

Secondary Diagnosis) to include in this DRG cases receiving high-dose Interleukin-2 (IL-2) chemotherapy for patients with advanced renal cell cancer and advanced melanoma.

We also presented our analysis of applicants for add-on payments for high-cost new medical technologies and proposed a revision to the high-cost threshold for a new technology or medical service to qualify for add-on payments.

- We proposed to continue to make add-on payments for Xigris.
- We discussed new applications for add-on payments for FY 2004.
- We proposed to reduce the high-cost threshold for a new technology or medical service to qualify for add-on payments from 1 standard deviation above the geometric mean standardized charge for cases in the DRGs to which the new technology is assigned to 75 percent of 1 standard deviation.

2. Changes to the Hospital Wage Index

We proposed revisions to the wage index and the annual update of the wage data. Specific issues addressed in this section included the following:

- The FY 2004 wage index update, using wage data from cost reporting periods that began during FY 2000.
- 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.
- 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.
- Revisions to the wage index based on hospital redesignations and reclassifications.
- 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 Changes to the PPS for Inpatient Operating and GME Costs

In the proposed rule, we discussed several provisions of the regulations in 42 CFR Parts 412 and 413 and set forth certain proposed changes concerning the following:

- Expansion of the current postacute transfer policy to 19 additional DRGs.
- 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.
- Changes in our policy relating to nursing and allied health education

payments to wholly owned subsidiary educational institutions of hospitals.

- Clarification of our policy relating to application of redistribution of costs and community support funds in determining a hospital's resident training costs.
- A change in the amount of rural training time required for an urban hospital to qualify for an increase in the rural track FTE limitation.
- Inclusion of FTE residents training in rural tracks in a hospital's rolling average calculation.

4. PPS for Capital-Related Costs

We discussed the payment requirements for capital-related costs. We did not propose any changes to the policies on payments to hospitals for capital-related costs.

5. Changes for Hospitals and Hospital Units Excluded From the IPPS

We discussed the following proposed revisions and clarifications concerning excluded hospitals and hospital units and CAHs:

- Revisions 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 the May 19, 2003 proposed rule, we proposed changes to the amounts and factors for determining the FY 2004 prospective payment rates for operating costs and capital-related costs. We also established the proposed threshold amounts for outlier cases. In addition, we addressed 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 of the proposed rule, we set forth an analysis of the impact that the proposed changes would have on affected hospitals.

8. Recommendation of Update Factor for Hospital Inpatient Operating Costs

In Appendix B of the proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we provided our recommendations of the appropriate percentage changes 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. In the proposed rule, we discussed the MedPAC recommendations concerning hospital inpatient payment policies and presented our response to those recommendations. For further information relating specifically to the MedPAC March 1 report or to obtain a copy of the report, contact MedPAC at (202) 220-3700 or visit MedPAC's Web site at: <http://www.medpac.gov>.

C. Public Comments Received in Response to the May 19, 2003 IPPS Proposed Rule

We received approximately 4,200 timely items of correspondence containing multiple comments on the May 19, 2003 proposed rule. Summaries of the public comments and our responses to those comments are set forth below under the appropriate heading.

II. 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