

regression analysis with the expectation that it would help give an alternative indication of the labor-related share. Second, we continue to reevaluate the methodology we currently use for determining the labor-related share using the hospital market basket.

Our regression analysis is an attempt 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). However, the findings from the regressions continue to be 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.

We also continue to explore all options for alternative data or methodology for determining the labor-related share using the hospital market basket. We have researched various alternative data sources for use in further breaking down the cost categories in the market basket and have evaluated alternative methodologies to determine the feasibility of separating the labor-related portion or the portion that varies with local labor markets from the portion that does not vary. While each of these alternatives has strengths and weaknesses, it is not clear at this point that any one alternative data source or methodology is superior to the current methodology. We will continue to research these alternatives.

Comment: Several commenters suggested the labor share should only be adjusted by those costs (wages and salaries and benefits) that are reflected in the wage index survey. Commenters suggested that CMS should consider reducing the labor-related share for rural hospitals or having different labor shares by geographic location.

Response: We define the labor-related share to include all costs that are likely related to, influenced by, or vary with local labor markets, even if they could be purchased in a national market. This differs from the hospital wage index survey, which only collects direct labor and patient-related contract costs. Using only those direct labor costs reflected in the wage index survey would mean redefining the term labor-related share and would likely leave out many of the other costs that do vary with the local labor market.

As indicated in prior rules, we continue to research alternative methodologies for determining the labor-related share, including

reexamining the labor portion of each of the individual market basket categories. However, due to a lack of one definitive data source, our analysis is still preliminary and, therefore, we will continue to use 71.066 percent as the labor-related share applicable to the standardized amounts while we conduct further analysis to determine the most appropriate methodology for determining the labor-related share.

It is currently our policy to use a national labor-related share to apply to the national PPS standardized amounts. This policy has been in effect since the implementation of the IPPS in 1983. We will consider the commenters' recommended alternative approaches, such as different labor shares for urban and rural hospitals or labor shares that vary by more detailed geographic area, as part of our ongoing research efforts. However, until we have completed our research, we will continue to use only a national labor-related share, which is currently 71.066 percent and was calculated from the 1992-based market basket.

Comment: One commenter believed that we should examine each of the categories currently included in the labor share and determine which portion of that category was actually labor-related or varied with the local labor market.

Response: We agree with the commenter that it is important that the labor-related portion of the market basket include only those categories that are actually labor-related or vary with the local labor market. As we indicated in the May 19, 2003 rule, we are continuing to explore all options for accounting for the labor-related share, including reexamining each of the categories included in the current labor share (particularly professional fees, postage, and other labor-intensive services) to make sure the labor share represents only those costs that do vary with the local labor market. However, our preliminary research has indicated that much of the data needed to break out details from each of the current market basket categories into labor and nonlabor-related components are not readily available on a national basis. We will continue to research various data sources for this information and will update the labor share as needed once our research is complete.

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>. In the May 19, 2003 proposed rule, we published a list of data files that are available for purchase from CMS or that may be downloaded from the Internet free of charge (68 FR 27226 through 27228).

B. Collection of Information Requirements

This final rule directly does not impose any collection and recordkeeping requirements. Consequently, it does not need to be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare,