

Specifically, the questioners have asked whether a CAH may obtain reasonable cost payment for such services to individuals in other locations by sending a CAH employee into the setting and registering the individual as a CAH patient while the blood is drawn or other specimen collection is accomplished. The settings that have been referred to most frequently are: (1) A rural health clinic (RHC), especially one that is provider-based with respect to the CAH; (2) the individual's home; and (3) a SNF.

We have considered these suggestions and understand the position taken by those who believe that nominal compliance with the requirements for outpatient status should be enough to warrant reasonable cost payment for clinical diagnostic laboratory tests for individuals at locations outside the CAH. However, we do not agree that providing reasonable cost payment under these circumstances would be appropriate. On the contrary, we believe that extending reasonable cost payment for services furnished to individuals who are not at the CAH when the specimen is drawn would duplicate existing coverage, create confusion for beneficiaries and others by blurring the distinction between CAHs and other providers, such as SNFs and HHAs, and increase the costs of care to Medicare patients without enhancing either the quality or the availability of that care.

To clarify our policies in this area and avoid possible misunderstandings about the scope of the CAH benefit, we are proposing to revise § 413.70(b)(2)(iii) to state that payment to a CAH for outpatient clinical diagnostic laboratory tests will be made on a reasonable cost basis only if the individuals for whom the tests are performed are outpatients of the CAH, as defined in 42 CFR 410.2, "and are physically present in the CAH" at the time the specimens are collected. (We note that, in some cases, the CAH outpatients from whom specimens are collected at the CAH may include individuals referred to the CAH from RHCs or other facilities to receive the tests.) We are proposing to further revise this paragraph to state that clinical diagnostic laboratory tests for individuals who do not meet these criteria but meet other applicable requirements will be paid for only in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act, that is, payment will be made only on a fee schedule basis. By making the second proposed change, we wish to emphasize that this proposal does not mean that no payment would be made for clinical diagnostic laboratory tests performed by CAHs that do not meet the

revised criteria. On the contrary, such tests would be paid, but on a fee schedule basis. We believe these clarifications are appropriate, as the CAH is not providing CAH services but is acting as an independent laboratory in providing these clinical diagnostic laboratory tests.

#### *E. Technical Change*

On July 30, 1999, we published in the **Federal Register** a final rule (64 FR 41532) that set forth criteria for a satellite facility of a hospital or hospital unit to be excluded from the IPPS under § 412.25. Section 412.25(e)(3) of the regulations specifies that any unit structured as a satellite facility on September 30, 1999, and excluded from the IPPS on that date, is grandfathered as an excluded hospital to the extent that the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit, in effect on September 30, 1999, except as we specified in § 412.25(e)(4). When we specified the exception for the number of beds and square footage requirement under § 412.25(e)(4), we inadvertently referred to paragraph (e)(4) as being an exception to paragraph (h)(3). We should have specified that it was an exception to paragraph (e)(3). We are proposing to correct this reference.

#### **VII. MedPAC Recommendations**

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's IPPS recommendations in our annual proposed rule. We have reviewed MedPAC's March 1, 2003 "Report to the Congress: Medicare Payment Policy" and have given it careful consideration in conjunction with the proposals set forth in this document. For further information relating specifically to the MedPAC 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>.

MedPAC's Recommendation 2A-6 concerning the update factor for inpatient hospital operating costs and for hospitals and distinct-part hospital units excluded from the IPPS is discussed in Appendix C to this proposed rule. MedPAC's other recommendations relating to payments for Medicare inpatient hospital services focused mainly on the expansion of DRGs subject to the postacute care transfer policy, a reevaluation of the labor-related share of the market basket used in determining the hospital wage index, an increase in the DSH adjustment, and payments to rural

hospitals. These recommendations and our responses are set forth below:

**Recommendation 2A-1:** The Secretary should add 13 DRGs to the postacute transfer policy in FY 2004 and then evaluate the effects on hospitals and beneficiaries before proposing further expansions.

**Response:** We are proposing to expand the postacute care transfer policy to 19 additional DRGs for FY 2004. A thorough discussion of this proposal, including a summary of MedPAC's analysis, can be found at section IV.A.3. of this preamble.

**Recommendation 2A-2:** The Congress should enact a low-volume adjustment to the rates used in the inpatient PPS. This adjustment should apply only to hospitals that are more than 15 miles from another facility offering acute inpatient care.

**Response:** MedPAC's analysis "revealed that hospitals with a small volume of total discharges have higher costs per discharge than larger facilities, after controlling for the other cost-related factors recognized in the payment system." Although there are special payment protections for some rural hospitals such as CAHs, SCHs, and MDHs, MedPAC believes these provisions do not sufficiently target hospitals with low discharge volume.

This recommendation, which MedPAC estimates would increase Medicare payments to hospitals by less than \$50 million in FY 2004, and others requiring Congressional action, should be considered in the context of larger discussions within Congress and between Congress and the Administration regarding Medicare reform and payment refinements. Therefore, we are not responding specifically to MedPAC's recommendation regarding a low-volume adjustment to the IPPS payments at this time.

**Recommendation 2A-3:** The Secretary should reevaluate the labor share used in the wage index system that geographically adjusts rates in the inpatient PPS, with any resulting change phased in over 2 years.

**Response:** CMS defines the labor-related share to include costs that are likely related to, influenced by, or vary with local labor markets, even if they could be purchased in a national market. Since the implementation of the IPPS, the labor-related share has been determined by adding together the cost weights from categories in the hospital market basket that are influenced by local labor markets. When the hospital market basket weights are updated or rebased, the labor-related share is updated. The estimate of the labor-