

in Table 2, to account for an IRF's geographic wage variation, low-income patients and, if applicable, location in a rural area.

The adjustment for an IRF's geographic wage variation includes the FY 2004 labor-related share adjustment

of 72.526 percent and the FY 2004 IRF urban or rural wage indices in Tables 3A and 3B of the Addendum of this final rule, respectively.

The adjustment for low-income patients is based on the formula used to account for the cost of furnishing care

to low-income patients as discussed in the August 7, 2001 IRF PPS final rule (67 FR 41360). The formula to calculate the low-income patient or LIP adjustment is as follows:

$(1 + \text{DSH})$  raised to the power of  $(.4838)$

$$\text{Where DSH} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non - Medicare Days}}{\text{Total Days}}$$

The adjustment for IRFs located in rural areas is an increase to the Federal prospective payment amount of 19.14 percent. This percentage increase is the same as the one described in the August 7, 2002 IRF PPS final rule (67 FR 41359).

To illustrate the methodology that we use to adjust the Federal prospective payments, we provide an example in Chart 7 below.

One beneficiary is in Facility A, an IRF located in rural Maryland, and

another beneficiary is in Facility B, an IRF located in the New York City metropolitan statistical area (MSA). Facility A's disproportionate share hospital (DSH) adjustment is 5 percent, with a low-income patient adjustment of (1.0239) and a wage index of (0.8946), and the rural area adjustment (19.14 percent) applies. Facility B's DSH is 15 percent, with a LIP adjustment of (1.0700) and a wage index of (1.4414).

Both Medicare beneficiaries are classified to CMG 0112 (without comorbidities). To calculate each IRF's total adjusted Federal prospective payment, we compute the wage-adjusted Federal prospective payment and multiply the result by the appropriate low-income patient adjustment and the rural adjustment (if applicable). Chart 7 illustrates the components of the adjusted payment calculation.

CHART 7.—EXAMPLE OF COMPUTING AN IRF'S FEDERAL PROSPECTIVE PAYMENT

	Facility A	Facility B
Federal Prospective Payment .....	\$25,068.79	\$25,068.79
Labor Share .....	$\times 0.72526$	$\times 0.72526$
Labor Portion of Federal Payment .....	18,181.39	18,181.39
Wage Index (shown in Tables 3A or 3B) .....	$\times 0.8946$	$\times 1.4414$
Wage-Adjusted Amount .....	= \$16,265.07	= \$26,206.65
Nonlabor Amount .....	+ \$6,887.40	+ \$6,887.40
Wage-Adjusted Federal Payment .....	= \$23,152.47	= \$33,094.05
Rural Adjustment .....	$\times 1.1914$	$\times 1.0000$
Subtotal .....	= \$27,583.85	= \$33,094.05
LIP Adjustment .....	$\times 1.0239$	$\times 1.0700$
Total FY 2004 Adjusted Federal Prospective Payment .....	= \$28,243.11	= \$35,410.64

Thus, the adjusted payment for facility A will be \$28,243.11, and the adjusted payment for facility B will be \$35,410.64.

#### F. Computing Total Payments Under the IRF PPS for the Transition Period

Under section 1886(j)(1) of the Act and § 412.626 of the regulations, payment for all IRFs with cost reporting periods beginning on or after October 1, 2002, will consist of 100 percent of the FY 2004 adjusted Federal prospective payment (plus any applicable outlier payments under § 412.624(e)(4)) and there will not be any blended payments. Accordingly, the FY 2004 IRF PPS rates set forth in this final rule will apply to all discharges on or after October 1, 2003 and before October 1, 2004.

#### G. IRF-Specific Wage Data

On page 41358 of the August 7, 2001 IRF PPS final rule, we responded to comments regarding the development of a separate wage index for IRFs. Our response indicated that we were unable to develop a separate wage index for rehabilitation facilities. Specifically, we responded to these comments as follows:

"At this time, we are unable to develop a separate wage index for rehabilitation facilities. There is a lack of specific IRF wage and staffing data necessary to develop a separate IRF wage index accurately. Further, in order to accumulate the data needed for such an effort, we would need to make modifications to the cost report. In the future, we will continue to research a wage index specific to IRF facilities. Because we do not have an IRF specific

wage index that we can compare to the hospital wage index, we are unable to determine at this time the degree to which the acute care hospital data fully represent IRF wages. However, we believe that a wage index based on acute care hospital wage data is the best and most appropriate wage index to use in adjusting payments to IRFs, since both acute care hospitals and IRFs compete in the same labor markets."

At the current time, we still do not have any IRF-specific wage data to determine the feasibility of developing an IRF-specific wage index or of developing an adjustment to refine the acute care hospital wage data to reflect inpatient rehabilitation services. We continue to look into alternative ways to collect, analyze, develop, and audit IRF-specific wage data that would reflect the