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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 413

[CMS-1534-F]

RIN 0938-AP11

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2009

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule updates the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2009. It also discusses our ongoing analysis of nursing home staff time measurement data collected in the Staff Time and Resource Intensity Verification (STRIVE) project. Finally, this final rule makes technical corrections in the regulations

text with respect to Medicare bad debt payments to SNFs and the reference to the definition of urban and rural as applied to SNFs.

EFFECTIVE DATE: This final rule becomes effective on October 1, 2008.

FOR FURTHER INFORMATION CONTACT:

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Jeanette Kranacs, (410) 786-9385 (for information related to the development of the payment rates and case-mix indexes).

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SUPPLEMENTARY INFORMATION:

To assist readers in referencing sections contained in this document, we are providing the following Table of Contents.

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Abbreviations

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

AIDS	Acquired Immune Deficiency Syndrome
ARD	Assessment Reference Date
BBA	Balanced Budget Act of 1997, Pub.L. 105-33
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub.L. 106-113
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub.L. 106-554
CAH	Critical Access Hospital
CARE	Continuity Assessment Record and Evaluation
CBSA	Core-Based Statistical Area

CFR	Code of Federal Regulations
CMI	Case-Mix Index
CMS	Centers for Medicare & Medicaid Services
DRA	Deficit Reduction Act of 2005, Pub.L. 109-171
FQHC	Federally Qualified Health Center
FR	Federal Register
FY	Fiscal Year
GAO	Government Accountability Office
HAC	Hospital-Acquired Condition
HCPCS	Healthcare Common Procedure Coding System
HIPPS	Health Insurance Prospective Payment System
HIT	Health Information Technology
IFC	Interim Final Rule with Comment Period
IPPS	Hospital Inpatient Prospective Payment System
MDS	Minimum Data Set
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub.L. 108-173
MSA	Metropolitan Statistical Area
MS-DRG	Medicare Severity Diagnosis-Related Group
NRST	Non-Resident Specific Time
NTA	Non-Therapy Ancillary
OBRA	Omnibus Budget Reconciliation Act of 1987, Pub.L. 100-203
OIG	Office of the Inspector General

OMB	Office of Management and Budget
OMRA	Other Medicare Required Assessment
PAC-PRD	Post-Acute Care Payment Reform Demonstration
POA	Present on Admission
PPS	Prospective Payment System
RAI	Resident Assessment Instrument
RAP	Resident Assessment Protocol
RAVEN	Resident Assessment Validation Entry
RFA	Regulatory Flexibility Act, Pub.L. 96-354
RHC	Rural Health Clinic
RIA	Regulatory Impact Analysis
RUG-III	Resource Utilization Groups, Version III
RUG-53	Refined 53-Group RUG-III Case-Mix Classification System
RST	Resident Specific Time
SCHIP	State Children's Health Insurance Program
SNF	Skilled Nursing Facility
STM	Staff Time Measurement
STRIVE	Staff Time and Resource Intensity Verification
TEP	Technical Expert Panel
UMRA	Unfunded Mandates Reform Act, Pub.L. 104-4
VBP	Value-Based Purchasing

I. Background

On May 7, 2008, we published a proposed rule (73 FR 25918) in the **Federal Register** (hereafter referred to as the FY 2009 proposed rule), setting forth updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2009. Annual updates to the prospective payment system rates for skilled nursing facilities are required by section 1888(e) of the Social Security Act (the Act), as added by section 4432 of the Balanced Budget Act of 1997 (BBA), and amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Our most recent annual update occurred in the August 3, 2007 final rule (72 FR 43412) that set forth updates to the SNF PPS payment rates for FY 2008. We subsequently published two correction notices (72 FR 55085, September 28, 2007, and 72 FR 67652, November 30, 2007) with respect to those payment rate updates.

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

Section 4432 of the BBA amended section 1888 of the Act to provide for the implementation of a per diem PPS for SNFs,

covering all costs (routine, ancillary, and capital-related) 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. In this final rule, we are updating the per diem payment rates for SNFs for FY 2009. Major elements of the SNF PPS include:

- Rates. As discussed in section I.F.1. of this final rule, we established per diem Federal rates 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 were furnished to Medicare beneficiaries in a SNF during a Part A covered stay. We update the rates annually using a SNF market basket index, and we adjust them by the hospital inpatient wage index to account for geographic variation in wages. We also apply a case-mix adjustment to account for the relative resource utilization of different patient types. This adjustment utilizes a refined, 53-group version of the Resource Utilization Groups, version III (RUG-III) case-mix classification system, based on information obtained from the required resident assessments using the Minimum Data Set (MDS) 2.0. Additionally, as noted in sections I.C through I.E of this final rule, the payment rates at various times have also reflected specific legislative provisions, including section

101 of the BBRA, sections 311, 312, and 314 of the BIPA, and section 511 of the MMA.

