

commenters recommended that, if CMS excludes paid hours associated with military and jury duty leave, for consistency, CMS should also exclude the related wages. Alternatively, the commenters recommended that CMS collect data on the wages and hours associated with military and jury duty first, so that the impact of excluding the hours can be determined before the policy is implemented. One commenter believed that CMS should only include in the wage index, hours associated with regular hours, overtime, and sick leave, because these paid leave or paid time off categories are consistently offered among hospitals. The commenter also believed other paid leave or paid time off categories such as vacation hours, maternity leave, bereavement leave, and vacation hours should be excluded because they are not consistently offered among hospitals. In addition, the commenter believed that when hospitals are competing for employees in the labor market, if offered, these paid leave or paid time off hours could vary from hospital to hospital. For example, hospital A will only pay 2 weeks for paid vacation leave, while hospital B will pay 4 weeks for paid vacation leave. Therefore, the commenter believed these other paid leave or paid time off leave hours should be excluded from the wage index.

*Response:* As we stated above and in the proposed rule, it has been our longstanding policy to include paid hours in the calculation of the wage index because they more appropriately reflect a hospital's total wage costs. We solicited comments on the possible exclusion of paid lunch hours and proposed to exclude the paid hours associated with military and jury duty hours because of our concern that there were significant issues with the consistent treatment of these issues across hospitals that may impact the validity of the wage index. However, the comments indicate to us there is substantial disagreement with respect to whether either category of paid hours should be excluded from the wage index calculation. Therefore, we are not proceeding with either change at this time. We intend to explore a more comprehensive assessment of the use of paid hours in a future rule. For the FY 2005 final wage index, we are including paid lunch hours, and hours associated with military leave and jury duty.

#### *D. Verification of Wage Data From the Medicare Cost Reports*

The data file used to construct the wage index includes FY 2000 data submitted to us as of June 27, 2003. As

in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We constructed the proposed FY 2004 wage index based on the wage data for facilities that were IPPS hospitals in FY 2000, even for those facilities that have terminated their participation in the program as hospitals or have since been designated as a critical access hospital (CAH), as long as those data do not fail any of our edits for reasonableness. We stated that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period.

Prior to the proposed rule, we had received correspondence suggesting that the wage data for hospitals that have subsequently been redesignated as CAHs should be removed from the wage index calculation because CAHs are a separate provider type and are unique compared to other short-term, acute care hospitals. CAHs are limited to only 15 acute care beds. An additional 10 beds may be designated as swing-beds, but only 15 beds can be used at one time to serve acute care patients. CAHs tend to be located in isolated, rural areas. In the May 19, 2003 proposed rule, we solicited comments on whether we should exclude wage data from such hospitals from the wage index calculation. However, we included the data for current CAHs in the proposed FY 2004 wage index if the CAH was paid under the IPPS during FY 2000 as an acute care hospital.

*Comment:* Commenters, including national hospital associations, generally supported the removal of CAH wage data from the wage index. One commenter agreed that CAHs are dissimilar to IPPS hospitals and described a situation in which including a CAH has a negative impact on the other hospitals' wage index. One commenter agreed that CMS should exclude the costs, but expressed concern about the immediate financial impact that excluding CAHs might have on all hospitals in FY 2004. The commenter recommended that CMS examine the impact of removing CAH wage data from the wage index and make this analysis available for public comment. Another commenter recommended that CMS establish a date prior to the release of the wage index public use file that the facility must be certified as a CAH to be excluded from the wage index calculation.

Several commenters opposed excluding CAH data from the wage index. Some commenters indicated that CMS does not exclude hospitals that

converted to CAH status subsequent to the year used to derive DRG weights. Another commenter opposed excluding CAHs from the wage index because the commenter believed that the wage index should reflect conditions of a labor market at a specific point in time. The commenter believed that other conditions, such as closures, mergers, or expansions, are analogous circumstances and warned that excluding these hospitals would also distort the wage index. Another commenter recommended that CMS apply a hold-harmless policy.

*Response:* CAHs represent a substantial number of hospitals with significantly different labor costs in many labor market areas where they exist. Using data collected for the proposed FY 2004 wage index, we found that, in 89 percent of all labor market areas with hospitals that converted to CAH status some time after FY 2000, the average hourly wage for CAHs is lower than the average hourly wage for other short-term hospitals in the area. In 79 percent of the labor market areas with CAHs, the average hourly wage for CAHs is lower than the average hourly wage for other short-term hospitals by 5 percent or greater. These results suggest that the wage data for CAHs, in general, are significantly different from other short-term hospitals.

Further, we found that removing CAHs from the wage index would have a minimal redistributive effect on Medicare payments to hospitals. The majority of the labor market areas would decrease by only 0.30 percent in their wage index value. The actual payment impact would be even smaller because the wage index is applied to only the labor-related portion of the average standardized amount. Only 10 areas would experience a decrease in their wage index values greater than 0.30 percent. The greatest negative impact is 9.57 percent. Meanwhile, positive impacts occur in 48 areas, 30 of which are in rural areas. Overall, removing CAHs from the wage index would have a minimal redistributive effect on Medicare payments to hospitals.

We believe that removing CAHs from the wage index is prudent policy, given the substantial negative impact these hospitals have on the wage indexes in the areas where they are located and the minimal impact they have on the wage indexes of other areas. We note that we would continue to include the wage data for other terminating or converting hospitals for the period preceding their change in Medicare provider status, as long as those data do not fail any of our edits for reasonableness. This is because