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Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 411, 413, and 489

[HCFA–1112–F]

RIN 0938–AJ93

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule sets forth updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year 2001. Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act, as amended by the Medicare, Medicaid and State Child Health Insurance Program Balanced Budget Refinement Act of 1999, related to Medicare payments and consolidated billing for SNFs. In addition, this rule sets forth certain conforming revisions to the regulations that are necessary in order to implement amendments made to the Act by section 103 of the Medicare, Medicaid and State Child Health Insurance Program Balanced Budget Refinement Act of 1999.

EFFECTIVE DATE: These regulations are effective on October 1, 2000.

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In addition, because of the many terms to which we refer by abbreviation in this rule, we are listing these abbreviations and their corresponding terms in alphabetical order below:

ADL Activity of Daily Living
BBA Balanced Budget Act of 1997, P.L. 105–33
BBRA Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999, P.L. 106–113, Appendix F
BLS (U.S.) Bureau of Labor Statistics
CPI Consumer Price Index
HCFA Health Care Financing Administration
HCPCS HCFA Common Procedure Coding System
IFC Interim Final Rule with Comments
MDS Minimum Data Set
MSA Metropolitan Statistical Area
PPI Producer Price Index
PPS Prospective Payment System
PRM Provider Reimbursement Manual
RUG–III Resource Utilization Groups, version III
SCHIP State Child Health Insurance Program
SNF Skilled Nursing Facility

I. Background

On April 10, 2000, we published in the **Federal Register** (65 FR 19188), a proposed rule that set forth updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2001. Furthermore, it specifically proposed changes to the SNF PPS case-mix methodology. Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act (the Act), as amended by the Medicare, Medicaid and State Child Health Insurance Program Balanced Budget Refinement Act of 1999, related to Medicare payments and consolidated billing for SNFs. In addition, the rule proposed certain conforming revisions to the regulations necessary in order to implement amendments made to the Act by section 103 of the Medicare, Medicaid and State Child Health Insurance Program Balanced Budget Refinement Act of 1999 (BBRA), Public Law 106–113, Appendix F.

A. Current System for Payment of Skilled Nursing Facility Services Under Part A of the Medicare Program

Section 4432 of the Balanced Budget Act of 1997 (BBA) (Public Law 105–33) mandated the implementation of a per diem PPS for SNFs, covering all costs (routine, ancillary, and capital) of covered SNF services furnished to beneficiaries under Part A of the Medicare program, effective for cost reporting periods beginning on or after July 1, 1998. We are updating the per

diem payment rates for SNFs, for FY 2001. Major elements of the SNF PPS include:

• *Rates*: Per diem Federal rates were established for urban and rural areas using allowable costs from FY 1995 cost reports. These rates also included an estimate of the cost of services that, before July 1, 1998, had been paid under Part B but furnished to Medicare beneficiaries in a SNF during a Part A covered stay. Rates are case-mix adjusted using a classification system (Resource Utilization Groups, version III (RUG–III)) based on beneficiary assessments (using the Minimum Data Set (MDS) 2.0). In addition, the Federal rates are adjusted by the hospital wage index to account for geographic variation in wages. Further, the rates are adjusted annually using an SNF market basket index.

• *Transition*: The SNF PPS includes a 3-year, phased transition that blends a facility-specific payment rate with the Federal case-mix adjusted rate. For each cost reporting period after a facility migrates to the new system, the facility-specific portion of the blend decreases and the Federal portion increases, in 25 percent increments. For most facilities, the facility-specific rate is based on allowable costs from FY 1995. As discussed later in this final rule, section 102 of the BBRA authorized facilities to elect to bypass the transition to be paid at the full Federal rate.

• *Coverage*: The PPS statute did not change Medicare's fundamental requirements for SNF coverage. However, because RUG–III classification is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have attempted where possible to coordinate claims review procedures with the outputs of beneficiary assessment and RUG–III classifying activities.

• *Consolidated Billing*: The statute includes a billing provision that requires a SNF to submit consolidated Medicare bills for its beneficiaries for virtually all services that are covered under either Part A or Part B. The statute excludes a small list of services (primarily those of physicians and certain other types of practitioners). As discussed later in this final rule, section 103 of the BBRA has identified certain additional services for exclusion, effective April 1, 2000.

B. Requirements of the Balanced Budget Act of 1997 for Updating the Prospective Payment System for Skilled Nursing Facilities

Section 1888(e)(4)(H) of the Act requires that we publish in the **Federal Register:**

1. The unadjusted Federal per diem rates to be applied to days of covered SNF services furnished during the FY.

2. The case-mix classification system to be applied with respect to these services during the FY.

3. The factors to be applied in making the area wage adjustment with respect to these services.

In addition, in the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to Part A SNF services or to the RUG–III classifications.

Along with a number of other revisions and refinements discussed later in this preamble, this final rule provides the annual updates to the Federal rates, as mandated by the Medicare statute.

C. The Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA)

As a result of enactment of the BBRA, there are several new provisions that result in adjustments to the PPS for SNFs. The following provisions were described in the proposed rule that we published on April 10, 2000 (65 FR 19188), and are discussed further in section III. of this preamble, to the extent that we received public comments concerning them:

• Section 101 provides for a temporary, 20 percent increase in the per diem adjusted payment rates for 15 specified RUG–III groups (SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, CA1, RHC, RMC, and RMB). This legislation provides that the 20 percent increase takes effect with SNF services that are furnished on or after April 1, 2000, and continues until the later of October 1, 2000, or implementation by the Secretary of a refined RUG system. Thus, the 20 percent increase serves as a temporary, interim adjustment to the payment rates and RUG–III classification system as published in the final rule of July 30, 1999, and will continue until implementation of the case-mix refinements described in the legislation. As discussed in Section III., we are not implementing such case-mix refinements in this final rule. Therefore, the 20 percent increase for the specified RUG–III groups will remain in effect during FY 2001. Section 101 also includes an across-the-board increase in the adjusted Federal per diem payment rates by 4 percent each year for FYs 2001 and 2002, exclusive of the 20 percent increase.

• Section 102 authorizes SNFs that would otherwise be subject to the three-year, phased transition from facility-specific to Federal rates to elect instead to make an immediate transition to the full Federal rate.

• Effective April 1, 2000, section 103 excludes from the SNF PPS bundle and the consolidated billing requirement certain types of ambulance services, certain customized prosthetic devices, and certain services involving chemotherapy and its administration; beginning with FY 2001, this section also requires a corresponding proportional reduction in Part A SNF payments.

• Section 104 provides for a Part B add-on for facilities participating in the Multistate Nursing Home Case-Mix and Quality (NHCMQ) Demonstration Project.

• Section 105 provides for a 50 percent Federal, 50 percent facility-specific payment rate for those SNFs that serve certain specialized patient populations.

• Section 155 provides that PPS payment to certain SNF providers located in Baldwin or Mobile County, Alabama, are based on 100 percent of their facility specific rates for cost reporting periods that begin in FY 2000 or FY 2001.

We included further information on these provisions in Program Memorandums A–99–53 and A–99–61 (December 1999), and Program Memorandum A–00–18 (March 2000).

D. Skilled Nursing Facility Prospective Payment—General Overview

The Medicare SNF PPS was implemented for cost reporting periods beginning on or after July 1, 1998. Under the PPS, SNFs are paid through prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services. These payment rates cover all the costs of furnishing covered skilled nursing services (that is, routine, ancillary, and capital-related costs) other than costs associated with approved educational activities. Covered SNF services include posthospital SNF services for which benefits are provided under Part A and all items and services that, before July 1, 1998, had been paid under Part B (other than physician and certain other services specifically excluded under the BBA) but furnished to Medicare beneficiaries in a SNF during a Part A covered stay. (A complete discussion of these provisions appears in the May 12, 1998 interim final rule (63 FR 26252)).

1. Payment Provisions—Federal Rate

The statute sets forth a fairly prescriptive methodology for calculating the amount of payment under the SNF PPS. The PPS utilizes per diem Federal payment rates based on mean SNF costs in a base year updated for inflation to the first effective period of the PPS. We developed the Federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in FY 1995. The data used in developing the Federal rates also incorporate an estimate of the amounts that would be payable under Part B for covered SNF services to individuals who were receiving Part A covered services in an SNF.

In developing the rates for the initial period, we updated costs to the first effective year of PPS (15-month period beginning July 1, 1998) using a SNF market basket index, and standardized for facility differences in case-mix and for geographic variations in wages. Providers that received ''new provider'' exemptions from the routine cost limits were excluded from the database used to compute the Federal payment rates. In addition, costs related to payments for exceptions to the routine cost limits were excluded from the database used to compute the Federal rates. In accordance with the formula prescribed in the BBA, we set the Federal rates at a level equal to the weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and weighted mean of all SNF costs (hospital-based and freestanding) combined. We compute and apply separately the payment rates for facilities located in urban and rural areas. In addition, we adjust the portion of the Federal rate attributable to wage related costs by a wage index.

The Federal rate also incorporates adjustments to account for facility case-mix using a classification system that accounts for the relative resource utilization of different patient types. This classification system, RUG–III, utilizes beneficiary assessment data (from the Minimum Data Set or MDS) completed by SNFs to assign beneficiaries into one of 44 groups. The May 12, 1998 interim final rule (63 FR 26252) has a complete and detailed description of the RUG–III classification system. The BBA requires us to publish the SNF PPS case-mix classification methodology applicable for the next Federal FY before August 1 of each year. In the proposed rule, we discussed options for refining the existing RUG–III classification system. Further discussion of this issue appears in Section III. A. of this rule.

The Federal rates reflected in this rule update the rates in the July 30, 1999 update notice (64 FR 41684) by a factor equal to the SNF market basket index minus 1 percentage point. According to section 1888(e)(4)(E)(ii) of the Act, for FYs 2001 and 2002, we will update the rate by adjusting the current rates by the SNF market basket change minus 1 percentage point. For subsequent FYs, we will adjust the rates by the applicable SNF market basket change.

2. Payment Provisions—Transition Period

Beginning with a provider's first cost reporting period beginning on or after July 1, 1998, there is a transition period covering three cost reporting periods. During the transition period, SNFs receive a payment rate comprising a blend between the Federal rate and a facility-specific rate based on each facility's FY 1995 cost report. Under section 1888(e)(2)(E)(ii) of the Act, SNFs that received their first payment from Medicare on or after October 1, 1995 receive payment according to the Federal rates only.

For SNFs subject to transition, the composition of the blended rate varies depending on the year of transition. For the first cost reporting period beginning on or after July 1, 1998, we make payment based on 75 percent of the facility-specific rate and 25 percent of the Federal rate. In the next cost reporting period, the rate consists of 50 percent of the facility-specific rate and 50 percent of the Federal rate. In the following cost reporting period, the rate consists of 25 percent of the facility-specific rate and 75 percent of the Federal rate. For all subsequent cost reporting periods, we base payments entirely on the Federal rates.

As noted elsewhere in this regulation, in accordance with section 102 of the BBRA, SNFs that would otherwise be subject to the statutory three-year, phased transition from facility-specific to Federal rates, may elect to bypass the transition and go directly to the full Federal rate. This amendment applies to elections made on or after December 15, 1999, except that no election will be effective for a cost reporting period beginning before January 1, 2000; an election is effective for a cost reporting period beginning no earlier than 30 days before the date of the election.

3. Payment Provisions—Facility-Specific Rate

For most facilities, we compute the facility-specific payment rate utilized for the transition using the allowable costs of SNF services for cost reporting periods beginning in FY 1995 (cost reporting periods beginning on or after October 1, 1994 and before October 1, 1995). Included in the facility-specific per diem rate is an estimate of the amount that would be payable under Part B for covered SNF services furnished during FY 1995 to those beneficiaries in the facility who were receiving Part A covered services. The facility-specific rate, in contrast to the Federal rates, includes amounts paid to SNFs for exceptions to the routine cost limits. In addition, we also take into account ''new provider'' exemptions from the routine cost limits, but only to the extent that routine costs do not exceed 150 percent of the routine cost limit.

We update the facility-specific rate for each cost reporting period after 1995 by a factor equal to the SNF market basket percentage increase minus 1 percentage point. In each subsequent year, we will update it by the applicable SNF market basket increase.

II. Provisions of the Proposed Rule

The proposed rule that we published in the **Federal Register** (65 FR 19188, April 10, 2000) included proposed FY 2001 updates to the Federal payment rates used under the SNF PPS. In accordance with section 1888(e)(4)(E)(ii)(II) of the Act, the proposed updates reflected the SNF market basket percentage change for that fiscal year minus 1 percentage point. Also, in order to facilitate the incorporation of proposed refinements into the case-mix classification system (see discussion in Section III. A. of this final rule), we created a separate component of the payment rates specifically to account for non-therapy ancillary costs (which have been included within the overall nursing case-mix component of the payment rates). In addition, the proposed rule described our methodology for adjusting the Federal rates in accordance with section 103 of the BBRA, in order to reflect that provision's exclusion of certain additional items and services from the SNF PPS and consolidated billing. Further, we provided for a 4 percent increase in the adjusted Federal rate, in accordance with section 101 of the BBRA. We also included a discussion of the rights of SNFs to appeal their payment rates under the PPS (65 FR 19192). In addition, we proposed to make certain refinements in the case-mix classification system, in accordance with section 101 of the BBRA (see discussion in Section III. A. of this final rule).

In addition to discussing these general issues in the proposed rule, we also proposed to make the following specific revisions to the existing text of the regulations:

- In § 411.15, paragraph (p)(2)(vii) would be revised to exclude from consolidated billing those ambulance services that are furnished to an SNF resident in conjunction with dialysis services that are covered under Part B.
- In § 411.15, paragraph (p)(2) would also be revised to list the additional services that section 103 of the BBRA has excluded from consolidated billing.
- In § 411.15, paragraph (p)(3)(iv), the phrase ''within 24 consecutive hours'' would be revised to read ''by midnight of the day of departure''.
- In § 489.20, paragraph (s) would be revised to list the additional services that the BBRA has excluded from consolidated billing, and a conforming change would be made in § 489.21(h).
- In § 489.20, paragraph (s)(7) would be revised to exclude from consolidated billing those ambulance services that are furnished to an SNF resident in conjunction with dialysis services that are covered under Part B.
- Section 489.20(s)(11) and § 411.15(p)(2)(xi), would be revised to reflect editorial revisions in the paragraphs concerning the transportation costs of electrocardiogram equipment.

