

IPF wage indices, because there is not an IPF-specific wage index available. We believe that the inpatient acute care hospital wage data reflects wage levels similar to psychiatric units as well as free-standing psychiatric hospitals. We also believe that IPFs generally compete in the same labor market as inpatient acute care hospitals.

Furthermore, we are proposing to adjust the labor-related portion of the proposed prospective payment rates for area differences in wage levels by a factor reflecting the relative facility wage level in the geographic area of the IPF compared to the national average wage level for these hospitals. We believe that the actual location of the IPF 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 IPF is located influence the cost of a case. Thus, we are using the inpatient acute care hospital wage data without regard to any approved geographic reclassification as specified in section 1886(d)(8) or 1886(d)(10) of the Act. We note this policy is

consistent with the area wage adjustments used in other non-acute care facility prospective payment systems.

To account for wage differences, we first identified the proportion of labor and non-labor components of costs. We used our proposed 1997-based excluded hospital market basket with capital to determine the labor-related share. We calculated the proposed labor-related share as the sum of the weights for those cost categories contained in the proposed 1997-based excluded hospital with capital market basket that are influenced by local labor markets. These cost categories include wages and salaries, employee benefits, professional fees, labor-intensive services, and a 46 percent share of capital-related expenses. The labor-related share for the base period of the proposed prospective payment system (April 1, 2004 through June 30, 2005) is the sum of the relative importance of each labor-related cost category for this period, and reflects the different rates of price change for these cost categories between the base year (FY 1997) and this period. The sum of the relative importance for operating

costs (wages and salaries, employee benefits, professional fees, and labor-intensive services) is 69.348 percent, as shown below in Table 6. The portion of capital that is influenced by local labor markets is estimated to be 46 percent. Because the relative importance of capital is 7.566 percent of the proposed 1997-based excluded hospital with capital market basket for the period April 1, 2004 through June 30, 2005, we would take 46 percent of 7.566 percent to determine the proposed labor-related share of capital. The result, 3.48 percent, is then added to the proposed 69.348 percent calculated for operating costs to determine the total proposed labor-related relative importance. The resulting labor-related share that we propose to use for the proposed IPF prospective payment system is 72.828 percent. The table below shows that the proposed labor-related share would have been 73.570 percent if we had not rebased the excluded hospital with capital market basket using more recent 1997 data rather than using 1992 data. As shown in Table 6, rebasing results in a lowering of the labor-related share by .742 percent.

TABLE 6.—PROPOSED LABOR-RELATED SHARE RELATIVE IMPORTANCE

| Cost Category | Relative Importance 1992-based Market Basket (April 2004 to June 2005) | Relative Importance 1997-based Market Basket (April 2004 to June 2005) |
|--|--|--|
| Wages and salaries | 50.714 | 49.158 |
| Employee benefits | 11.930 | 11.077 |
| Professional fees | 2.060 | 4.540 |
| Postage | 0.252 | |
| All other labor intensive services | 5.252 | 4.572 |
| Subtotal | 70.209 | 69.348 |
| Labor-related share of capital costs | 3.360 | 3.480 |
| Total | 73.570 | 72.828 |

A precedent exists for using this method to determine the proportion of payments adjusted for geographic differences in labor costs. Specifically, the labor-related share for acute care hospitals is determined from the prospective payment system hospital operating market basket using a similar method.

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 for IPFs, since both the acute care hospitals and IPFs compete in the same labor markets. This wage data includes the following categories of data: (1) Salaries and hours from short-term acute care hospitals; (2) home office costs and hours; (3) certain

contract labor costs and hours; and (4) wage-related costs. The wage data excludes wages for services provided by teaching physicians, interns and residents, and nonphysician anesthetists under Medicare Part B, because we would not cover these services under the proposed IPF prospective payment system.

Consistent with the wage index methodologies in other prospective payment systems, we are proposing to divide IPFs into labor market areas. For the purpose of defining labor market areas, we are proposing to define an urban area as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Office of Management and

Budget (OMB). In addition, we are proposing to define a rural area as any area outside an urban area. The proposed IPFs wage indices would be computed as follows:

- Compute an average hourly wage for each urban and rural area.
- Compute a national average hourly wage.
- Divide the average hourly wage for each urban and rural area by the national average hourly wage.

The result is a proposed wage index for each urban and rural area (see Addendum B1 for the proposed wage index for urban areas and Addendum B2 for the proposed wage index for rural areas).