

between the value derived from claims data and any decrease of 15 percent or more.

Our analyses indicate that application of this method of adjustment would result in payment levels that will be fair and accurate. However, based on more complete claims data we expect to have for the final rule and on the comments from the public, we will re-evaluate the appropriateness of adjusting median costs for drugs for which median costs would decline in 2004.

#### Conclusion

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

The OPPS rates for CY 2004 would have, overall, a positive effect for every category of hospital with the exception of cancer hospitals and children's hospitals, which are held harmless under the OPPS. These changes in the OPPS for 2004 would result in an overall 3.8 percent increase in Medicare payments to hospitals, exclusive of outlier and transitional pass-through payments and transitional corridor payments. As described in the preamble, budget neutrality adjustments are made to the conversion factor and the relative weights to ensure that the revisions in the wage index, APC groups, and relative weights do not affect aggregate payments. The impact of the wage and recalibration changes does vary somewhat by hospital group. Estimates of these impacts are displayed on Table 23.

The overall projected increase in payments for urban hospitals is slightly lower (3.7 percent) than the average increase for all hospitals (3.8 percent) while the increase for rural hospitals is slightly greater (4.0 percent) than the average increase. The introduction of a new wage index combined with changes to the APC structure would result in small distributional changes for all categories of hospitals. Rural hospitals would gain 0.1 percent from the wage index change but show no gains from APC changes. Large urban hospitals would lose 0.1 percent from the wage index change, whereas "other" urban hospitals show a decrease of -0.2 percent from the APC changes. A discussion of the distribution of outlier payments that we project under this

proposed rule can be found under section XV.E below. Table 24 presents the outlier distribution that we expect to see under this proposed rule.

#### C. Limitations of Our Analysis

The distributional impacts represent the projected effects of the policy changes, as well as statutory changes effective for 2004, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. In addition, we are not proposing to make adjustments for future changes in variables such as service volume, service mix, or number of encounters.

#### D. Estimated Impacts of This Proposed Rule on Hospitals

The OPPS is a budget neutral payment system under which the increase to the total payments made under OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The impact tables show the redistribution of hospital payments among providers as a result of a new wage index and APC structure. In some cases, under this proposed rule, hospitals would receive more total payment than in 2003 while in other cases they would receive less total payment than they received in 2003. The impact of this proposed rule would depend on a number of factors, most significant of which are the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services would change) and the impact of the wage index changes on the hospital.

Column 4 in Table 23 represents the full impact on each hospital group of all the changes for 2004. Columns 2 and 3 in the table reflect the independent effects of the proposed change in the wage index and the APC reclassification and recalibration changes, respectively. We excluded critical access hospitals (CAHs) from the analysis of the impact of the proposed 2004 OPPS rates that is summarized in Table 23. For that reason, the total number of hospitals included in Table 23 (4,352) is lower than in previous years. CAHs are excluded from the OPPS.

To a very limited extent, wage index changes favor all hospital categories with the exception of large urban hospitals with 500 or more beds that show a -0.3 percentage change. Rural

hospitals show modest increases of 0.1 percent for most bed sizes but show the largest gains for categories with 200 or more beds, a 0.3 percent increase. Rural hospitals located in Puerto Rico show the largest negative impact (-2.2 percent) due to changes in the wage index. Hospitals located in the Middle Atlantic, South Atlantic, and in the East North Central part of the country experience a negative impact due to wage index changes regardless of urban or rural designation. However, this effect is somewhat lessened by the distribution of outlier payments as discussed in more detail below.

The APC reclassification and recalibration changes also favor rural hospitals with the exception of rural hospitals with 200 or more beds that show a negative effect (-1.2 percent). Conversely, urban hospitals with 200 to 299 beds (-0.1 percent decrease), and urban hospitals with 300 to 499 beds (-0.5 percent) show a decrease attributed to APC recalibration. Urban hospitals in excess of 500 beds show a 0.1 percent increase as a result of APC recalibration. In general, APC changes are small and result in very few distributional changes among hospital categories.

In both urban and rural areas, hospitals that provide a lower volume of outpatient services are projected to receive a larger increase in payments than higher volume hospitals. In rural areas, hospitals with volumes of fewer than 5,000 services are projected to experience an increase in payments (4.4 percent). Urban hospitals that provide low-volume services experience an even larger increase (5.0 percent) in payments attributable to both wage index and APC changes. Conversely, urban and rural hospitals providing more than 21,000 services are projected to lose as a result of APC recalibration but gain from the introduction of the new wage index for a combined effect in the range of 3.4 to 3.9 percent.

Major teaching hospitals are projected to experience a smaller increase in payments (3.4 percent) than the aggregate for all hospitals (3.8 percent) due to negative impacts of the wage index (-0.4 percent). Hospitals with less intensive teaching programs are projected to experience an overall increase (3.7 percent) that is smaller than the average for all hospitals. There is little difference in impact among hospitals that serve low-income patients where increases in payments range from 3.4 to 4.2 percent higher than in 2003.