

wages and wage-related costs attributable to rehabilitation facilities.

We believe that the best source to collect IRF-specific wage data is the Medicare cost report—the same source for the acute care hospital wage data. These data must be accurate and reliable; thus, collecting these data would increase the recordkeeping and reporting burden on IRFs. Initially, this burden would be imposed to collect data just to determine the feasibility of developing an IRF-specific wage index or development of an adjustment to the current IRF wage index.

In addition, as stated earlier in this section of this final rule, any adjustment or update to the wage index must be made in a budget neutral manner in accordance with section 1886(j)(6) of the Act. Thus, the PPS rates for any one IRF could be affected in a positive or negative direction, due to the application of the updates to the labor-related share and wage indices in a budget neutral manner. Accordingly, given the current trend of reducing the Medicare cost reporting burden of collecting data and given that any change to the wage index be budget neutral, in the May 16, 2003 proposed rule, we did not propose to require facilities to record additional information at this time, however we solicited comments on possible ways to adjust or refine the current IRF wage index, given those restraints.

Comment: One commenter offered to meet with us to discuss the feasibility and effort involved with developing an IRF-based wage index.

Response: We appreciate the commenter's willingness to meet and we will contact them to arrange a meeting in the future.

In this final rule, we are not imposing the burden of collecting these data and we will continue to explore options to adjust or refine the current IRF wage index, given the restraints previously discussed.

Since IRFs and hospitals compete in the same labor markets, we will continue to use the acute care hospital wage data to develop the IRF wage index as described earlier in this section of this final rule.

Comment: One commenter requested that we reconsider the decision in the August 7, 2001 final rule to use pre-reclassification wage data to determine a facilities wage adjustment and suggested the use of the post-reclassification wage index. The commenter asserted that using the pre-reclassification wage index disadvantages IRFs because they must compete in the same labor market as their affiliated acute care hospital for

the same pool of highly trained personnel.

Response: In the November 2, 2000 proposed rule, we proposed to use the pre-reclassification wage index. In the August 7, 2001 final rule, we addressed comments that we received regarding the use of the post-reclassification wage index. In the August 7, 2001 final rule we stated that we believe the actual location of an IRF as opposed to the location of affiliated providers is most appropriate for determining the wage adjustment because the data support the premise that the prevailing wages in the area in which the facility is located influence the cost of a case. We also stated that IRFs provide services that are considered part of the post-acute continuum of care and in order to be consistent with the area wage adjustments made to other post-acute care providers (that is, under the existing SNF and HHA prospective payment systems), we are using the inpatient acute care hospital wage data without regard to any approved geographic reclassifications under section 1886(d)(8) or 1886(d)(10) of the Act. Therefore, for all of the reasons stated above, we will continue to use the pre-reclassification wage index to adjust an IRF's PPS payments and base this payment adjustment on the facility's actual location.

We would also like to point out that on June 6, 2003, the Office of Management and Budget (OMB) issued "OMB Bulletin No.03-04," announcing revised definitions of Metropolitan Statistical Areas, and new definitions of Micropolitan Statistical Areas and Combined Statistical Areas. A copy of the Bulletin may be obtained at the following Internet address: <http://www.whitehouse.gov/omb/bulletins/b03-04.html>. These new definitions will not be applied to the FY 2004 IRF wage index. However, we will be studying the new definitions and their impact and, if warranted, may adopt them at a later point in time using the appropriate administrative processes. To the extent these definitions are used, the concerns expressed by many for the use of a geographical reclassification system may be mitigated.

H. Adjustment for High-Cost Outliers Under the IRF PPS

In the May 16, 2003 proposed rule, we proposed changes to the methodology for determining IRF payments for high-cost outliers. The intent of the proposed changes was to ensure that outlier payments are paid only for truly high-cost cases. Further, we indicated that these proposed changes would allow us to create policies that are consistent

among the various Medicare prospective payment systems when appropriate.

We have become aware that under the IPPS, some hospitals have taken advantage of two features in the IPPS outlier policy to maximize their outlier payments. The first is the time lag between the current charges on a submitted bill and the cost-to-charge ratio taken from the most recent settled cost report. Second, statewide average cost-to-charge ratios are used in those instances in which an acute care hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. We set forth these parameters and the statewide cost-to-charge ratios in the annual notices of prospective payment rates that are published by August 1 of each year in accordance with § 412.8(b). Currently, these parameters represent 3.0 standard deviations (plus or minus) from the geometric mean of cost-to-charge ratios for all hospitals. In some cases, hospitals may increase their charges so far above costs that their cost-to-charge ratios fall below 3 standard deviations from the geometric mean of the cost-to-charge ratio and a higher statewide average cost-to-charge ratio is applied to determine if the acute care hospital should receive an outlier payment. This disparity results in their cost-to-charge ratios being set too high, which in turn results in an overestimation of their current costs per case.

We believe the Congress intended that outlier payments under both the IPPS and the IRF PPS would be made only in situations where the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. Under the IPPS outlier methodology, if hospitals' charges are not sufficiently comparable in magnitude to their costs, the legislative purpose underlying the outlier regulations is thwarted. Thus, on March 4, 2003, we published in the **Federal Register** a proposed rule "Proposed Changes in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient Prospective Payment System" (68 FR 10420-10429) with an extensive discussion proposing new regulations to ensure outlier payments are paid for truly high-cost cases under the IPPS. This policy was finalized in a final regulation on June 9, 2003 (68 FR 34494), effective August 8, 2003.

We believe the use of these parameters is appropriate in determining cost-to-charge ratios to ensure these values are reasonable and outlier payments can be made in the most equitable manner possible.