers other than cancer hospitals and children's hospitals. Cancer hospitals and children's hospitals are held harmless permanently under the transitional corridor provisions of the statute.

We are concerned that small rural hospitals are not able to achieve the same level of operating efficiencies as larger rural hospitals and urban hospitals, and we are concerned that the decrease in payments these hospitals may experience once they stop receiving transitional corridor payments will result in these hospitals having to decrease or altogether cease to provide certain outpatient services. A reduction of services could have consequences for Medicare beneficiaries and their continued access to care in rural areas.