- Transition. Under sections 1888(e)(1)(A) and (e)(11) of the Act, the SNF PPS included an initial, three-phase transition that blended a facility-specific rate (reflecting the individual facility's historical cost experience) with the Federal case-mix adjusted rate. The transition extended through the facility's first three cost reporting periods under the PPS, up to and including the one that began in FY 2001. Thus, the SNF PPS is no longer operating under the transition, as all facilities have been paid at the full Federal rate effective with cost reporting periods beginning in FY 2002. As we now base payments entirely on the adjusted Federal per diem rates, we no longer include adjustment factors related to facility-specific rates for the coming FY.

- Coverage. The establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because the 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 output of beneficiary assessment and RUG-III classifying activities. This approach

includes an administrative presumption that utilizes a beneficiary's initial classification in one of the upper 35 RUGs of the refined 53-group system to assist in making certain SNF level of care determinations, as discussed in greater detail in section III.B.5 of this final rule.

- Consolidated Billing. The SNF PPS includes a consolidated billing provision that requires a SNF to submit consolidated Medicare bills to its fiscal intermediary or Medicare Administrative Contractor for almost all of the services that its residents receive during the course of a covered Part A stay. In addition, this provision places with the SNF the Medicare billing responsibility for physical, occupational, and speech-language therapy that the resident receives during a noncovered stay. The statute excludes a small list of services from the consolidated billing provision (primarily those of physicians and certain other types of practitioners), which remain separately billable under Part B when furnished to a SNF's Part A resident. A more detailed discussion of this provision appears in section V. of this final rule.

- Application of the SNF PPS to SNF services furnished by swing-bed hospitals. Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare

swing-bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF services furnished under a swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, these services are paid under the SNF PPS when furnished by non-CAH rural hospitals, effective with cost reporting periods beginning on or after July 1, 2002. A more detailed discussion of this provision appears in section VI. of this final rule.

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

Section 1888(e)(4)(H) of the Act requires that we publish annually 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 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

modifications in the RUG-III classification structure (see section III.B.5 of this final rule for a discussion of the relationship between the case-mix classification system and SNF level of care determinations).

Along with other revisions outlined later in this preamble, this final rule provides the annual updates to the Federal rates as mandated by the Act.

C. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA)

There were several provisions in the BBRA that resulted in adjustments to the SNF PPS. We described these provisions in detail in the SNF PPS final rule for FY 2001 (65 FR 46770, July 31, 2001). In particular, section 101(a) of the BBRA provided for a temporary 20 percent increase in the per diem adjusted payment rates for 15 specified RUG-III groups. In accordance with section 101(c)(2) of the BBRA, this temporary payment adjustment expired on January 1, 2006, with the implementation of case-mix refinements (see section I.F.1. of this final rule). We included further information on BBRA provisions that affected the SNF PPS in Program Memorandums A-99-53 and A-99-61 (December 1999).

Also, section 103 of the BBRA designated certain additional services for exclusion from the consolidated billing requirement, as discussed in greater detail in section

V. of this final rule. Further, for swing-bed hospitals with more than 49 (but less than 100) beds, section 408 of the BBRA provided for the repeal of certain statutory restrictions on length of stay and aggregate payment for patient days, effective with the end of the SNF PPS transition period described in section 1888(e)(2)(E) of the Act. In the SNF PPS final rule for FY 2002 (66 FR 39562, July 31, 2001), we made conforming changes to the regulations at §413.114(d), effective for services furnished in cost reporting periods beginning on or after July 1, 2002, to reflect section 408 of the BBRA.

D. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

The BIPA also included several provisions that resulted in adjustments to the SNF PPS. We described these provisions in detail in the SNF PPS final rule for FY 2002 (66 FR 39562, July 31, 2001). In particular:

- Section 203 of the BIPA exempted CAH swing-beds from the SNF PPS. We included further information on this provision in Program Memorandum A-01-09 (Change Request #1509), issued January 16, 2001, which is available online at www.cms.hhs.gov/transmittals/downloads/a0109.pdf.

- Section 311 of the BIPA revised the statutory update formula for the SNF market basket, and also directed us to

conduct a study of alternative case-mix classification systems for the SNF PPS. In 2006, we submitted a report to the Congress on this study, which is available online at www.cms.hhs.gov/SNFPPS/Downloads/RC_2006_PC-PPSSNF.pdf.

- Section 312 of the BIPA provided for a temporary increase of 16.66 percent in the nursing component of the case-mix adjusted Federal rate for services furnished on or after April 1, 2001, and before October 1, 2002; accordingly, this add-on is no longer in effect. This section also directed the Government Accountability Office (GAO) to conduct an audit of SNF nursing staff ratios and submit a report to the Congress on whether the temporary increase in the nursing component should be continued. The report (GAO-03-176), which GAO issued in November 2002, is available online at www.gao.gov/new.items/d03176.pdf.

