

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 do not make adjustments for future changes in variables such as service volume, service mix, or number of encounters.

D. Estimated Impacts of This Final Rule on Hospitals

The OPSS is a budget neutral payment system under which the increase to the total payments made under OPSS 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 final rule, hospitals will receive more total payment than in 2003 while in other cases they will receive less total payment than they received in 2003. The impact of this final rule will 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 will change) and the impact of the wage index changes on the hospital.

Column 4 in Table 15 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 final 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 final 2004 OPSS rates that is summarized in Table 15. For that reason, the total number of hospitals included in Table 15 (4,378) is lower than in previous years. CAHs are excluded from the OPSS.

To a very limited extent, wage index changes favor rural hospital categories. Large urban hospitals with greater than 500 beds show the largest percent decrease (–3.0) attributable to wage index changes. Rural hospitals show modest increases of 0.2 percent for most bed sizes but show the largest gains for categories with fewer than 50 beds or 150 to 199 beds where the wage index change results in a 0.4 percent increase. Rural hospitals located in Puerto Rico show the largest negative impact (–2.5 percent) due to changes in the wage index. Hospitals located in the Middle Atlantic region also experience a large negative impact –0.6 percent 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 (–0.8 percent). Conversely, urban hospitals with greater than 199 beds show a decrease attributed to APC recalibration. Urban hospitals in excess of 500 beds show a 0.5 percent decrease 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 between 5,000 and 20,999 are projected to experience increases larger than 5.0 percent. Urban hospitals that provide low-volume services show similar rates of increases (5.0 percent). Conversely, urban and rural hospitals providing more than 21,000 services are projected to experience a rate of increase in the 4.0 to 4.7 percent range.

Major teaching hospitals are projected to experience a smaller increase in payments (3.7 percent) than the aggregate for all hospitals (4.5 percent) due to negative impacts from both the wage index (–0.4 percent) and APC recalibration (–0.4 percent). Hospitals with less intensive teaching programs are projected to experience an overall increase (4.5 percent) that is equal to the average for all hospitals. There is little difference in impact among hospitals that serve low-income patients where increases in payments range from 4.3 to 4.7 percent higher than in 2003.

Psychiatric hospitals and long term care facilities show the largest increase in payment rates among all categories of hospital providers. Psychiatric hospitals show an increase of 18.2 percent as a result of an increase in payment rates for partial hospitalization programs and for other services such as psychotherapy. Also, payments made to psychiatric facilities represent a small portion of total spending for OPSS, approximately 60.6 million dollars for 2004. Long-term care facilities show a growth rate of 7.5 percent over payments made in 2003. We believe this is the result of a policy change that removes payments made for therapy services from the physician fee schedule to the hospital outpatient prospective payment system. Payments made for long-term care account for a small amount of OPSS payments, approximately 14.5 million for 2004.

TABLE 15.—IMPACT OF CHANGE FOR CY 2004 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

[Percent change in total payments to hospital (program and beneficiary); does not include hold harmless, corridor, outlier or transitional pass-through payments]

	Number of hospitals (1)	New Wage index (2)	APC changes (3)	All CY 2004 changes (4)
ALL HOSPITALS	4,378	0	0	4.5
NON-TEFRA HOSPITALS	3,854	0	–0.1	4.4
URBAN HOSPS	2,383	–0.1	–0.1	4.3
LARGE URBAN (GT 1 MILL.)	1,377	0	–0.2	4.2
OTHER URBAN (LE 1 MILL.)	1,006	–0.1	0.1	4.4
RURAL HOSPS	1,471	0.2	0.2	4.9
BEDS (URBAN)				
0–99 BEDS	538	0.1	0.6	5.2
100–199 BEDS	878	–0.1	0.3	4.8
200–299 BEDS	454	–0.1	–0.1	4.3
300–499 BEDS	363	0.1	–0.4	4.2
500 + BEDS	150	–0.3	–0.5	3.7
BEDS (RURAL)				
0–49 BEDS	699	0.4	0.6	5.6