More detailed information on each of these issues can be found in the discussion contained in the following section of this final rule.

III. Analysis of and Responses to Public Comments

In response to the publication of the proposed rule on April 10, 2000, we received approximately 750 comments. The majority consisted of form letters, in which we received multiple copies of an identically-worded letter that had been signed and submitted by different individuals. Furthermore, we received over 30 comments from various trade associations and other major organizations. Comments originated from nursing homes and other providers, suppliers and practitioners (both individually, and through their respective trade associations), nursing home resident advocacy groups, health care consulting firms, and private citizens. While the comments fell into several broad areas, by far the largest number involved the refinements that we proposed to make in the PPS case-mix classification system, in accordance with section 101 of the BBRA.

A. Case-Mix Refinements

The proposed rule discussed options for refinements to the RUG-III system, described ongoing research and analyses, shared the initial results that we proposed be incorporated into the Medicare PPS system effective October 1, 2000, and solicited comments from all interested parties.

1. Potential Case-Mix Refinements Described in the Proposed Rule

Comment: We received numerous comments on the potential refinements, the supporting data, and the analyses planned to validate the data. Commenters were concerned first about our ability to complete the analyses on a timely basis, and then on how we would use the additional analyses in setting the FY 2001 rates. They also expressed concerns that the proposed refinements might not adequately address the problems that they perceived with current PPS payment levels.

Response: In the proposed rule (65 FR 19202), we indicated that we believed our preliminary research findings to be valid, but we also noted that

> * * * it is certainly possible that additional testing will identify new issues or suggest alternative refinements to those presented here. We remain open to suggestions during the comment period and will carefully evaluate the validation analyses before proceeding to final rulemaking.

We conducted the validation analyses discussed in the proposed rule to identify the actual distribution of the Medicare population, to determine any cost or acuity differences associated with short stay beneficiaries, and to validate the predictive power of the unweighted and weighted models in identifying variations in ancillary costs using national data from a current period (for example, after the implementation of the SNF PPS). We identified several important variations in the volume and distribution of beneficiaries and ancillary services costs using the 1999 national data which appear to have affected the performance of the index models described in the proposed rule.

In examining the 1999 data, it is apparent that the introduction of the PPS and consolidated billing provisions for covered Part A SNF stays has caused changes in facility practice patterns and billing, although some of this change may be the effect of using national data. In part, these variations may be related to changes in facility practices regarding the use of pharmaceuticals and in the way respiratory therapy services are provided to Medicare beneficiaries. For example, respiratory therapy (RT) was a significant portion of the non-therapy ancillary services in the pre-PPS data base used to develop the refinement models. This component of cost provided a significant contribution to the predictive power of the index models presented in the proposed rule. However, mean RT costs decreased from $16.04 based on a re-analysis of the six State sample to $5.46 in the 1999 national data base (or a 66 percent decrease). We believe that the decrease may be a result of both more prudent use of the services (RT has been a target of OIG studies in utilization and pricing) and the incentives created by the PPS (for example, the use of nurses to provide RT care). On the other hand, average drug costs increased from $29.93 based on a re-analysis of the six State sample to $92.38 in 1999 national data base. Therefore, when applying the non-therapy ancillary index indicators to the national PPS data, we found the models were less effective in predicting ancillary cost variations than when applied to the earlier research data.

As stated in the proposed rule, we were committed to validating the research results before proceeding to a refinement which required such a large expansion of the RUG–III classification system and impact on the delivery of SNF care. Since our latest validation analyses do not confirm the effectiveness of index models in the current PPS environment, we are not proceeding with implementation of the RUG refinements discussed in the proposed rule. Therefore, for FY 2001, we will be maintaining the existing 44-group RUG–III configuration. Consequently, we will also maintain the 20 percent add-on to the Federal rates for the 15 selected RUG-III groups, in accordance with section 101 of BBRA.

The inability to validate the specific non-therapy ancillary index models described in the proposed rule does not preclude us from further efforts to improve the payment system's ability to allocate payments based on expected ancillary use. However, additional research will be needed to identify variables that will be effective predictors in the PPS environment. Now that we have developed a large national database of claims and MDS records from 1999, we plan to continue research on the development of a non-therapy ancillary index, as well as to investigate other potential refinement approaches. In continuing this research, we will carefully consider the comments we received, and use these comments to assist us in exploring potential solutions.

Finally, as indicated in the April 10, 2000, proposed rule, both non-therapy ancillary index models were designed in conjunction with an addition to the RUG–III hierarchy; for example, 14 combined Extensive Services/ Rehabilitation groups. While this approach may warrant further exploration, we are not adopting it at this time. The validation analyses looked at the impact of both components of the proposed refinements: the expansion of the RUG–III groups and the creation of a non-therapy ancillary index. The combined predictive power of both components was approximately 3 percent. Measured separately, the added predictive power of either component would be negligible. The benefit of expanding the number of RUG–III groups would be too small to justify the added complexity of the RUG–III system. We will continue to work to develop ways to address the needs of those beneficiaries who require an unusually heavy combination of clinical care, rehabilitation services, and ancillary utilization, without creating perverse incentives that could negatively affect the quality of care for this vulnerable segment of the beneficiary population.

2. Clinical Issues

Comment: One commenter raised an issue involving certain restrictions placed by SNF administrators on staff's provision of therapies. The commenter reported that SNFs frequently constrain the amount of therapy therapists are permitted to provide the beneficiaries in particular facilities. Specifically, the commenter stated that therapists have been instructed by SNFs to limit therapy minutes to the minimum required for the medium RUG–III groups.

Response: In view of this comment, in addition to other anecdotal evidence, we believe it is appropriate to reiterate some key points of Medicare policy. As we previously stated in the final rule of July 30, 1999 (64 FR 41662), the number of minutes per week that are used as qualifiers for classification into the rehabilitation RUG–III groups ''are minimums and are not to be used as upper limits for service provision.'' Facilities with patterns of therapy service provided at the minimum levels may be targeted for medical review and other audit activities. Arbitrary decisions by facility administrative staff to override the professional decision-making regarding which types and how much therapy service are needed by, and will be provided to, the individual beneficiary are inconsistent with our requirements for individual evaluations by a licensed professional therapist, care plan development that involves the physician and the professional therapist, and the strict rules we have promulgated regarding supervision of therapy service provision when service is provided by someone other than the licensed professional.

Further, the Medicare requirements for participation (at section 1819(b) of the Act) require SNFs to provide the services necessary to attain each resident's highest level of physical functioning. Any facility level policy that obstructs this goal is in direct conflict with Medicare policy.

In addition, because we are not implementing the RUG–III refinements as proposed, we are concerned about some of the payment incentives associated with the 20 percent add-ons for 15 of the RUG–III groups. We are especially concerned about the effect on provider behavior that could result from the incentive provided by the add-on for such groups as those in the extensive services category, and for three of the rehabilitation RUG–III groups. For example, the additional payment for the RHC, RMC, and RMB groups results in higher payment for these groups than for some other, higher-level rehabilitation groups. We want to make clear that although this may create a fiscal incentive to provide less service in order to receive a higher rate of payment, we expect that facilities will continue to provide therapy at the levels most appropriate for each individual beneficiary.

However, we realize that this is a powerful incentive and, therefore, are working on ways to monitor the inappropriate denial of services to beneficiaries in facilities' attempts to achieve higher payment. We are exploring our monitoring options and strategies to detect and deter inappropriate practices in this area, and will be able to present more specific information about our plans at our fall fiscal intermediary and provider training sessions. Monitoring activities will include our use of MDS data linked to SNF bills (which allows us to identify patterns and trends of SNF use and RUG–III group distributions), the SNF PPS Quality Medical Review Pilot and Data Analysis Peer Review Organization (which will specifically focus on the impact of the PPS in terms of quality of care and the potential for underutilization), and survey reports. At the facility level, we would certainly expect that any significant shift in beneficiary RUG–III classifications (for example, all beneficiaries being classified into the rehabilitation groups that have the 20 percent add-on), would result in closer monitoring and possible intervention.

Comment: We received a few comments regarding the clinical items used as indicators for the non-therapy ancillary index. The commenters suggested additional MDS items that they believe should be used to trigger additional payment.

Response: The clinical items used as indicators for the non-therapy ancillary indices, in the models discussed in the proposed rule are based on the data analyses performed to create the models. We did not undertake the research with any preconceived expectations or preferences as to the variables we believed would be most predictive of non-therapy ancillary cost. Rather, we looked to the data itself to identify the MDS items that were predictive of costs. We did not make decisions about the inclusion of these items and the values accepted for them unless the decision could be supported by the data analyses. As we continue to perform data analyses to identify the best way to recognize non-therapy ancillary costs, we will take into consideration the suggestions offered during the comment period. We plan to reexamine, using national data, which MDS items are predictive of non-therapy ancillary costs.

3. Medical Review and Fiscal Intermediary Issues

Comment: Many comments suggested that implementation of the refinements should be accompanied by HCFA-sponsored provider training. The reasons given for the additional training request are the expectation that the refinements will require software changes as well as some other operational changes. A few also suggested that clinical staff in particular, needed additional training because the refined RUG–III groups would necessitate changes in assessing, coding and documenting clinical decisions.

Response: Although we are not going forward with the proposed refinements, we do intend to proceed with our plans for provider and fiscal intermediary training, in order to ensure that they have the most current information available on medical review procedures, claims processing requirements, and other aspects of the SNF PPS. We have already made plans for the provision of both ''train-the-trainer'' sessions for the fiscal intermediaries and for other HCFA-sponsored provider training to present updates on all aspects of the SNF PPS. We believe that having a full understanding of the payment and classification systems will help

providers achieve their highest levels of performance.

4. Section U of the Minimum Data Set

Comment: We received a few comments expressing disappointment at our decision not to collect medication data using Section U of the minimum data set (MDS). These commenters suggested that we are losing an opportunity to collect very important information about the medications being offered to Medicare beneficiaries. They point out the importance of this data collection from both quality of care and payment perspectives. We also received a comment applauding our decision not to collect the medication data, which stated that the MDS should be streamlined rather than expanded.

Response: We appreciate the commenters' concerns but, as stated in the proposed rule, we cannot collect the medication data beginning in October 2000, as we had planned. However, we are continuing our evaluation and will take all of the comments into consideration in that process.

B. Update of Payment Rates Under the Prospective Payment System for Skilled Nursing Facilities

1. Federal Prospective Payment System

This final rule sets forth a schedule of Federal prospective payment rates applicable to Medicare Part A SNF services beginning October 1, 2000. The schedule incorporates per diem Federal rates that provide Part A payment for all costs of services furnished to a beneficiary in an SNF during a Medicare-covered stay. Tables 1 and 2 reflect the updated components of the unadjusted Federal rates.

TABLE 1.—UNADJUSTED FEDERAL RATE PER DIEM

[Urban]

Rate component	Nursing—Case-mix	Therapy—Case-mix	Therapy—Non-case mix	Non-case-mix
Per Diem Amount	$114.38	$86.16	$11.35	$58.38

TABLE 2.—UNADJUSTED FEDERAL RATE PER DIEM

[Rural]

Rate component	Nursing—Case-mix	Therapy—Case-mix	Therapy—Non-case mix	Non-case-mix
Per Diem Amount	$109.29	$99.34	$12.13	$59.45

2. Case-Mix Adjustment

As noted earlier in this final rule, we are not proceeding with the implemenation of the RUG refinements discussed in the proposed rule. Accordingly, the payment rates set forth in this final rule reflect the continued use of the 44-group RUG-III classification system discussed in the May 12, 1998 interim final rule (63 FR 26252). The case-mix adjusted payment rates are listed separately for urban and rural SNFs in Tables 3 and 4, with the corresponding case-mix index values.

TABLE 3.—CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES

RUG IV category	Nursing index	Therapy index	Nursing component	Therapy component	Therapy non-case-mix component	Non-case-mix component	Total rate
RUC	1.30	2.25	$148.69	$193.86	.....	$58.38	$400.93
RUB	0.95	2.25	108.66	193.86	.....	58.38	360.90
RUA	0.78	2.25	89.22	193.86	.....	58.38	341.46
RVC	1.13	1.41	129.25	121.49	.....	58.38	309.12
RVB	1.04	1.41	118.96	121.49	.....	58.38	298.83
RVA	0.81	1.41	92.65	121.49	.....	58.38	272.52
RHC	1.26	0.94	144.12	80.99	.....	58.38	283.49
RHB	1.06	0.94	121.24	80.99	.....	58.38	260.61
RHA	0.87	0.94	99.51	80.99	.....	58.38	238.88
RMC	1.35	0.77	154.41	66.34	.....	58.38	279.13
RMB	1.09	0.77	124.67	66.34	.....	58.38	249.39
RMA	0.96	0.77	109.80	66.34	.....	58.38	234.52
RLB	1.11	0.43	126.96	37.05	.....	58.38	222.39
RLA	0.80	0.43	91.50	37.05	.....	58.38	186.93
SE3	1.70	.....	194.45	.....	$11.35	58.38	264.18
SE2	1.39	.....	158.99	.....	11.35	58.38	228.72
SE1	1.17	.....	133.82	.....	11.35	58.38	203.55
SSC	1.13	.....	129.25	.....	11.35	58.38	198.98
SSB	1.05	.....	120.10	.....	11.35	58.38	189.83
SSA	1.01	.....	115.52	.....	11.35	58.38	185.25
CC2	1.12	.....	128.11	.....	11.35	58.38	197.84
CC1	0.99	.....	113.24	.....	11.35	58.38	182.97
CB2	0.91	.....	104.09	.....	11.35	58.38	173.82

TABLE 3.—CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES—Continued

RUG IV category	Nursing index	Therapy index	Nursing component	Therapy component	Therapy non-case-mix component	Non-case-mix component	Total rate
CB1	0.84	.....	96.08	.....	11.35	58.38	165.81
CA2	0.83	.....	94.94	.....	11.35	58.38	164.67
CA1	0.75	.....	85.79	.....	11.35	58.38	155.52
IB2	0.69	.....	78.92	.....	11.35	58.38	148.65
IB1	0.67	.....	76.63	.....	11.35	58.38	146.36
IA2	0.57	.....	65.20	.....	11.35	58.38	134.93
IA1	0.53	.....	60.62	.....	11.35	58.38	130.35
BB2	0.68	.....	77.78	.....	11.35	58.38	147.51
BB1	0.65	.....	74.35	.....	11.35	58.38	144.08
BA2	0.56	.....	64.05	.....	11.35	58.38	133.78
BA1	0.48	.....	54.90	.....	11.35	58.38	124.63
PE2	0.79	.....	90.36	.....	11.35	58.38	160.09
PE1	0.77	.....	88.07	.....	11.35	58.38	157.80
PD2	0.72	.....	82.35	.....	11.35	58.38	152.08
PD1	0.70	.....	80.07	.....	11.35	58.38	149.80
PC2	0.65	.....	74.35	.....	11.35	58.38	144.08
PC1	0.64	.....	73.20	.....	11.35	58.38	142.93
PB2	0.51	.....	58.33	.....	11.35	58.38	128.06
PB1	0.50	.....	57.19	.....	11.35	58.38	126.92
PA2	0.49	.....	56.05	.....	11.35	58.38	125.78
PA1	0.46	.....	52.61	.....	11.35	58.38	122.34

TABLE 4.—CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES

[Rural]

RUG IV category	Nursing index	Therapy index	Nursing component	Therapy component	Therapy non-case-mix component	Non-case-mix component	Total rate
RUC	1.30	2.25	$142.08	$223.52	.....	$59.45	$425.05
RUB	0.95	2.25	103.83	223.52	.....	59.45	386.80
RUA	0.78	2.25	85.25	223.52	.....	59.45	368.22
RVC	1.13	1.41	123.50	140.07	.....	59.45	323.02
RVB	1.04	1.41	113.66	140.07	.....	59.45	313.18
RVA	0.81	1.41	88.52	140.07	.....	59.45	288.04
RHC	1.26	0.94	137.71	93.38	.....	59.45	290.54
RHB	1.06	0.94	115.85	93.38	.....	59.45	268.68
RHA	0.87	0.94	95.08	93.38	.....	59.45	247.91
RMC	1.35	0.77	147.54	76.49	.....	59.45	283.48
RMB	1.09	0.77	119.13	76.49	.....	59.45	255.07
RMA	0.96	0.77	104.92	76.49	.....	59.45	240.86
RLB	1.11	0.43	121.31	42.72	.....	59.45	223.48
RLA	0.80	0.43	87.43	42.72	.....	59.45	189.60
SE3	1.70	.....	185.79	.....	12.13	59.45	257.37
SE2	1.39	.....	151.91	.....	12.13	59.45	223.49
SE1	1.17	.....	127.87	.....	12.13	59.45	199.45
SSC	1.13	.....	123.50	.....	12.13	59.45	195.08
SSB	1.05	.....	114.75	.....	12.13	59.45	186.33
SSA	1.01	.....	110.38	.....	12.13	59.45	181.96
CC2	1.12	.....	122.40	.....	12.13	59.45	193.98
CC1	0.99	.....	108.20	.....	12.13	59.45	179.78
CB2	0.91	.....	99.45	.....	12.13	59.45	171.03
CB1	0.84	.....	91.80	.....	12.13	59.45	163.38
CA2	0.83	.....	90.71	.....	12.13	59.45	162.29
CA1	0.75	.....	81.97	.....	12.13	59.45	153.55
IB2	0.69	.....	75.41	.....	12.13	59.45	146.99
IB1	0.67	.....	73.22	.....	12.13	59.45	144.80
IA2	0.57	.....	62.30	.....	12.13	59.45	133.88
IA1	0.53	.....	57.92	.....	12.13	59.45	129.50
BB2	0.68	.....	74.32	.....	12.13	59.45	145.90
BB1	0.65	.....	71.04	.....	12.13	59.45	142.62
BA2	0.56	.....	61.20	.....	12.13	59.45	132.78
BA1	0.48	.....	52.46	.....	12.13	59.45	124.04
PE2	0.79	.....	86.34	.....	12.13	59.45	157.92
PE1	0.77	.....	84.15	.....	12.13	59.45	155.73
PD2	0.72	.....	78.69	.....	12.13	59.45	150.27
PD1	0.70	.....	76.50	.....	12.13	59.45	148.08

TABLE 4.—CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES—Continued

[Rural]

RUG IV category	Nursing index	Therapy index	Nursing component	Therapy component	Therapy non-case-mix component	Non-case-mix component	Total rate
PC2	0.65	.....	71.04	.....	12.13	59.45	142.62
PC1	0.64	.....	69.95	.....	12.13	59.45	141.53
PB2	0.51	.....	55.74	.....	12.13	59.45	127.32
PB1	0.50	.....	54.65	.....	12.13	59.45	126.23
PA2	0.49	.....	53.55	.....	12.13	59.45	125.13
PA1	0.46	.....	50.27	.....	12.13	59.45	121.85

C. Wage Index Adjustment to Federal Rates

Section 1888(e)(4)(G)(ii) of the Act requires that we provide for adjustments to the Federal rates to account for differences in area wage levels using an ''appropriate'' wage index as determined by the Secretary. It is our intent to evaluate a wage index based specifically on SNF data once it becomes available. The SNF wage data are currently being collected and evaluated to determine if we can utilize them in the future. If a wage index based on SNF data is developed, we will publish it for comment. However, in the interim, many commenters urged us to incorporate the latest wage data available. We continue to believe that, until a wage index based on SNF wage data is collected and analyzed, the hospital wage index's wage data provide the best available measure of comparable wages that should be paid by SNFs. Since hospitals and SNFs compete in the same labor market area, we believe that the use of this index's wage data results in an appropriate adjustment to the labor portion of SNF costs based on an ''appropriate'' wage index, as required under section 1888(e) of the Act.

The computation of the wage index is similar to past years in that we incorporate the latest data and methodology used to construct the hospital wage index (see the discussion in the May 12, 1998 interim final rule (63 FR 26274)). The wage index adjustment is applied to the labor-related portion of the Federal rate, which is 77.870 percent of the total rate. Tables 5 and 6 below shows the Federal rates by labor-related and non-labor-related components.

TABLE 5.—CASE-MIX ADJUSTED FEDERAL RATES FOR URBAN SNFS BY LABOR AND NON-LABOR COMPONENT

RUGs IV category	Labor-related	Non-labor-related	Total federal rate
RUC	$312.20	$88.73	$400.93
RUB	281.03	79.87	360.90
RUA	265.89	75.57	341.46
RVC	240.71	68.41	309.12
RVB	232.70	66.13	298.83
RVA	212.21	60.31	272.52
RHC	220.75	62.74	283.49
RHB	202.94	57.67	260.61
RHA	186.02	52.86	238.88
RMC	217.36	61.77	279.13
RMB	194.20	55.19	249.39
RMA	182.62	51.90	234.52
RLB	173.18	49.21	222.39
RLA	145.56	41.37	186.93
SE3	205.72	58.46	264.18
SE2	178.10	50.62	228.72
SE1	158.50	45.05	203.55
SSC	154.95	44.03	198.98
SSB	147.82	42.01	189.83
SSA	144.25	41.00	185.25
CC2	154.06	43.78	197.84
CC1	142.48	40.49	182.97
CB2	135.35	38.47	173.82
CB1	129.12	36.69	165.81
CA2	128.23	36.44	164.67
CA1	121.10	34.42	155.52
IB2	115.75	32.90	148.65
IB1	113.97	32.39	146.36
IA2	105.07	29.86	134.93
IA1	101.50	28.85	130.35
BB2	114.87	32.64	147.51
BB1	112.20	31.88	144.08
BA2	104.17	29.61	133.78
BA1	97.05	27.58	124.63
PE2	124.66	35.43	160.09
PE1	122.88	34.92	157.80

TABLE 5.—CASE-MIX ADJUSTED FEDERAL RATES FOR URBAN SNFS BY LABOR AND NON-LABOR COMPONENT—Continued

RUGs IV category	Labor-related	Non-labor-related	Total federal rate
PD2	118.42	33.66	152.08
PD1	116.65	33.15	149.80
PC2	112.20	31.88	144.08
PC1	111.30	31.63	142.93
PB2	99.72	28.34	128.06
PB1	98.83	28.09	126.92
PA2	97.94	27.84	125.78
PA1	95.27	27.07	122.34

TABLE 6.—CASE-MIX ADJUSTED FEDERAL RATES FOR RURAL SNFS BY LABOR AND NON-LABOR COMPONENT

RUGs IV category	Labor-related	Non-labor-related	Total federal rate
RUC	$330.99	$94.06	$425.05
RUB	301.20	85.60	386.80
RUA	286.73	81.49	368.22
RVC	251.54	71.48	323.02
RVB	243.87	69.31	313.18
RVA	224.30	63.74	288.04
RHC	226.24	64.30	290.54
RHB	209.22	59.46	268.68
RHA	193.05	54.86	247.91
RMC	220.75	62.73	283.48
RMB	198.62	56.45	255.07
RMA	187.56	53.30	240.86
RLB	174.02	49.46	223.48
RLA	147.64	41.96	189.60
SE3	200.41	56.96	257.37
SE2	174.03	49.46	223.49
SE1	155.31	44.14	199.45
SSC	151.91	43.17	195.08
SSB	145.10	41.23	186.33
SSA	141.69	40.27	181.96
CC2	151.05	42.93	193.98
CC1	139.99	39.79	179.78
CB2	133.18	37.85	171.03
CB1	127.22	36.16	163.38
CA2	126.38	35.91	162.29
CA1	119.57	33.98	153.55
IB2	114.46	32.53	146.99
IB1	112.76	32.04	144.80
IA2	104.25	29.63	133.88
IA1	100.84	28.66	129.50
BB2	113.61	32.29	145.90
BB1	111.06	31.56	142.62
BA2	103.40	29.38	132.78
BA1	96.59	27.45	124.04
PE2	122.97	34.95	157.92
PE1	121.27	34.46	155.73
PD2	117.02	33.25	150.27
PD1	115.31	32.77	148.08
PC2	111.06	31.56	142.62
PC1	110.21	31.32	141.53
PB2	99.14	28.18	127.32
PB1	98.30	27.93	126.23
PA2	97.44	27.69	125.13
PA1	94.88	26.97	121.85

As discussed above and in the proposed rule, until an appropriate wage index based specifically on SNF data is available, we will use the latest available hospital wage index data in making annual updates to the payment rates. In making these annual updates, section 1888(e)(4)(G)(ii) of the Act requires that the application of this wage index be made in a manner that does not result in aggregate payments that are greater or less than would otherwise be made in the absence of the wage adjustment. In this third PPS year (Federal rates effective October 1, 2000), we are updating the wage index applicable to SNF payments using the most recent hospital wage data and applying an adjustment to fulfill the budget neutrality requirement. This requirement will be met by multiplying

each of the per diem rate components by the ratio of the volume weighted mean wage adjustment factor (using the wage index from the previous year) to the volume weighted mean wage adjustment factor, using the wage index for the FY beginning October 1, 2000. The same volume weights are used in both the numerator and denominator and will be derived from 1997 Medicare Provider Analysis and Review File (MedPar) data. The wage adjustment factor used in this calculation is defined as the labor share of the rate component multiplied by the wage index plus the non-labor share. The budget neutrality factor for FY 2001 is 0.99909, which is multiplied by each of the Federal rate components.

Comment: We received one comment suggesting that the differences in the rural and urban wage indexes exacerbate rural access problems. The commenter indicates that the loss of adequate indirect and overhead reimbursement has taken away the incentive for ancillary providers to travel long distances, particularly to rural SNFs.

Response: The wage index used to adjust the SNF payment rate is currently based upon the wage and hourly data derived directly from the hospital cost report and, therefore, reflects the relative wage difference between a rural and urban area. In addition, the wages are adjusted to account for overhead allocated to excluded areas that are carved out of the computation. We do not believe that using the wage index to adjust payments to SNFs will affect access to care in rural SNFs.

Comment: We received several comments concerning the use of the hospital wage index to adjust payments for SNFs. Several of these commenters suggested that the hospital wage index does not adequately reflect the wages paid in the SNF setting. They argued that this is compounded by the fact that the SNF along with other areas are carved out or excluded from the computation of the hospital wage index. These commenters strongly suggested that we move quickly to a SNF-specific wage index. We also received other comments suggesting that we only implement a SNF-specific wage index if the data is significantly better, in order to justify the efforts involved in collecting and cleaning up the data.

Response: We are currently reviewing the data collected on the SNF cost reports to evaluate the possibility of developing a SNF-specific wage index. We are developing edits and screens on the data to evaluate the reasonableness and accuracy of the data. A full year's worth of data under the PPS will not be available until late fall 2000. We will review the data and consider the reasonableness of a SNF specific wage index. We hope to be able to provide detailed information on a SNF-specific wage index in our next proposed rule.

However, until that time, we continue to believe that the hospital wage data are an appropriate measure to adjust for area differences in wage rates. The statute provides that the Secretary use an ''appropriate'' wage index. We believe that the use of hospital wage data is appropriate because the relative difference between labor markets for hospitals and SNFs does not vary significantly, as they compete in the same labor market area.

Comment: One commenter suggested that we update the wage index every six months to attract the best nursing staff to nursing homes.

Response: We are not adopting this suggestion, because we do not believe that revising the wage index every six months would achieve the goal that the commenter seeks.

For any RUG–III group, to compute a wage-adjusted Federal payment rate, the labor-related portion of the payment rate is multiplied by the SNF's appropriate wage index factor listed in Table 7. The product of that calculation is added to the corresponding non-labor-related component. The resulting amount is the Federal rate applicable to a beneficiary in that RUG–III group for that SNF.

TABLE 7.—WAGE INDEX FOR URBAN AREAS

Urban area (Constituent Counties or County Equivalents)	Wage Index
0040 Abilene, TX	0.8240
Taylor, TX	
0060 Aguadilla, PR	0.4391
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9736
Portage, OH	
Summit, OH	
0120 Albany, GA	0.9933
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY	0.8549
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9136
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.8151
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	1.0040
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9346
Blair, PA	
0320 Amarillo, TX	0.8715
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2793
Anchorage, AK	
0440 Ann Arbor, MI	1.1254
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8284
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.9052
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4525
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9516
Buncombe, NC	
Madison, NC	
0500 Athens, GA	0.9739
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA	1.0096
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
De Kalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic City-Cape May, NJ	1.1182
Atlantic City, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8106
Lee, AL	
0600 Augusta-Aiken, GA–SC	0.9160
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX	0.9577
Bastrop, TX	
Caldwell, TX	
Hays, TX	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent Counties or County Equivalents)	Wage Index
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA	0.9678
Kern, CA	
0720 Baltimore, MD	0.9365
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Annes, MD	
0733 Bangor, ME	0.9561
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.3839
Barnstable, MA	
0760 Baton Rouge, LA	0.8842
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8744
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1439
Whatcom, WA	
0870 Benton Harbor, MI	0.8671
Berrien, MI	
0875 Bergen-Passaic, NJ	1.1848
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9585
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8236
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY	0.8690
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.8452
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7705
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8733
Monroe, IN	
1040 Bloomington-Normal, IL	0.9095
McLean, IL	
1080 Boise City, ID	0.9006
Ada, ID	
Canyon, ID	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1160
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	0.9731
Boulder, CO	
1145 Brazoria, TX	0.8658
Brazoria, TX	
1150 Bremerton, WA	1.0975
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.8722
Cameron, TX	
1260 Bryan-College Station, TX	0.8237
Brazos, TX	
1280 Buffalo-Niagara Falls, NY	0.9580
Erie, NY	
Niagara, NY	
1303 Burlington, VT	1.0735
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4562
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.8584
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.8724
Natrona, WY	
1360 Cedar Rapids, IA	0.8736
Linn, IA	
1400 Champaign-Urbana, IL	0.9198
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9038
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.9240
Kanawha, WV	
Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC–SC	0.9407
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0789
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN–GA	0.9833
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY	0.8308
Laramie, WY	
1600 Chicago, IL	1.1146
Cook, IL	
De Kalb, IL	
Du Page, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	0.9918
Butte, CA	
1640 Cincinnati, OH–KY–IN	0.9415
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN–KY	0.8204
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH	0.9597
Ashtabula, OH	
Geauga, OH	
Cuyahoga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9697
El Paso, CO	
1740 Columbia, MO	0.8961
Boone, MO	
1760 Columbia, SC	0.9554
Lexington, SC	
Richland, SC	
1800 Columbus, GA–AL	0.8568
Russell, AL	
Chattanoochee, GA	
Harris, GA	
Muscogee, GA	
1840 Columbus, OH	0.9619
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8726
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1326
Benton, OR	
1900 Cumberland, MD–WV	0.8369
Allegany, MD	
Mineral, WV	
1920 Dallas, TX	0.9913
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.8589

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent Counties or County Equivalents)	Wage Index
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA–IL	0.8898
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9442
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9200
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8534
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL	0.8125
Macon, IL	
2080 Denver, CO	1.0181
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.9118
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI	1.0510
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7943
Dale, AL	
Houston, AL	
2190 Dover, DE	1.0078
Kent, DE	
2200 Dubuque, IA	0.8746
Dubuque, IA	
2240 Duluth-Superior, MN–WI	1.0032
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0249
Dutchess, NY	
2290 Eau Claire, WI	0.8790
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9346
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9145
Elkhart, IN	
2335 Elmira, NY	0.8546
Chemung, NY	
2340 Enid, OK	0.8610
Garfield, OK	
2360 Erie, PA	0.8985
Erie, PA	
2400 Eugene-Springfield, OR	1.0965
Lane, OR	
2440 Evansville-Henderson, IN–KY	0.8173
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND–MN	0.8749
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8655
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.7910
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ–UT	1.0686
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.1205
Genesee, MI	
2650 Florence, AL	0.7616
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8777
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0647
Larimer, CO	
2680 Ft. Lauderdale, FL	1.0121
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9247
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	0.9538
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR–OK	0.8052
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.9607
Okaloosa, FL	
2760 Fort Wayne, IN	0.8665
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Fort Worth-Arlington, TX	0.9527
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0104
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8423
Etowah, AL	
2900 Gainesville, FL	1.0074
Alachua, FL	
2920 Galveston-Texas City, TX	0.9918
Galveston, TX	
2960 Gary, IN	0.9454
Lake, IN	
Porter, IN	
2975 Glens Falls, NY	0.8361
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8423
Wayne, NC	
2985 Grand Forks, ND–MN	0.8816
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9109
Mesa, CO.	
3000 Grand Rapids-Muskegon-Holland, MI	1.0248
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.9065
Cascade, MT	
3060 Greeley, CO	0.9814
Weld, CO	
3080 Green Bay, WI	0.9225
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC	0.9131
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9384
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9003
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9409
Washington, MD	
3200 Hamilton-Middletown, OH	0.9061
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9386
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT	1.1373
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 Hattiesburg, MS	0.7490
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9008
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1863
Honolulu, HI	
3350 Houma, LA	0.8086
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX	0.9732
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent Counties or County Equivalents)	Wage Index
3400 Huntington-Ashland, WV–KY–OH	0.9876
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8932
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN	0.9787
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9657
Johnson, IA	
3520 Jackson, MI	0.9134
Jackson, MI	
3560 Jackson, MS	0.8812
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.8796
Chester, TN	
Madison, TN	
3600 Jacksonville, FL	0.9208
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC	0.7777
Onslow, NC	
3610 Jamestown, NY	0.7818
Chautaqua, NY	
3620 Janesville-Beloit, WI	0.9585
Rock, WI	
3640 Jersey City, NJ	1.1502
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN–VA	0.8272
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8846
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7832
Craighead, AR	
3710 Joplin, MO	0.8148
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0453
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	0.9902
Kankakee, IL	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent Counties or County Equivalents)	Wage Index
3760 Kansas City, KS–MO	0.9498
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9611
Kenosha, WI	
3810 Killeen-Temple, TX	1.0119
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8340
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.9518
Howard, IN	
Tipton, IN	
3870 La Crosse, WI–MN	0.9211
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8490
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.8834
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7399
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.9239
Polk, FL	
4000 Lancaster, PA	0.9259
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9934
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8168
Webb, TX	
4100 Las Cruces, NM	0.8658
Dona Ana, NM	
4120 Las Vegas, NV–AZ	1.0796
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.8190
Douglas, KS	
4200 Lawton, OK	0.8996
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9036
Androscoggin, ME	
4280 Lexington, KY	0.8866
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent Counties or County Equivalents)	Wage Index
Woodford, KY	
4320 Lima, OH	0.9320
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	0.9626
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8906
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8922
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA	1.1996
Los Angeles, CA	
4520 Louisville, KY–IN	0.9350
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8838
Lubbock, TX	
4640 Lynchburg, VA	0.8867
Amherst, VA	
Bedford City, VA	
Bedford, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.8974
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0271
Dane, WI	
4800 Mansfield, OH	0.8690
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4589
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8566
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0344
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.9688
Brevard, Fl	
4920 Memphis, TN–AR–MS	0.8723
Crittenden, AR	
De Soto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	0.9646
Merced, CA	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent Counties or County Equivalents)	Wage Index
5000 Miami, FL	1.0059
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ	1.1075
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 Milwaukee-Waukesha, WI	0.9767
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St Paul, MN–WI	1.1017
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Sherburne, MN	
Washington, MN	
Wright, MN	
Pierce, WI	
St. Croix, WI	
5140 Missoula, MT	0.9274
Missoula, MT	
5160 Mobile, AL	0.8163
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0396
Stanislaus, CA	
5190 Monmouth-Ocean, NJ	1.1278
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8396
Ouachita, LA	
5240 Montgomery, AL	0.7653
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	1.0969
Delaware, IN	
5330 Myrtle Beach, SC	0.8440
Horry, SC	
5345 Naples, FL	0.9661
Collier, FL	
5360 Nashville, TN	0.9490
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY	1.3932
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2297
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT	1.2063
New London, CT	
5560 New Orleans, LA	0.9295
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John The Baptist, LA	
St. Tammany, LA	
5600 New York, NY	1.4651
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ	1.1837
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY–PA	1.0847
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA–NC	0.8412
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City VA	
Williamsburg City, VA	
York, VA	
5775 Oakland, CA	1.4983
Alameda, CA	
Contra Costa, CA 5790 Ocala, FL	0.9243
Marion, FL	
5800 Odessa-Midland, TX	0.9205
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK	0.8822
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.0677
Thurston, WA	
5920 Omaha, NE–IA	0.9572
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA	1.1467
Orange, CA	
5960 Orlando, FL	0.9610
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8159
Daviess, KY	
6015 Panama City, FL	0.9010
Bay, FL	
6020 Parkersburg-Marietta, WV–OH	0.8274
Washington, OH	
Wood, WV	
6080 Pensacola, FL	0.8176
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8645
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA–NJ	1.0937
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ	0.9669
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7791
Jefferson, AR	
6280 Pittsburgh, PA	0.9741
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA	1.0288
Berkshire, MA	
6340 Pocatello, ID	0.9076
Bannock, ID	
6360 Ponce, PR	0.5006
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9748
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR–WA	1.0910
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Pawtucket, RI	1.0864
Bristol, RI	
Kent, RI	
Newport, RI	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent Counties or County Equivalents)	Wage Index
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	1.0029
Utah, UT	
6560 Pueblo, CO	0.8815
Pueblo, CO	
6580 Punta Gorda, FL	0.9613
Charlotte, FL	
6600 Racine, WI	0.9246
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC	0.9646
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8865
Pennington, SD	
6680 Reading, PA	0.9152
Berks, PA	
6690 Redding, CA	1.1664
Shasta, CA	
6720 Reno, NV	1.0550
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.1460
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9617
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 Riverside-San Bernardino, CA	1.1239
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8750
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.1315
Olmsted, MN	
6840 Rochester, NY	0.9182
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.8819
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.8849
Edgecombe, NC	
Nash, NC	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent Counties or County Equivalents)	Wage Index
6920 Sacramento, CA	1.1950
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9575
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	1.0016
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO	0.9071
Andrews, MO	
Buchanan, MO	
7040 St. Louis, MO–IL	0.9049
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
Sullivan City, MO	
7080 Salem, OR	1.0189
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4502
Monterey, CA	
7160 Salt Lake City-Ogden, UT	0.9807
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8083
Tom Green, TX	
7240 San Antonio, TX	0.8580
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA	1.1784
San Diego, CA	
7360 San Francisco, CA	1.4156
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA	1.3652
Santa Clara, CA	
7440 San Juan-Bayamon, PR	0.4690
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Ceiba, PR	
Comerio, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent Counties or County Equivalents)	Wage Index
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Morovis, PR	
Naguabo, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.0673
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0597
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.4040
Santa Cruz, CA	
7490 Santa Fe, NM	1.0537
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.2646
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9809
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9697
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton—Wilkes-Barre—Hazleton, PA	0.8421
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA	1.0996
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA	0.7928
Mercer, PA	
7620 Sheboygan, WI	0.8379
Sheboygan, WI	
7640 Sherman-Denison, TX	0.8694
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.8750
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA–NE	0.8473
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.8790
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	1.0000
St. Joseph, IN	
7840 Spokane, WA	1.0513
Spokane, WA	
7880 Springfield, IL	0.8685
Menard, IL	
Sangamon, IL	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent Counties or County Equivalents)	Wage Index
7920 Springfield, MO	0.8488
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.0637
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.9038
Centre, PA	
8080 Steubenville-Weirton, OH–WV	0.8548
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0629
San Joaquin, CA	
8140 Sumter, SC	0.8271
Sumter, SC	
8160 Syracuse, NY	0.9549
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1564
Pierce, WA	
8240 Tallahassee, FL	0.8545
Gadsden, FL	
Leon, FL	
8280 Tampa-St. Petersburg-Clearwater, FL	0.8982
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN	0.8304
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana, AR-Texarkana, TX	0.8363
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9832
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9117
Shawnee, KS	
8480 Trenton, NJ	1.0137
Mercer, NJ	
8520 Tucson, AZ	0.8794
Pima, AZ	
8560 Tulsa, OK	0.8454
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8064
Tuscaloosa, AL	
8640 Tyler, TX	0.9404
Smith, TX	
8680 Utica-Rome, NY	0.8560
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.2847
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.1030
Ventura, CA	
8750 Victoria, TX	0.8154
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0501
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA	0.9551
Tulare, CA	
8800 Waco, TX	0.8314
McLennan, TX	
8840 Washington, DC–MD–VA–WV	1.0755
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpepper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 Waterloo-Cedar Falls, IA	0.8404
Black Hawk, IA	
8940 Wausau, WI	0.9418
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL	0.9682
Palm Beach, FL	
9000 Wheeling, OH–WV	0.7733
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9544
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.7668
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8392
Lycoming, PA	
9160 Wilmington-Newark, DE–MD	1.1191
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9402
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	0.9907
Yakima, WA	
9270 Yolo, CA	1.0199
Yolo, CA	
9280 York, PA	0.9264
York, PA	
9320 Youngstown-Warren, OH	0.9543
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0706
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.9529
Yuma, AZ	

TABLE 8.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7489
Alaska	1.2392
Arizona	0.8317
Arkansas	0.7445
California	0.9861
Colorado	0.8968
Connecticut	1.1715
Delaware	0.9074
Florida	0.8919
Georgia	0.8329
Guam	0.9611
Hawaii	1.1059
Idaho	0.8678
Illinois	0.8160
Indiana	0.8602
Iowa	0.8030
Kansas	0.7605
Kentucky	0.7931
Louisiana	0.7668
Maine	0.8766
Maryland	0.8651
Massachusetts	1.1204
Michigan	0.8987
Minnesota	0.8881
Mississippi	0.7491
Missouri	0.7698
Montana	0.8688
Nebraska	0.8109
Nevada	0.9232
New Hampshire	0.9845
New Jersey [1]	.....
New Mexico	0.8497
New York	0.8499
North Carolina	0.8445
North Dakota	0.7716
Ohio	0.8670
Oklahoma	0.7491
Oregon	1.0132
Pennsylvania	0.8578
Puerto Rico	0.4264
Rhode Island [1]	.....
South Carolina	0.8370
South Dakota	0.7570
Tennessee	0.7838
Texas	0.7502
Utah	0.9037
Vermont	0.9274
Virginia	0.8189
Virgin Islands	0.6306
Washington	1.0434

TABLE 8.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
West Virginia	0.8231
Wisconsin	0.8880
Wyoming	0.8817

[1] All counties within the State are classified urban.

D. Updates to the Federal Rates

In accordance with section 1888(e)(4)(E) of the Act, the proposed payment rates listed here have been updated by the SNF market basket minus 1 percentage point, which equals 2.161 percent. For each succeeding FY, we will publish the rates in the **Federal Register** before August 1 of the year preceding the affected Federal FY.

For the current FY (FY 2001), and for FY 2002, section 1888(e)(4)(E)(ii) of the Act requires the rates to be increased by a factor equal to the SNF market index change minus 1 percentage point. For subsequent FYs, this section requires the rates to be increased by the applicable SNF market basket index increase.

E. Relationship of RUG–III Classification System to Existing Skilled Nursing Facility Level-of-Care Criteria

Regulations at § 413.345 provide that the information included in each update of the Federal payment rates in the **Federal Register** will include the designation of those specific RUGs under the classification system that represent the required SNF level of care, as provided in § 409.30. In the proposed rule (65 FR 19228), we proposed to designate the following RUG–III classifications for this purpose: All groups within the proposed new Rehabilitation and Extensive category; all groups within the Ultra High Rehabilitation category; all groups within the Very High Rehabilitation category; all groups within the Medium Rehabilitation category; all groups within the Low Rehabilitation category; all groups within the Extensive Services category; and, all groups within the Clinically Complex category.

Comment: A few commenters raised issues regarding specific aspects of the process for making SNF level of care determinations. One commenter recommended that the level of care presumption in existing regulations at § 409.30 (which extends through the assessment reference date (ARD) for the initial 5-day, Medicare-required assessment) be expanded to extend through the ARD for the 30-day assessment. This commenter also favored revising the regulations to allow for using a beneficiary's assignment to one of the designated RUG–III groups in lieu of following the physician certification and recertification procedures described in § 424.20. Another commenter suggested that requiring individual level of care determinations for those beneficiaries who are assigned to one of the ''lower 18'' RUG–III groups (that is, to a RUG–III group that is not designated for purposes of the administrative presumption) creates a barrier to care for beneficiaries with dementing diseases. However, by far the majority of comments in this area observed that the High Rehabilitation and Special Care categories, which had been included in the most recent update notice (64 FR 41696, July 30, 1999), were missing from the list in the proposed rule, and urged their restoration.

Response: We believe that the suggestion for expanding the administrative presumption's timeframe to encompass the 30-day assessment is inconsistent with the underlying rationale for this presumption. In the preamble to the final rule that was published on July 30, 1999 (64 FR 41666–67), we noted that the Medicare SNF benefit is a ''posthospital'' benefit, and

> * * * that SNF residents tend to be relatively unstable and require fairly intensive skilled care during the period immediately following admission from the prior hospitalization, but that this tendency typically diminishes as they get further on in the SNF stay * * *. [This] means, in effect, that the basis for making any type of presumption with regard to coverage would tend to become progressively less conclusive as a resident moves farther into the SNF stay, and would be at its most conclusive at the very outset of the stay, during the period immediately following the resident's admission from the prior hospitalization.

Further, the requirement for an initial physician certification and periodic recertification as to level of care is mandated by the law itself (at section 1814(a)(2)(B) of the Act) and, thus, cannot be eliminated administratively. We also note that the implementing regulations at § 424.20(a)(1)(ii) already allow, at the option of the physician, for the required initial certification to be completed simply by confirming that the beneficiary has been correctly assigned to one of the designated RUG–III groups, as provided in § 409.30.

In the preamble to the interim final rule that was published on May 12, 1998 (63 FR 26283), we provided that beneficiaries assigned to one of the upper 26 RUG–III groups would be automatically classified as meeting the SNF level of care definition under the administrative presumption, ''* * * while those beneficiaries assigned to any of the lower 18 groups are not automatically classified as either meeting or not meeting the definition, but instead receive an individual level of care determination using the existing administrative criteria.'' This presumption recognized the strong likelihood that beneficiaries assigned to one of the upper 26 groups during the immediate posthospital period would actually require a covered level of care, which would be significantly less likely for those beneficiaries assigned to one of the lower 18 groups. However, we do not share the view of the commenter who characterized as a barrier to coverage the policy of providing for an individual level of care determination when a beneficiary is assigned to one of the lower 18 groups. To the contrary, we chose this particular approach—rather than a policy of summarily deeming all of the lower 18 groups to be noncovered—precisely in order to ensure coverage under the SNF PPS for individual beneficiaries within those groups who would have met the previous administrative criteria for determining a SNF level of care. This policy also helps ensure that any beneficiary who does, in fact, require a covered level of care will actually be able to receive coverage, without regard to the beneficiary's particular diagnosis.

Finally, we note that the omission of the High Rehabilitation and Special Care categories from the designation list that appeared in the proposed rule was inadvertent, and we concur with the recommendation of the commenters who urged that these categories be restored to the list. Further, as discussed elsewhere in this final rule, we have decided not to adopt the case-mix refinements (including the creation of a new Rehabilitation and Extensive category) that we had previously proposed. Accordingly, we hereby designate the upper 26 RUG–III groups for purposes of the administrative presumption described in § 409.30, as follows: all groups within the Ultra High Rehabilitation category; all groups within the Very High Rehabilitation category; all groups within the High Rehabilitation category; all groups within the Medium Rehabilitation category; all groups within the Low Rehabilitation category; all groups within the Extensive Services category; all groups within the Special Care category; and, all groups within the Clinically Complex category.

F. Three-Year Transition Period

Under sections 1888(e)(1) and (2) of the Act, during a facility's first three cost reporting periods that begin on or after July 1, 1998 (that is, the transition period), the facility's PPS rate will be equal to the sum of a percentage of an adjusted facility-specific per diem rate and a percentage of the adjusted Federal per diem rate. After the transition period, the PPS rate will equal the adjusted Federal per diem rate. The transition period payment method will not apply to SNFs that first received Medicare payments (interim or otherwise) on or after October 1, 1995 under present or previous ownership, or to those facilities choosing to bypass the transition in accordance with section 102 of the BBRA; these facilities will be paid based on 100 percent of the Federal rate.

The facility-specific per diem rate is the sum of the facility's total allowable Part A Medicare costs and an estimate of the amounts that would be payable under Part B for covered SNF services for cost reporting periods beginning in FY 1995 (base year). The base year cost report used to compute the facility-specific per diem rate in the transition period may be settled (either tentative or final) or as-submitted for Medicare payment purposes. Under section 1888(e)(3) of the Act, any adjustments to the base year cost report made as a result of settlement or other action by the fiscal intermediary, including cost limit exceptions and exemptions, or results of an appeal, will result in a revision to the facility-specific per diem rate. The instructions for calculating the facility-specific per diem rate are described in detail in the May 12, 1998 interim final rule. In order to implement section 104 of the BBRA, for providers that received payment under the RUG–III demonstration during a cost reporting period that began in calendar year 1997, we will determine their facility-specific per diem rate using the methodology described below.

It is possible that some providers participated in the demonstration but did not have a cost reporting period that began in calendar year 1997. For those providers, we will determine their facility-specific per diem rate by using the calculations outlined in the May 12, 1998 **Federal Register** interim final rule (63 FR 26251, section III. (A)(1)(a), (b), or (c)). As with the facility-specific per diem applicable to other providers, the allowable costs will be subject to change based on the settlement of the cost report used to determine the total payment under the demonstration. In addition, we derive a special market basket inflation factor, which is 1.105788, to adjust the 1997 costs to the midpoint of the rate setting period (October 1, 2000 to September 30, 2001.)

Step 1—Determine the aggregate payment during the cost reporting period that began in calendar year 1997—RUG–III payment plus routine capital costs plus ancillary costs (other than occupational therapy, physical therapy, and speech pathology).

Step 2—Divide the amount in Step 1 by the applicable total inpatient days for the cost reporting period.

Step 3—Adjust the amount in Step 2 by 1.105788 (inflation factor).

Step 4—Add the amount determined in Step 3 to the appropriate Part B add-on amount determined according to Program Memorandum transmittal no. A–99–53 (December 1999).

The amount in Step 4 is the facility-specific rate that is applicable for the facility's first cost reporting period beginning on or after October 1, 2000.

1. Computation of the Skilled Nursing Facility Prospective Payment System Rate During the Transition

For the first three cost reporting periods beginning on or after July 1, 1998 (the transition period), an SNF's payment under the PPS is the sum of a percentage of the facility-specific per diem rate and a percentage of the adjusted Federal per diem rate. Under section 1888(e)(2)(C) of the Act, for the first cost reporting period in the transition period, the SNF payment will be the sum of 75 percent of the facility-specific per diem rate and 25 percent of the Federal per diem rate. For the second cost reporting period, the SNF payment will be the sum of 50 percent of the facility-specific per diem rate and 50 percent of the Federal per diem rate. For the third cost reporting period, the SNF payment will be the sum of 25 percent of the facility-specific per diem rate and 75 percent of the Federal per diem rate. For all subsequent cost reporting periods beginning after the transition period, the SNF payment will be equal to 100 percent of the Federal per diem rate. An example is given below computing the SNF PPS rate and SNF payment.

Example of computation of adjusted PPS rates and SNF payment: Using the XYZ SNF described in Table 9, the following shows the adjustments made to the facility-specific per diem rate and the Federal per diem rate to compute the provider's actual per diem PPS payment in the transition period. XYZ's 12-month cost reporting period begins October 1, 2000. (This is the provider's third cost reporting period under the transition.)

Step 1

Compute:

Facility-specific per diem rate	$570.00
Market Basket Adjustment (Table 10.B)	× 1.14457
Adjusted facility-specific rate	$652.40

Step 2

Compute Federal per diem rate:

TABLE 9.—SNF XYZ FROM ABOVE IS LOCATED IN STATE COLLEGE, PA WITH A WAGE INDEX OF 0.9038

RUG group	Labor portion*	Wage index	Adjusted labor	Nonlabor portion*	Adjusted rate	Percent adjustment	Medicare Days	Payment
RVC	$240.71	0.9038	$217.55	$68.41	$285.96	**$297.40	50	$14,870
SSC	154.95	0.9038	140.04	44.03	184.07	***228.25	50	11,413
Total							100	26,283

*From Table 5.
**Reflects a 4 percent adjustment.
***Reflects a 24 percent adjustment.

Step 3

Apply transition period percentages:	
Facility-specific per diem rate $652.40 × 100 days =	$65,240
Times transition percentage (25 percent)	.25
Actual facility-specific PPS payment	$16,310
Federal PPS payment	$26,283
Times transition percentage (75 percent)	.75
Actual Federal PPS payment	$19,712

Step 4

Compute total PPS payment:	
XYZ's total PPS payment ($16,310 + $19,712)	$36,022

G. The Skilled Nursing Facility Market Basket Index

Section 1888(e)(5)(A) of the Act requires the Secretary to establish an SNF market basket index (input price index) that reflects changes over time in the prices of an appropriate mix of goods and services included in the SNF PPS. The proposed rule incorporated the latest estimates of the SNF market basket index at that time. This rule incorporates updated projections based on the latest available projections as of this point in time. Accordingly, we have developed a SNF market basket index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses. In the May 12, 1998 **Federal Register**, we included a complete discussion on rebasing the SNF market basket to FY 1992, and revising the index to include capital and ancillary costs. There are 21 separate cost categories and respective price proxies. These cost categories were illustrated in Tables 4.A, 4.B, and Appendix A, found in the May 12, 1998 **Federal Register**.

Each year we calculate a revised labor-related share based on the relative importance of labor-related cost categories in the input price index. Table 10.A summarizes the updated labor-related share for FY 2001.

TABLE 10.A.—FY 2001 LABOR-RELATED SHARE

Cost category	FY 2000 relative importance*	FY 2001 relative importance
Wages and Salaries	56.647	56.734
Employee Benefits	12.321	12.654
Nonmedical Professional Fees	1.959	1.957
Labor-intensive Services	3.738	3.719
Capital-related	2.880	2.807
Total	77.545	77.870

The forecasted rates of growth used to compute the projected SNF market basket percentages, described in the next section, are shown in Table 10.B, and the 12-month cost reporting period facility specific rate update factors are shown in Table 10C.

TABLE 10.B.—SKILLED NURSING FACILITY TOTAL COST MARKET BASKET, FORECASTED CHANGE, 1997–2002

Fiscal years beginning October 1	Skilled nursing facility total cost market basket
October 1996, FY 1997	2.4
October 1997, FY 1998	2.7
October 1998, FY 1999	3.0
October 1999, FY 2000	3.6
October 2000, FY 2001	3.2
October 2001, FY 2002	3.2
Forecasted Average: 2000–2002	3.3

Source: Standard & Poor's DRI HCC, 2nd QTR 2000; @USSIM/TRENDLONG0500@CISSIM/TRENDLONG0500. Released by HCFA, OACT, National Health Statistics Group.

Use of the Skilled Nursing Facility Market Basket Percentage: Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage as the percentage change in the SNF market basket index, described in the previous section, from the midpoint of the prior FY (or period) to the midpoint of the current FY (or other period) involved. The facility-specific portion and Federal portion of the SNF PPS rates addressed in the proposed rule were based on cost reporting periods beginning in the base year, Federal FY 1995. For the Federal rates, the percentage increases in the SNF market basket index will be used to compute the update factors occurring between the midpoint of FY 2000 and the midpoint of FY 2001. We used the Standard & Poor's DRI CC, 2nd quarter 2000 historical and forecasted percentage increases of the revised and rebased SNF market basket index for routine, ancillary, and capital-related expenses, to compute the update factors. Finally, we used the update factors to adjust the base year costs for computing the facility-specific portion and Federal portion of the SNF PPS rates.

Comment: A number of commenters expressed concern with the SNF market basket. The commenters asserted that the market basket index used for updating the PPS rates does not reflect Medicare SNF care costs accurately. They added that we have the authority to address this issue through modifications to the market basket index. The comments included: trending forward the 1995 data to 1997 significantly understates the actual increase observed over this period; the market basket index is based on 1992 data that do not reflect the dynamic changes in the health care system that occurred between 1992 and 1997; the market basket labor inputs significantly understate the actual increases in labor costs for Medicare SNFs; and the one percentage point reduction to the market basket should be restored.

Response: A number of the provisions that were the subjects of the commenters' concerns are specifically mandated by the law itself. Section 1888(e)(4)(A) of the Act requires the use of 1995 costs as a base. Section 1888(e)(5)(A) of the Act specifically provides for the establishment of an SNF market basket, while section 1888(e)(4)(E) of the Act requires that the SNF PPS rates be updated annually using that index. Furthermore, for the current FY 2001, and for FY 2002, section 1888(e)(4)(E)(ii)(II) of the Act requires that the rates be increased by a factor equal to the SNF market basket index change minus 1 percentage point. For subsequent fiscal years, section 1888(e)(4)(E)(i)(III) of the Act requires the rates to be increased by the applicable SNF market basket index increase.

The statute at section 1888(e)(5)(A) specifies that the market basket should reflect ''changes over time in the prices of an appropriate mix of goods and services included in covered SNF services''. The SNF market basket index meets this statutory requirement. The SNF market basket captures the pure price change of inputs such as labor,

capital, etc., used to provide SNF services. While several commenters pointed to the large growth in per diem SNF costs between 1995 and 1998 (as indicated on SNF cost report data) as evidence that the SNF market basket was inaccurate, we wish to emphasize that we do not consider reported historical per diem SNF costs an appropriate benchmark for determining its accuracy. The SNF market basket index, like the market basket indices used for other Medicare payment systems, measures pure price changes of inputs associated with the efficient delivery of care. It should not reflect changes in historical reported SNF costs associated with inefficient care or medically unnecessary services. Suggestions that it should are antithetical to the very notion of a PPS. It should also not reflect changes in non-price factors, such as adding staff or purchasing additional supplies. In any event, the statute provides that, once the initial PPS rates have been established, the unadjusted payment rates for a given year are calculated by applying an update to the rates for the previous year; the statute does not provide for a complete recalculation of the rates by applying a revised market basket methodology retroactively to 1995.

It is also important to note that the statute itself sets forth a fairly prescriptive methodology for calculating and updating the initial per diem payments established under the SNF PPS in 1998. The statute requires the use of an FY 1995 base year to calculate the Federal rates, and the statute specifies the amount of the updates to the base year costs (market basket minus one). It further reduces the base year cost pool by eliminating the costs associated with atypical services exceptions and exemptions (under § 413.30 of the regulations), and sets the base payments at just above the freestanding mean. The current SNF PPS per diem payment rates reflect the methodology prescribed by statute, an intended consequence of which was the accumulation of budgetary savings. Thus, concerns regarding the level of funding associated with the base payment rates may actually have more to do with the statutory formula for establishing the payments than the market basket used to update them.

With regard to the weights used to allocate many of the price proxies within the market basket, these are based on 1992 data because these are the latest complete data available from the Bureau of the Census and the Bureau of Economic Analysis. When more recent data become available, we will review the data and determine whether to rebase the market basket index to a more recent year. However, previous experience has shown that there is very little impact in the overall percent change in the market basket index when it is rebased. This was shown in the May 12, 1998 **Federal Register** (63 FR 26292), when the SNF market basket index was last rebased to a 1992 base from a 1977 base.

All of the price proxies used in the calculation of the SNF market basket are based on the latest data released by their respective data sources. Therefore, the price proxies capture all of the dynamic price change which occurred or is expected to occur in any given period.

In response to the specific comment concerning the labor portion of the market basket, the labor input proxies used in the SNF market basket are based the Employment Cost Index, a proven national survey of wages, salaries, and benefits for nursing home and personal care facilities, published by the BLS. These measures are based on a fixed skill mix of workers and do not reflect changes in skill mix. They measure only actual changes in the wages of workers and not shifts in wage costs caused by a shift in the skill mix of workers used. This makes it the preferred proxy to use, since it measures only pure price changes and not changes caused by other factors.

As has always been our policy, we will continue to monitor and respond to any changes in the market for SNF services that affect the SNF market basket index. When data from the first fiscal year after full implementation of the SNF PPS become available, we plan to review the SNF market basket index to ensure that it accurately and appropriately captures all price changes faced by SNFs in providing services. This review includes updating weights used in allocating the price proxies within the market basket, as well as ensuring that our price proxies reflect market trends. For example, we monitor the proxy for prescription drugs to make sure that it reflects the price changes associated with both new and older medications.

Finally, HCFA and MedPAC recognize that the SNF input price index developed by HCFA is only one component of the change in SNF cost per day. The index is designed to capture only the pure price change of inputs used to produce a constant quantity and quality of care in a SNF. This is consistent with the definition as it is used by HCFA and MedPAC in the existing payment methodologies for SNFs, hospitals, home health agencies, and other settings.

Other factors in addition to input prices help determine the overall change in costs per day. These factors include changes in case-mix, intensity, and productivity. Under the inpatient hospital PPS, HCFA and MedPAC use an update framework to account for these other factors and to make annual recommendations to Congress on the magnitude of the update. HCFA and MedPAC are both exploring the possibility of developing a SNF PPS update framework to make similar annual recommendations to Congress. As part of this update framework, we would address non-market basket factors such as intensity, productivity, and changes in site of service. This would allow us to maintain the integrity (and stability) of the market basket by keeping it separate and distinct from these other factors.

It is very important to note that the non-market basket factors can be negative as well as positive. As SNFs move from a cost-based system to a fixed price PPS, there are likely to be substantial decreases in cost per unit of service. Increases in productivity, changes in site of service, elimination of ineffective practice patterns, and renegotiation to lower price contracts for inputs are some of the behavioral changes which result in negative factors.

1. Facility-Specific Rate Update Factor

Under section 1888(e)(3)(D)(i) of the Act, for the facility-specific portion of the SNF PPS rate, we will update a facility's base year costs up to the corresponding cost reporting period beginning October 1, 2000, and ending September 30, 2001, by the SNF market basket percentage. We took the following steps to develop the 12-month cost reporting period facility-specific rate update factors shown in Table 10.C.

TABLE 10.C.—UPDATE FACTORS [1] FOR FACILITY-SPECIFIC PORTION OF THE SNF PPS RATES—ADJUST TO 12-MONTH COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2000 AND BEFORE OCTOBER 1, 2001 FROM COST REPORTING PERIODS BEGINNING IN FY 1995

[Base year]

If 12-month cost reporting period in initial period begins:	Adjust from 12-month cost reporting period in base year that begins:	Using update factor of:
October 1, 2000	October 1, 1994	1.14457
November 1, 2000	November 1, 1994	1.14475
December 1, 2000	December 1, 1994	1.14494
January 1, 2001	January 1, 1995	1.14522
February 1, 2001	February 1, 1995	1.14567
March 1, 2001	March 1, 1995	1.14630
April 1, 2001	April 1, 1995	1.14693
May 1, 2001	May 1, 1995	1.14739
June 1, 2001	June 1, 1995	1.14768
July 1, 2001	July 1, 1995	1.14797
August 1, 2001	August 1, 1995	1.14843
September 1, 2001	September 1, 1995	1.14905

[1] Source: Standard & Poor's DRI HCC, 2nd QTR 2000; @USSIM/TRENDLONG0500@CISSIM/TRENDLONG0500.

For the facility rate, we developed factors to inflate data from cost reporting periods beginning October 1, 1994, through September 30, 1995, to the corresponding cost reporting period beginning in FY 2001. According to section 1888(e)(3)(D) of the Act, the years through FY 1999 were inflated at a rate of market basket minus 1 percentage point, while FY 2000 and FY 2001 are to be inflated at the full market basket rate of increase.

2. Federal Rate Update Factor

To update each facility's costs up to the common period, we:

A. Determined the total growth from the average market basket level for the period of October 1, 1999, through September 30, 2000, to the average market basket level for the period of October 1, 2000, through September 30, 2001.

B. Calculated the rate of growth between the midpoints of the two periods.

C. Calculated the annual average rate of growth for number 2, above.

D. Subtracted 1 percentage point from this annual average rate of growth.

E. Using the annual average minus 1 percentage point rate of growth, determined the cumulative growth between the midpoints of the two periods specified above.

This revised update factor was used to compute the Federal portion of the SNF PPS rate shown in Tables 1 and 2.

H. Consolidated Billing

The consolidated billing requirement places with the SNF itself the Medicare billing responsibility for virtually all of the services that an SNF resident receives. The original SNF PPS legislation in the BBA identified several service categories that were excluded from the SNF consolidated billing requirement, as well as from the bundled Part A payment made under the SNF PPS itself. As noted in the proposed rule, section 103(a) of the BBRA amended section 1888(e)(2)(A) of the Act, effective with services furnished on or after April 1, 2000, to exclude certain additional types of services from the consolidated billing requirement, thus allowing these services to be billed separately to Part B. We listed these excluded services, by HCPCS code, in Program Memorandum AB–00–18 (March 2000). Section 103(b) of the BBRA also amended section 1888(e)(4)(G) of the Act to provide for a corresponding proportional reduction in Part A SNF payments, beginning with FY 2001.

Comment: In addition to identifying certain individual services (within a number of broader service categories) for exclusion from the consolidated billing requirement, section 103 of the BBRA also gives the Secretary the authority to designate additional services within each of those categories for exclusion from this requirement. A number of commenters recommended that we exercise this authority to designate a variety of additional services for exclusion, such as modified barium swallow, stress tests, hyperbaric oxygen treatment, doppler studies, nuclear medicine, orthotic devices, gastrointestinal procedures performed in endoscopy rooms, and outpatient surgery performed in hospital treatment rooms or ambulatory surgical centers. Alternatively, some commenters suggested that we could accomplish this result by adding these services to the existing exclusion list (in regulations at § 411.15(p)(3)(iii)) for certain high-intensity outpatient hospital services. Others expressed the view that this latter authority should not be limited to only those services that actually require the intensity of a hospital setting, but rather, should also encompass services furnished in other, nonhospital settings as well. As an example, they cited magnetic resonance imaging (MRIs) furnished in freestanding imaging centers, which may be cheaper and more accessible in certain particular localities than those furnished by hospitals.

Response: The BBRA's discretionary authority applies only to identifying additional excluded services *within* the particular categories that are specified in the legislation itself (that is, chemotherapy and its administration; radioisotope services; and, customized prosthetic devices) and not to other services that fall outside of those particular categories. Further, we are not exercising this discretionary authority at the present time, because we believe that the particular HCPCS codes identified in the BBRA represent the service exclusions within the specified categories that are appropriate under current circumstances. We note that language in the BBRA conference agreement requests the GAO to conduct a review of the appropriateness of the particular HCPCS codes that this legislation has designated for exclusion from consolidated billing. As we indicated in the proposed rule, we will carefully consider the GAO's findings when they become available, in order to determine whether further refinements in the codes identified on the exclusion list might be warranted.

Moreover, we believe that the comments advocating broader exclusions, beyond the particular services identified in the BBRA, may reflect a misunderstanding of the overall objective of the consolidated billing provision. We do not view the identification of new service categories for exclusion from this provision in terms of a process of continual expansion to encompass an ever-broadening array of excluded services. As we noted in the May 12, 1998 interim final rule (63 FR 26297), the fundamental purpose of the consolidated billing provision is ''* * * to make the SNF itself responsible for billing Medicare for essentially all of its residents' services, other than those identified in a small number of narrow and specifically delimited exclusions.'' This is consistent with the type of discretionary authority that the BBRA provided, which we regard as essentially affording the flexibility to revise the list of excluded codes in response to changes of major significance that may occur over time (for example, the development of new medical technologies or other advances in the state of medical practice).

Finally, regarding the comment on MRIs, we noted in the May 1998, interim final rule (63 FR 26298) that the exclusion of certain outpatient hospital services (in regulations at § 411.15(p)(3)(iii)) is targeted specifically at those services ''* * * that, under commonly accepted standards of medical practice, lie *exclusively* within the purview of hospitals * * *'' (emphasis added); that is, services which generally require the intensity of the hospital setting in order to be furnished safely and effectively. Thus, to the extent that advances in medical practice over time may make it feasible to perform such a service more widely in a less intensive, nonhospital setting, this would not argue in favor of unbundling the nonhospital performance of the service, but rather, of considering whether to rebundle the service entirely back to the SNF.

Comment: A number of commenters noted that the BBRA has now excluded from consolidated billing those ambulance services that are furnished in conjunction with dialysis services, and asked that we extend this exclusion to apply as well to those ambulance services furnished in conjunction with the other newly excluded service categories identified in the BBRA (chemotherapy, radioisotope, etc.). Some suggested that we could accomplish this by administratively expanding the existing exclusion of certain high-intensity outpatient hospital services (in regulations at § 411.15(p)(3)(iii)) to encompass these newly excluded services (which would, in turn, result in excluding the associated ambulance services as well). Another argued that since many ambulance services have already been excluded from consolidated billing, it would be less complicated from an administrative standpoint simply to establish a categorical exclusion for all ambulance services.

Response: We note that, prior to the BBRA's exclusion of dialysis-related ambulance services from consolidated billing, we received a number of similar recommendations to designate the statutorily-excluded category of dialysis services as also being one of the excluded outpatient hospital services under § 411.15(p)(3)(iii), as a means of permitting the associated ambulance transportation to be excluded as well. In response, we noted in the preamble to the July 30, 1999 final rule (64 FR 41673) that such a recommendation reflects

> * * * a misunderstanding of the underlying purpose of the outpatient hospital exclusion. This exclusion from consolidated billing does not serve as a mechanism for unbundling ambulance services per se. The * * * unbundling of ambulance services associated with * * * excluded outpatient hospital services occurs simply because the bundling of ambulance services is itself tied to a beneficiary's status as an SNF ''resident'' for consolidated billing purposes, which is suspended by the receipt of these excluded types of outpatient hospital services.

Further, while the statute itself excludes a number of service categories from the consolidated billing requirement—including services of physicians and certain other practitioners that are defined as being entirely outside the scope of the Part A SNF benefit (see sections 1861(h)(7) and 1861(b)(4) of the Act)—the receipt of such services offsite does not have the effect of ending a beneficiary's status as an SNF ''resident'' for consolidated billing purposes and, consequently, does not result in unbundling the associated ambulance transportation. Thus, unbundling the ambulance transportation that is associated with the statutorily-excluded types of chemotherapy services, radioisotope services, and customized prosthetic devices would require legislation to amend the law itself, like that which Congress enacted in section 103(a)(2) of the BBRA with respect to dialysis-related ambulance services. Similarly, establishing a categorical exclusion of all ambulance services whatsoever would also require legislation to amend the law.

Comment: A number of commenters raised issues regarding so-called ''Part B'' consolidated billing, in connection with services furnished to those beneficiaries in the SNF who are not in a covered Part A stay. (As we noted in the proposed rule, implementation of this aspect of consolidated billing has been delayed as a result of higher-priority systems renovations that had to be completed timely in order to achieve Year 2000 (Y2K) compliance.) Most of these commenters recommended extending the timeframe for implementation of Part B consolidated billing until after implementation of the PPS case-mix refinements set forth in the proposed rule, and a few even suggested reconsidering whether to implement this aspect of consolidated billing at all. One commenter suggested that bills for those types of items that are currently submitted to the Durable Medical Equipment Regional Carriers (DMERCs) should continue to be submitted to them under Part B consolidated billing, since the DMERCs have acquired specialized expertise in this area. Another recommended that HCFA should impose limitations on the amounts that suppliers can charge SNFs for Part B services.

Response: Since the law provides that consolidated billing applies to services furnished to a SNF ''resident'' (regardless of whether Medicare covers a particular resident's stay), we do not have the discretion simply to decline to implement this aspect of the provision. As we indicated in the July 30, 1999 final rule (64 FR 41671), once we have determined the specific implementation timeframe for this aspect of consolidated billing, we will provide at least 90 days' advance notice in the **Federal Register**. However, specific operational instructions (such as those describing the details of particular billing procedures) are beyond the scope of this final rule, and will be addressed instead in HCFA program issuances. With regard to the suggestion that we limit the amount a supplier can charge a SNF for its services, we note that the Medicare transaction for a service that is subject to consolidated billing is the one that takes place between the Medicare program and the SNF itself. As we pointed out in the July 1999 final rule (64 FR 41677), a SNF's relationship with its supplier under consolidated billing is essentially a private contractual matter, and the specific terms of the supplier's payment by the SNF must be arrived at through direct negotiations between the two parties themselves.

Comment: Under the current regulations at § 411.15(p)(3)(iv), a beneficiary's status as a SNF ''resident''

(for consolidated billing purposes) generally ends at the point of departure from the SNF. However, if the beneficiary returns to that or another SNF within 24 hours of departure, the beneficiary's status as a ''resident'' of the SNF from which he or she departed would continue during the absence, along with that SNF's consolidated billing responsibilities. As we noted in the proposed rule, since consolidated billing is currently in effect only for those SNF stays that are covered by Part A and paid by the PPS, this means in actual practice that such a beneficiary remains a SNF ''resident'' after leaving the SNF only if he or she then returns to the SNF by midnight. (This is because, under longstanding Medicare policy, a beneficiary generally must be present in the SNF at midnight of a given day in order for that day to be considered a Part A day.) We then proposed to revise the regulations to adopt this ''midnight rule'' in place of the current ''24-hour rule,'' which would essentially extend the policy currently in effect under Part A consolidated billing to apply to Part B consolidated billing as well. The commenters overwhelmingly supported this proposal, indicating that the resulting uniformity in policy would reduce the potential for confusion and billing errors. One commenter, while supporting the idea of following a uniform policy for both aspects of consolidated billing, suggested that the policy should be the ''24-hour rule'' that currently appears in the regulations rather than the ''midnight rule.'' The commenter cited, as a reason for taking this position, a concern over whether Part A payment under the SNF PPS recognizes those services that are furnished on the day of a beneficiary's discharge from the SNF, but before the actual moment of departure.

Response: As recommended by the majority of commenters, we are revising the regulations to adopt the ''midnight rule.'' Thus, a beneficiary's status as a SNF ''resident'' for consolidated billing purposes ends upon departure, unless the beneficiary returns to that or another SNF by midnight of the day of departure. (As we explained in the proposed rule, a patient ''day'' begins at 12:01 A.M. and ends the following midnight, so that the phrase ''midnight of the day of departure'' refers to the midnight that immediately follows the actual moment of departure, rather than to the midnight that immediately precedes it.) With regard to the concern expressed by one commenter about services that are furnished on the day of (but before the actual moment of) discharge, we note that the SNF PPS does, in fact, recognize such services, as discussed below. Even though the day of discharge from a covered SNF stay is not itself a covered Part A day, under the pre-PPS (reasonable cost) SNF payment methodology, ancillary services furnished on that day but before the actual moment of departure were covered, included on the SNF's cost report, and reflected in final cost settlement. Accordingly, the cost of such services has been built into the SNF PPS base. This makes the PPS per diem amount somewhat higher than it would otherwise have been for all of the preceding SNF days that Part A *does* cover, even though the day of discharge itself is not a covered Part A day. Further, with regard to room and board, although the Medicare program uses a midnight-to-midnight approach as a convention for counting inpatient days, the routine costs for the covered day that immediately precedes the date of discharge would include (much like a hotel bill) the accommodations for that entire night.

Comment: In excluding the additional services from consolidated billing and the SNF PPS (and, thus, qualifying them for separate payment under Part B), section 103 of the BBRA also mandated a corresponding proportional reduction in Part A SNF payments, beginning with FY 2001. We described our methodology for making this adjustment in the proposed rule (65 FR 19202), and indicated that we expected the amount of the adjustment to be minimal. However, due to the complexity of the process and the amount of time involved in completing it, we added that we would publish the actual adjusted rates themselves prospectively in the final rule. One commenter requested us to share the methodology that we actually used in making this adjustment. Another argued that the reduction in Part A payment essentially cancels out the fiscal relief provided by allowing the newly-excluded services to be billed to Part B.

Response: Regarding our adjustment methodology, we have computed a reduction of 5 cents ($0.05) in the unadjusted urban and rural rates, using the identical data as used to establish the Part B add-on for a sample of approximately 1,500 SNFs from the 1995 base period. By matching the excluded codes specified in section 103 of the BBRA to the Part B bills, we identified an amount equal to a reduction of $0.05 in the Federal rate. While the amount of the reduction reflects those excluded codes that we were specifically able to identify, there may be additional excluded services that were not captured, since certain of these services were billed differently in 1995 than now, in a manner that may not have utilized the codes by which they were specified in the BBRA. We are, therefore, continuing to examine the billing practices in the PPS base year, and may revise our estimate of this reduction in the future to capture additional elements of allowable charges, as appropriate. Regarding the comment that characterized this adjustment as canceling out the fiscal relief that was otherwise provided by this section of the BBRA, we note that the reduction in Part A payment rates is specifically required by that same section of the law, in order to prevent the Medicare program from paying twice (once under Part A, and again under Part B) for the same service. Further, we believe that this comment may reflect a misunderstanding of the overall effect of this provision's fiscal relief. As amended by section 103(b) of the BBRA, section 1888(e)(4)(G)(iii) of the Act provides that the adjustment is to be made in such a way that the *aggregate* reduction in Part A payments is estimated to equal the *aggregate* increase in Part B payments attributable to the exclusion. Further, we note that the particular services were excluded in recognition that SNFs could experience ''* * * high-cost, low probability events that could have devastating financial impacts because their costs far exceed'' an individual SNF's PPS payment (H.R. Conf. Rep. No. 106–479 at 854). Thus, the actual result of this provision's mandatory Part A payment reduction is to take the expense of the excluded items (which could be financially devastating to an individual SNF that actually incurs it, if borne solely by that particular facility) and effectively redistribute it over the entire universe of providers. In much the same way that an insurance pool reduces the degree of financial risk to an individual member of the pool in the event of a catastrophic loss, effectively spreading the expense of the excluded items over such a large provider population helps minimize the potential financial liability that any individual provider might otherwise incur.

I. Appeal Rights

In the proposed rule, we discussed the appeal rights of SNFs to appeal their payment rates under SNF PPS. We received no comments on this discussion.

J. Impact Analysis of the Proposed Rule

As required by Executive Order 12866, the Unfunded Mandates Reform Act of 1995 (UMRA, Public Law 104–4),

and the Regulatory Flexibility Act (RFA, Public Law 96–354), the proposed rule included a Regulatory Impact Statement, on which we received comments. (A regulatory impact analysis for this final rule appears in Section VI. below.)

Comment: Several commenters alleged that there is a large variance between the projections for FY 2001, including the 20 percent add-on, and the most recent actual SNF program expenditure data. Some added that the Congressional Budget Office (CBO) baseline spending estimates differ from HCFA's. They noted that changes in rates due to inflation updates and statutory amendments do not necessarily account for the variance between FY 1999 and FY 2001. The commenters requested clarification of our projections and fiscal impacts, including any assumptions about volume growth or behavioral changes in response to payment changes.

Response: We have, in the past, included a behavioral offset in estimates required by legislation; however, we do not include them in estimating the effects of regulations merely for purposes of routinely updating the rates. The calculation of $1 billion for the 20 percent add-on assumes a baseline for FY 2001 of $15.3 billion. Our estimate of the days covered by the 20 percent add-on is 43 percent and our estimate of the Federal portion of payments is 85 percent. We note that CBO's baseline spending estimates differ from HCFA's due to different assumptions about SNF utilization patterns. Further, since the time we did these estimates, we have in fact reduced our own baseline estimate for FY 2001 to $14.4 billion, which still yields $1 billion in the calculation. However, we have since revised our estimate to reflect the latest available SNF data, as indicated in the impact analysis for this final rule (see section VI., below).

Comment: There were a number of comments expressing concern over the financial viability of providers. In particular, commenters were concerned with the number of nursing home chains that have filed for bankruptcy nationwide.

Response: We are aware of the challenges that certain providers have faced in moving from a payment system that was based on reasonable costs to a PPS, which uses mean-based prices. One of the intended consequences of the BBA was an overall reduction in SNF payments. However, we do not agree that the changes introduced by the SNF PPS are the exclusive—or even the primary—cause of their current financial difficulties. We believe that many of these financial constraints are directly attributable to business decisions on the part of the providers themselves. For example, a GAO review (''Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments but Maintain Access,'' GAO/HEHS–00–23, December 1999) of two of the largest publicly held chains found that the financial position of both firms suffered from high capital-related costs; substantial, non-recurring expenses and write-offs; and reduced demand for ancillary services related to several of the other BBA provisions. In fact, in one of these chains, SNF operations themselves remained profitable after the introduction of the SNF PPS. This scenario is consistent with reports of other chains experiencing financial difficulties. In addition, media reports cite rapid expansion into other lines of business, high capital costs, and inadequate cost controls as other factors influencing current financial status within the SNF industry.

IV. Provisions of the Final Regulations

The provisions of this final rule restate the provisions of the April 10, 2000, proposed rule as discussed previously and a minor technical correction of a cross-reference in parts 413 and 489. Following is a highlight of the changes made:

- In § 411.15, paragraph (p)(2)(vii) is revised to exclude from consolidated billing those ambulance services that are furnished to a SNF resident in conjunction with dialysis services that are covered under Part B.
- In § 411.15, paragraph (p)(2) is also revised to list the additional services that section 103 of the BBRA has excluded from consolidated billing.
- In § 411.15, paragraph (p)(3)(iv), the phrase ''within 24 consecutive hours'' is revised to read ''by midnight of the day of departure''.
- In § 413.1, paragraph (b), the phrase ''paragraphs (c) through (f) of this section'' is revised to read ''paragraphs (c) through (h) of this section'', in order to reflect previous revisions to this section that provide for prospective payment to SNFs (63 FR 26309, May 12, 1998) and home health agencies (65 FR 41211, July 3, 2000).
- In § 489.20, paragraph (s) is revised to list the additional services that the BBRA has excluded from consolidated billing, and a conforming change is made at § 489.21(h) regarding a cross-reference to this list.
- In § 489.20, paragraph (s)(7) is revised to exclude from consolidated billing those ambulance services that are furnished to a SNF resident in conjunction with dialysis services that are covered under Part B.
- Sections 489.20(s)(11) and 411.15(p)(2)(xi) are revised to reflect editorial revisions in the paragraphs concerning the transportation costs of electrocardiogram equipment.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

VI. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order (EO) 12866, the Unfunded Mandates Reform Act (UMRA) (Public Law 104–4), the Regulatory Flexibility Act (RFA) (Public Law 96–354), and the Federalism Executive Order (EO) 13132.

Executive Order 12866 directs agencies to assess costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). This final rule is a major rule as defined in Title 5, United States Code, section 804(2), because we estimate its impact will be to increase the payments to SNFs by approximately $3.1 billion in FY 2001. The update set forth in this final rule applies to payments in FY 2001. Accordingly, the analysis that follows describes the impact of this one year only. In accordance with the requirements of the Act, we will publish a notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis.

