

related share using the most recently revised and rebased hospital market basket (1997-based) is 72.495 percent. This was the labor-related share proposed in the FY 2003 proposed rule.

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.

We are not proposing to use the updated labor-related share at this time because we have not yet completed our research into the appropriateness of this measure. Specifically, we are currently reviewing the labor-related share in two ways. First, we are updating the regression analysis that was done when the IPPS was originally developed, with the expectation that it would help give an alternative indication of the labor-related share. Second, we are reevaluating the methodology we currently use for determining the labor-related share using the hospital market basket.

Our regression analysis attempts to explain the variation in operating cost per case for a given year using many different explanatory variables, such as case-mix, DSH status, and ownership type. We described this methodology and some of our initial results in the May 9, 2002 **Federal Register** (67 FR 31447–31479). When included in the regression, the area wage index produces a coefficient that can be interpreted as the proportion of operating costs that vary with the geographic location of the hospital. The latest results on 1997 data produced a coefficient for the area wage index of 0.621, which can be interpreted as a labor share of 62.1 percent and is very close to the results reached by other groups. However, using the same specification produced coefficients of 76.7 percent for rural hospitals and 47.6 percent for urban hospitals, a disparity that cannot be supported either by theory or existing cost data. For example, the proportion of costs accounted for by wages, benefits, and contract labor is 60.8 percent for urban hospitals and 62.3 percent for rural hospitals, a spread much smaller than the regressions indicate. In addition, when the regressions were run separately by case-mix quartile and with hospital-specific wage variation (as opposed to using the area wage index), the findings were both difficult to explain and inconsistent with the underlying cost data. Thus, we believe at this point that the regression results

are not robust enough to support changing the current labor-related share measurement.

A second approach was to reevaluate our methodology for determining the labor-related share using the hospital market basket. We have researched various alternative data sources for further breaking down the cost categories in the market basket and have begun to evaluate alternative methodologies. While each of these alternatives has strengths and weaknesses, it is not clear at this point that any one alternative is superior to the current methodology. We want to continue researching these alternatives, in part, because changing from the current methodology would impact the labor-related shares for SNFs, HHAs, and all of the excluded hospital payment systems, since they use a similar methodology. Our research plan includes consulting with experts on these issues, including MedPAC, to evaluate the various alternative approaches to determining the labor-related share. We plan to invite public comments on any proposed change to the labor-related share.

In conclusion, we are proposing to continue using the 71.066 percent labor-related share that was calculated from the 1992-based market basket until we have completed our research.

Recommendation 2A–4: The Congress should raise the inpatient base rate for hospitals in rural and other urban areas to the level of the rate for those in large urban areas, phased in over 2 years.

Response: This recommendation, which MedPAC estimates would increase Medicare payments to hospitals by between \$200 and \$600 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 raising the base rate for hospitals in rural and other urban areas at this time.

Recommendation 2A–5: The Congress should raise the cap on the disproportionate share add-on a hospital can receive in the inpatient PPS from 5.25 percent to 10 percent, phased in over 2 years.

Response: This recommendation, which MedPAC estimates would increase Medicare payments to hospitals by between \$50 and \$200 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 raising the maximum DSH adjustments at this time.

VIII. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at <http://www.hcfa.gov/stats/pufiles.htm>. Data files and the cost for each file, if applicable, are listed below. Anyone wishing to purchase data tapes, cartridges, or diskettes should submit a written request along with a company check or money order (payable to CMS–PUF) to cover the cost to the following address: Centers for Medicare & Medicaid Services, Public Use Files, Accounting Division, PO Box 7520, Baltimore, MD 21207–0520, (410) 786–3691. Files on the Internet may be downloaded without charge.

1. CMS Wage Data

This file contains the hospital hours and salaries for FY 2000 used to create the proposed FY 2004 prospective payment system wage index. The file will be available by the beginning of February for the NPRM and the beginning of May for the final rule.

Processing year	Wage data year	PPS fiscal year
2003	2000	2004
2002	1999	2003
2001	1998	2002
2000	1997	2001
1999	1996	2000
1998	1995	1999
1997	1994	1998
1996	1993	1997
1995	1992	1996
1994	1991	1995
1993	1990	1994
1992	1989	1993
1991	1988	1992

These files support the following:

- NPRM published in the **Federal Register**.
- Final Rule published in the **Federal Register**.

Media: Diskette/most recent year on the Internet.

File Cost: \$165.00 per year.

Periods Available: FY 2004 PPS Update.