

chemotherapy for patients with advanced renal cell cancer and advanced melanoma.

We also are presenting our analysis of applicants for add-on payments for high-cost new medical technologies.

2. Proposed Changes to the Hospital Wage Index

In section III. of this preamble, we discuss proposed revisions to the wage index and the annual update of the wage data. Specific issues addressed in this section include the following:

- The proposed FY 2004 wage index update, using wage data from cost reporting periods that began during FY 2000.
- Proposed exclusion of the wage data for rural health centers (RHCs) and Federally qualified health centers (FQHCs) from the calculation of the FY 2004 wage index.
- Proposed exclusion of paid hours associated with military and jury duty leave from the wage index calculation, and request for comments on possible exclusion of paid lunch or meal break hours.
- Proposed revisions to the wage index based on hospital redesignations and reclassifications.
- Proposed amendments to the timetable for reviewing and verifying the wage data that will be in effect for the FY 2005 wage index.

3. Other Decisions and Proposed Changes to the PPS for Inpatient Operating and GME Costs

In section IV. of this preamble, we discuss several provisions of the regulations in 42 CFR parts 412 and 413 and set forth certain proposed changes concerning the following:

- Proposed expansion of the current postacute transfer policy to 19 additional DRGs.
- Proposed clarification of our policies that would be applied to counting hospital beds and patient days, in particular with regard to the treatment of swing-beds and observation beds, for purposes of the IME and DSH adjustments.
- Proposed changes in our policy relating to nursing and allied health education payments to wholly owned subsidiary educational institutions of hospitals.
- Proposed clarification of policy relating to application of redistribution of costs and community support funds in determining a hospital's resident training costs.
- Proposed change in the amount of rural training time required for an urban hospital to qualify for an increase in the rural track FTE limitation.

- Proposed inclusion of FTE residents training in rural tracks in a hospital's rolling average calculation.

4. PPS for Capital-Related Costs

In section V., of this preamble, we discuss the payment requirements for capital-related costs. We are not proposing any changes to the policies on payments to hospitals for capital-related costs.

5. Proposed Changes for Hospitals and Hospital Units Excluded from the IPPS

In section VI., of this preamble, we discuss the following proposals concerning excluded hospitals and hospital units and CAHs:

- Revisions relating to the operation of excluded "grandfathered" hospitals-within-hospitals in effect on September 30, 1999.
- Clarification of the classification criteria for LTCHs.
- Clarification of the policy on payments for laboratory services provided by a CAH to patients outside a CAH.

6. Determining Prospective Payment Operating and Capital Rates and Rate-of-Increase Limits

In the Addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2004 prospective payment rates for operating costs and capital-related costs. We also establish the proposed threshold amounts for outlier cases. In addition, we address update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2004 for hospitals and hospital units excluded from the PPS.

7. Impact Analysis

In Appendix A, we set forth an analysis of the impact that the proposed changes described in this proposed rule would have on affected hospitals.

8. Proposed Recommendation of Update Factor for Hospital Inpatient Operating Costs

As required by sections 1886(e)(4) and (e)(5) of the Act, Appendix B provides our recommendation of the appropriate percentage change for FY 2004 for the following:

- Large urban area and other area average standardized amounts (and hospital-specific rates applicable to SCHs and MDHs) for hospital inpatient services paid under the IPPS for operating costs.
- Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the IPPS.

9. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, the Medicare Payment Advisory Commission (MedPAC) is required to submit a report to Congress, no later than March 1 of each year, that reviews and makes recommendations on Medicare payment policies. This annual report makes recommendations concerning hospital inpatient payment policies. In section VII., of this preamble, we discuss the MedPAC recommendations and any actions we are proposing to take with regard to them (when an action is recommended). For further information relating specifically to the MedPAC March 1 report or to obtain a copy of the report, contact MedPAC at (202) 653-7220 or visit MedPAC's Web site at: <http://www.medpac.gov>.

II. Proposed Changes to DRG Classifications and Relative Weights

A. Background

Section 1886(d) of the Act specifies that the Secretary shall establish a classification system (referred to as DRGs) for inpatient discharges and adjust payments under the IPPS based on appropriate weighting factors assigned to each DRG. Therefore, under the IPPS, we pay for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the average resources used to treat cases in all DRGs.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The proposed changes to the DRG classification system and the proposed recalibration of the DRG weights for discharges occurring on or after October 1, 2003 are discussed below.