

a hospital. The major difference between the two proxies is in the treatment of professional and technical wages (legal, accounting, management, and consulting services from outside the facility). In the blended occupational wage proxy, the professional and technical category was blended evenly

between the ECI for wages and salaries for hospitals and the ECI for wages and salaries for professional and technical occupations in the overall economy. The ECI for hospitals reflects hospital-specific occupations. This revision had a similar impact on the hospital PPS and excluded market baskets, as

described in the IPPS final rule published in the August 1, 2001 **Federal Register**. The proposed FY 2004 increase in the 1997-based excluded hospital with capital market basket is 3.3 percent.

CHART 5.—PERCENT CHANGES IN THE 1992-BASED AND PROPOSED 1997-BASED EXCLUDED HOSPITAL WITH CAPITAL MARKET BASKETS, FY 1999–2004

Fiscal Year	Percent Change, FY 1992-based Market Basket	Percent Change, Proposed FY 1997-based Mar- ket Basket
Actual Historical % Increase (FY 1999–2001)		
1999	2.3	2.7
2000	3.4	3.1
2001	3.9	4.0
Average historical	3.2	3.3
Forecasts (FY 2002–2004)		
2002	2.7	3.6
2003	3.0	3.5
2004	3.0	3.3
Average forecast	2.9	3.5

Section 1886(j)(3)(c) requires that the increase in the IRF PPS payment rate be based on an “appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii).” To date, we have used a market basket based on the cost structure of all excluded hospitals to satisfy this requirement, and have discussed in prior rules why we feel this market basket provides a reasonable measure of the price changes facing exempt hospitals.

In its March 2002 Report, the Medicare Payment Advisory Commission (MedPAC) recommended the development of a market basket specific to IRF services. As we mentioned in last year’s final rule, we have been researching the feasibility of developing such a market basket. This research included analyzing data sources for cost category weights, specifically the Medicare cost reports, and investigating other data sources on cost, expenditure, and price information specific to IRFs. As described in greater detail below, based on this research, we are not proposing at this time to develop a market basket specific to IRF services.

Our analysis of the Medicare cost reports indicates that the distribution of costs among major cost report categories (wages, pharmaceuticals, capital) for

IRFs is not substantially different from the 1997-based excluded hospital with capital market basket we propose to use. In addition, the only data available to us was for these cost categories (wages, pharmaceuticals, and capital) presenting a potential problem since no other major cost category would be based on IRF data.

We conducted a sensitivity analysis of annual percent changes in the market basket when the IRF weights for wages, pharmaceuticals, and capital were substituted into the excluded hospital with capital market basket. Other cost categories were recalibrated using ratios available from the inpatient PPS hospital market basket. On average, between the years 1995 through 2002, the excluded hospital with capital market basket increased at essentially the same average annual rate (2.9 percent) as the market basket with IRF weights for wages, pharmaceuticals, and capital (2.8 percent). In addition, in almost any individual year the difference was 0.1 percentage point or less, which is less than the 0.25 percentage point criterion that is used under the IPPS update framework to determine whether a forecast error adjustment is warranted.

The 0.25 percentage point criterion that determines whether a forecast error adjustment is warranted has been used in the IPPS update framework since the implementation of the IPPS. It serves as

a guideline for the level of forecast accuracy, since any forecast is likely to contain enough imprecision that differences of one tenth or two-tenths of a percentage point are not thought to be significant. Thus, in this case if the forecast error is not at least greater than two-tenths of a percentage point, it is thought to be similar enough to the actual data as not to warrant an adjustment.

Based on the above, we continue to believe that the excluded hospital with capital market basket is doing an adequate job of reflecting the price changes facing IRFs. We will continue to solicit comments about issues particular to IRFs that should be considered in our development of the proposed 1997-based excluded hospital with capital market basket, as well as encourage suggestions for additional data sources that may be available. Our hope is that the additional cost data being collected under the IRF PPS will eventually allow for the development of a market basket derived specifically from IRF data.

As shown in Chart 4, for the payment rates set forth in this proposed rule, the proposed FY 2004 IRF market basket increase factor using 1997 data is 3.3 percent. Thus, we propose to apply the 3.3 percent increase, in addition to the proposed budget neutral wage adjustment factor described below, to the FY 2003 standard payment