The UMRA also requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in an expenditure in any year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million or more in any given year. This rule will have no consequential effect on State, local, or tribal governments. We believe the private sector cost of this rule falls below these thresholds as well.

Executive Order 13132 (effective November 2, 1999), establishes certain

requirements that an agency must meet when it promulgates regulations that impose substantial direct compliance costs on State and local governments, preempt State law, or otherwise have Federalism implications. As stated above, this rule will have no consequential effect on State and local governments.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and governmental agencies. Most SNFs and most other providers and suppliers are small entities, either by virtue of their nonprofit status or by having revenues of $5 million or less annually. For purposes of the RFA, all States and tribal governments are not considered to be small entities, nor are intermediaries or carriers. Individuals and States are not included in the definition of a small entity. The policies contained in this rule would update the SNF PPS rates by increasing the payment rates published in the July 30, 1999 notice, but will not have a significant effect upon small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds. We are not preparing a rural impact statement since we have determined, and the Secretary certifies, that this notice will not have a significant economic impact on the operations of a substantial number of small rural hospitals.

A. Background

Section 1888(e) of the Act establishes the SNF PPS for the payment of Medicare SNF services for periods beginning on or after July 1, 1998. This section specifies that the base year cost data to be used for computing the RUG-III payment rates must be from FY 1995 (that is, October 1, 1994, through September 30, 1995.) In accordance with the statute, we also incorporated a number of elements into the SNF PPS, such as case-mix classification methodology, the MDS assessment schedule, a market basket index, a wage index, the urban and rural distinction used in the development or adjustment of the Federal rates, and other features.

This final rule sets forth updates of the SNF PPS rates contained in the April 10, 2000 proposed rule. Table 11 below, presents the projected effects of the policy changes in the SNF PPS from FY 2000 to FY 2001, as well as statutory changes effective for FY 2001 on SNFs. In so doing, we estimate the effects of each policy change by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as days or case-mix.

This analysis incorporates the latest estimates of growth in service use and payments under the Medicare SNF benefit based on the latest available Medicare claims data and MDS 2.0 assessment data from 1999. Because we are not incorporating the refinements to the case-mix classification system, we are not presenting any additional information regarding their distributional impact on facility payments as we had indicated we would in the proposed rule. We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, very susceptible to forecasting errors due to other changes in the forecasted impact time period. Some examples of such possible events are newly legislated general Medicare program funding changes by the Congress, or changes specifically related to SNFs. In addition, changes to the Medicare program may continue to be made as a result of the BBA, BBRA, or new statutory provisions. Although these changes may not be specific to SNF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon SNFs.

B. Impact of This Final Rule

The purpose of this final rule is not to initiate significant policy changes with regard to the SNF PPS; rather, it is to respond to the comments on the proposed rule and establish the update methodology for FY 2001 after completion of our validation of the analysis presented in the proposed rule, based upon national data. Accordingly, we believe that the revisions and clarifications mentioned elsewhere in the preamble (for example, the update to the wage index used for adjusting the Federal rates) will have, at most, only a negligible overall effect upon the regulatory impact estimate specified in the proposed rule. As such, these revisions will not represent an additional burden to the industry.

As stated previously in this rule, the aggregate increase in payments associated with this final rule is estimated to be $3.1 billion. There are three areas of change that produce this increase for facilities—

1. The effect of the Federal transition, that results in many facilities being paid 75 percent at the Federal rate and 25 percent at the facility-specific rate instead of the current 50 percent Federal rate and 50 percent facility-specific rate. There is also the additional effect of the BBRA option to bypass the transition and be paid according to 100 percent of the Federal rate;

2. The implementation of various other provisions in the BBRA, such as the 20 percent and 4 percent add-ons to the Federal rates; and,

3. The total change in payments from FY 2000 levels to FY 2001 levels. This includes all of the previously noted changes in addition to the effect of the update to the rates.

As seen in Table 11 below, some of these areas result in increased aggregate payments and others tend to lower them. The breakdown of the various categories of data in the table are as follows:

The first row of the table describes the effects of the various policies on all facilities. The next six rows show the effects on facilities split by hospital-based, freestanding, urban and rural categories. The remainder of the table shows the effects on urban versus rural status by census region.

The second column in the table shows the number of facilities in the impact database. The third column shows the effect of the transition to the Federal rates. It includes the impact of the normal progression of facilities in the transition to new cost reporting periods and, therefore, blended payment amounts (that is, facility-specific versus Federal rates) as well as those facilities that, as a result of the BBRA, elect to bypass the transition and go immediately to the full Federal rate. This change has an overall effect of raising payments by 4.2 percent, with most of the increase coming from freestanding facilities. There are several regions that have decreased payments due to this provision, but the majority (and most populous) of the regions evidence higher payments, with the largest increase being in the New England and mid-Atlantic regions for both urban and rural facilities.

We estimate that approximately 63 percent of SNFs under the transition at the enactment of the BBRA have or will elect to be paid based on 100 percent of

the Federal rate. Of these facilities, we estimate 22 percent are hospital-based and 78 percent are freestanding, consistent with the proposed rule.

The fourth column shows the projected effect of the 4 percent add-on to the adjusted Federal rate mandated by the BBRA. As expected, this provision results in an increase in payments for all facilities. However, as seen in the table, the varying effect of the SNF PPS transition results in a distributional impact of this provision. In addition, since this increase only applies to the Federal portion of the payment rate, the effect on total expenditures is less than 4 percent.

The fifth column of the table shows the effect of the update to the Federal and facility-specific payment rates. It reflects an update to the Federal rates of 2.161 percent, which is equivalent to the market basket increase minus 1 percentage point, as required by law. In addition, it reflects an update to the facility-specific rates of 3.161 percent, which is equivalent to the full market basket increase for this period. For this analysis, it is assumed that payments will increase by 2.3 percent in total if there are no behavioral changes by the facilities. As can be seen from this table, the effects of the update itself do not vary significantly by specific types of providers or by location.

The sixth column of the table shows the effect of all of the revised wage index on the FY 2001 payments. The total impact of this change is 0 percent since the law requires this component of the update to be budget neutral. However, there are distributional effects of this change, as seen in the table.

The seventh column of the table indicates the overall impact of the 20 percent add-on for 15 specific RUG–III groups required under the BBRA.

Finally, the eighth column of the table shows the effect of all of the changes on the FY 2001 payments. This includes all of the previous changes, including the update to this year's payment rates by the market basket, and the 20 percent add-on. It is assumed that payments will increase by 21.8 percent in total, assuming facilities do not change their care delivery and billing practices in response. As can be seen from this table, the combined effects of all of the changes vary much more widely by specific types of providers and by location. For example, freestanding facilities enjoy more significant payment increases due to the policy changes, while the effects of the transition tend to diminish the increase for hospital-based providers.

TABLE 11.—PROJECTED IMPACT OF FY 2001 UPDATE TO THE SNF PPS

	Number of facilities	Transition to federal rates (percent)	Add on to Federal rates (percent)	Update change (percent)	Wage index change (percent)	20% add on (percent)	Total FY 2001 change (percent)
Total	9034	4.2	3.5	2.3	0.0	10.4	21.8
Urban	6300	3.6	3.5	2.3	−0.1	10.2	20.8
Rural	2737	7.1	3.7	2.2	0.8	11.3	27.3
Hospital based urban	683	−4.5	3.0	2.4	0.0	9.6	10.4
Freestanding urban	5617	5.1	3.6	2.3	−0.1	10.2	22.6
Hospital based rural	533	2.0	3.4	2.3	0.9	12.2	22.1
Freestanding rural	2204	8.2	3.7	2.2	0.7	11.1	28.3
Urban by region.							
New England	630	10.5	3.8	2.2	−0.8	10.9	29.0
Middle Atlantic	877	14.3	3.8	2.2	−0.3	12.9	36.5
South Atlantic	959	−0.4	3.3	2.3	−0.4	8.9	14.2
East North Central	1232	6.1	3.6	2.2	0.4	10.1	24.2
East South Central	212	1.9	3.5	2.3	−0.7	9.8	17.6
West North Central	469	3.6	3.5	2.3	0.4	10.2	21.4
West South Central	519	−5.2	3.0	2.4	1.0	8.8	9.9
Mountain	303	−4.0	3.1	2.4	0.0	7.1	8.5
Pacific	1070	−2.3	3.2	2.4	−0.5	9.6	12.6
Rural by region:							
New England	88	14.4	3.9	2.2	−0.9	12.6	35.6
Middle Atlantic	144	13.1	3.9	2.2	0.0	13.4	36.2
South Atlantic	373	5.3	3.6	2.2	1.1	11.1	25.2
East North Central	561	9.2	3.7	2.2	1.0	11.1	29.9
East South Central	255	4.2	3.6	2.3	0.6	12.3	24.8
West North Central	581	11.1	3.7	2.2	0.8	12.5	33.5
West South Central	354	1.2	3.4	2.3	1.1	9.8	18.8
Mountain	204	3.3	3.5	2.3	0.7	9.4	20.5
Pacific	151	3.2	3.5	2.3	0.3	9.2	19.7

While not specifically detailed in Table 11, we would also like to indicate the impact of the proportional reduction in the Federal rates to account for the new services excluded from consolidated billing (and, therefore, SNF PPS) under section 103 of the BBRA. The 5 cent ($0.05) reduction to the urban and rural unadjusted Federal rate results in an overall impact of a $2 million decrease in SNF payments for FY 2001.

Finally, in accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

VII. Federalism

We have reviewed this final rule under the threshold criteria of Executive Order 13132, Federalism, and we have determined that it does not significantly affect the rights, roles, and responsibilities of States.

List of Subjects

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR chapter IV is amended as follows:

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

A. Part 411 is amended as set forth below:

1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Exclusions and Exclusion of Particular Services

2. Section 411.15 is amended by:

A. Republishing the introductory text, and paragraph (p)(2) introductory text.

B. Revising paragraphs (p)(2)(vii) and (p)(2)(xi).

C. Adding new paragraphs (p)(2)(xii), (p)(2)(xiii), (p)(2)(xiv), and (p)(2)(xv).

D. Revising paragraph (p)(3)(iv).

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage.

* * * * *

(p) *Services furnished to SNF residents.*

* * * * *

(2) *Exceptions.* The following services are not excluded from coverage:

* * * * *

(vii) Dialysis services and supplies, as defined in section 1861(s)(2)(F) of the Act, and those ambulance services that are furnished in conjunction with them.

* * * * *

(xi) The transportation costs of electrocardiogram equipment (HCPCS code R0076), but only with respect to those electrocardiogram test services furnished during 1998.

(xii) Those chemotherapy items identified, as of July 1, 1999, by HCPCS codes J9000–J9020; J9040–J9151; J9170–J9185; J9200–J9201; J9206–J9208; J9211; J9230–J9245; and J9265–J9600.

(xiii) Those chemotherapy administration services identified, as of July 1, 1999, by HCPCS codes 36260–36262; 36489; 36530–36535; 36640; 36823; and 96405–96542.

(xiv) Those radioisotope services identified, as of July 1, 1999, by HCPCS codes 79030–79440.

(xv) Those customized prosthetic devices (including artificial limbs and their components) identified, as of July 1, 1999, by HCPCS codes L5050–L5340; L5500–L5611; L5613–L5986; L5988; L6050–L6370; L6400–6880; L6920–L7274; and L7362–L7366, which are delivered for a resident's use during a stay in the SNF and intended to be used by the resident after discharge from the SNF.

(3) *SNF resident defined.* * * *

(iv) The beneficiary is formally discharged (or otherwise departs) from the SNF, unless the beneficiary is readmitted (or returns) to that or another SNF by midnight of the day of departure.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END–STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

B. Part 413 is amended as set forth below:

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

Subpart A—Introduction and General Rules

2. Section 413.1, paragraph (b), is amended by revising the phrase ''paragraphs (c) through (f) of this section'' to read ''paragraphs (c) through (h) of this section''.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

C. Part 489 is amended to read as follows:

1. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Essentials of Provider Agreements

2. Section 489.20 is amended by:

A. Republishing the introductory text and paragraph (s) introductory text.

B. Revising paragraphs (s)(7) and (s)(11).

C. Adding new paragraphs (s)(12), (s)(13), (s)(14), and (s)(15).

§ 489.20 Basic commitments.

The provider agrees to the following:

* * * * *

(s) In the case of an SNF, either to furnish directly or make arrangements (as defined in § 409.3 of this chapter) for all Medicare-covered services furnished to a resident (as defined in § 411.15(p)(3) of this chapter) of the SNF, except the following:

* * * * *

(7) Dialysis services and supplies, as defined in section 1861(s)(2)(F) of the Act, and those ambulance services that are furnished in conjunction with them.

* * * * *

(11) The transportation costs of electrocardiogram equipment (HCPCS code R0076), but only with respect to those electrocardiogram test services furnished during 1998.

(12) Those chemotherapy items identified, as of July 1, 1999, by HCPCS codes J9000–J9020; J9040–J9151; J9170–J9185; J9200–J9201; J9206–J9208; J9211; J9230–J9245; and J9265–J9600.

(13) Those chemotherapy administration services identified, as of July 1, 1999, by HCPCS codes 36260–36262; 36489; 36530–36535; 36640; 36823; and 96405–96542.

(14) Those radioisotope services identified, as of July 1, 1999, by HCPCS codes 79030–79440.

(15) Those customized prosthetic devices (including artificial limbs and their components) identified, as of July 1, 1999, by HCPCS codes L5050–L5340; L5500–L5611; L5613–L5986; L5988; L6050–L6370; L6400–6880; L6920–L7274; and L7362–L7366, which are delivered for a resident's use during a stay in the SNF and intended to be used by the resident after discharge from the SNF.

§ 489.21 [Amended]

3. In § 489.21, paragraph (h), the phrase ''§ 489.20(s)(1) through (11)'' is revised to read ''§ 489.20(s)(1) through (15)''.

(Catalog of Federal Domestic Assistance Program No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 18, 2000.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Approved: July 21, 2000.

Donna E. Shalala,

Secretary.

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