

travel costs. Given this payment provision, adding another, more expensive payment option for the services would duplicate existing coverage without providing any benefit to anyone other than the operators of the CAHs. Despite the commenters' claims to the contrary, we continue to believe patients under the care of one provider (such as a SNF or RHC) might have questions as to why personnel from another provider are coming in to perform functions that could be performed by staff of the facility in which they are being treated. Finally, while there is no deductible or coinsurance liability associated with laboratory services, paying for services on a reasonable cost basis rather than on a fee schedule basis will ultimately drive up the cost of laboratory care provided under Medicare, increasing costs for taxpayers and contributing to general health care cost increases. To the extent Medicare Part B premiums will increase in the future because of current spending rises, we believe adopting the policy recommended by commenters would increase out-of-pocket costs for beneficiaries as well as for all other taxpayers.

*Comment:* One commenter asked whether the proposed clarification of our policy on payment for clinical diagnostic laboratory tests would be applied prospectively only, or also retroactively.

*Response:* Although this proposal represents a clarification of policy, we recognize that this policy has not been well understood in all areas. Therefore, we do not plan to direct Medicare contractors to routinely reopen and review past claims for compliance.

After full consideration of public comments on these issues as summarized above, we are adopting our proposed changes to § 413.70 as final without change.

#### *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 proposed to correct this reference.

We did not receive any comments on this proposal and, therefore, are adopting the proposed technical change as final.

#### **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 IPPS rules. 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 policies 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 B to this final 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:* After reevaluation of this recommendation, in this final rule we are expanding the postacute care transfer policy to include 21 additional DRGs for FY 2004, although we are removing 2 DRGs from the current list. A thorough discussion of this provision, 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:* We define 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-related share using the most recently revised and rebased hospital market basket (1997-based) is 72.495 percent.

In the August 1, 2002 IPPS final rule, we elected to continue to use 71.066 percent as the labor-related share applicable to the standardized amounts (67 FR 50041). At that time, we indicated that we would conduct further analysis to determine the most appropriate methodology for the labor-related share. Again, in the May 19, 2003 proposed rule, we did not propose to use the updated labor-related share for FY 2004 because we have not yet completed our research into the appropriateness of this updated measure. Specifically, we continue to review the labor-related share in two ways. First, we are performing