- Section 313 of the BIPA repealed the consolidated billing requirement for services (other than physical, occupational, and speech-language therapy) furnished to SNF residents during noncovered stays, effective January 1, 2001. (A more detailed discussion of this provision appears in section V. of this final rule.)

- Section 314 of the BIPA corrected an anomaly involving three of the RUGs that the BBRA had designated to receive the temporary payment adjustment discussed above in

section I.C. of this final rule. (As noted previously, in accordance with section 101(c)(2) of the BBRA, this temporary payment adjustment expired upon the implementation of case-mix refinements on January 1, 2006.)

- Section 315 of the BIPA authorized us to establish a geographic reclassification procedure that is specific to SNFs, but only after collecting the data necessary to establish a SNF wage index that is based on wage data from nursing homes. To date, this has proven to be infeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data.

We included further information on several of the BIPA provisions in Program Memorandum A-01-08 (Change Request #1510), issued January 16, 2001, which is available online at www.cms.hhs.gov/transmittals/downloads/a0108.pdf.

E. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)

The MMA included a provision that resulted in further adjustment to the SNF PPS. Specifically, section 511 of the MMA amended section 1888(e)(12) of the Act, to provide for a temporary increase of 128 percent in the PPS per diem payment for any SNF resident with Acquired Immune Deficiency Syndrome (AIDS), effective with services furnished on or after

October 1, 2004. This special AIDS add-on was to remain in effect until ". . . such date as the Secretary certifies that there is an appropriate adjustment in the case mix . . . ." The AIDS add-on is also discussed in Program Transmittal #160 (Change Request #3291), issued on April 30, 2004, which is available online at www.cms.hhs.gov/transmittals/downloads/r160cp.pdf. As discussed in the SNF PPS final rule for FY 2006 (70 FR 45028, August 4, 2005), the implementation of the case-mix refinements did not address the certification regarding the AIDS add-on, allowing the temporary add-on payment created by section 511 of the MMA to continue in effect.

For the limited number of SNF residents that qualify for the AIDS add-on, implementation of this provision results in a significant increase in payment. For example, using FY 2006 data, we identified less than 2,700 SNF residents with a diagnosis code of 042 (Human Immunodeficiency Virus (HIV) Infection). For FY 2009, an urban facility with a resident with AIDS in RUG group "SSA" would have a case-mix adjusted payment of $259.40 (see Table 4) before the application of the MMA adjustment. After an increase of 128 percent, this urban facility would receive a case-mix adjusted payment of $591.43.

In addition, section 410 of the MMA contained a provision that excluded from consolidated billing certain practitioner

and other services furnished to SNF residents by rural health clinics (RHCs) and Federally Qualified Health Centers (FQHCs). (Further information on this provision appears in section V. of this final rule.)

F. Skilled Nursing Facility Prospective Payment -- General Overview

We implemented the Medicare SNF PPS effective with cost reporting periods beginning on or after July 1, 1998. This PPS pays SNFs through prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services. These payment rates cover all costs of furnishing covered skilled nursing services (routine, ancillary, and capital-related costs) other than costs associated with approved educational activities. Covered SNF services include post-hospital 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 covered Part A stay. A comprehensive discussion of these provisions appears in the May 12, 1998 interim final rule (63 FR 26252).

1. Payment Provisions - Federal Rate

The PPS uses 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 incorporated an estimate of the amounts that would be payable under Part B for covered SNF services furnished to individuals during the course of a covered Part A stay in a SNF.

In developing the rates for the initial period, we updated costs to the first effective year of the PPS (the 15-month period beginning July 1, 1998) using a SNF market basket index, and then standardized for the costs of facility differences in case-mix and for geographic variations in wages. In compiling the database used to compute the Federal payment rates, we excluded those providers that received new provider exemptions from the routine cost limits, as well as costs related to payments for exceptions to the routine cost limits. Using the formula that the BBA prescribed, 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 computed and applied separately the payment rates for facilities located in urban and rural areas. In addition, we adjusted 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. The RUG-III classification system uses beneficiary assessment data from the Minimum Data Set (MDS) completed by SNFs to assign beneficiaries to one of 53 RUG-III groups. The original RUG-III case-mix classification system included 44 groups. However, under refinements that became effective on January 1, 2006, we added nine new groups--comprising a new Rehabilitation plus Extensive Services category--at the top of the RUG hierarchy. The May 12, 1998 interim final rule (63 FR 26252) included a detailed description of the original 44-group RUG-III case-mix classification system. A comprehensive description of the refined 53-group RUG-III case-mix classification system (RUG-53) appeared in the proposed rule for FY 2006 (70 FR 29070, May 19, 2005) and in the final rule for FY 2006 (70 FR 45026, August 4, 2005).

Further, in accordance with section 1888(e)(4)(E)(ii)(IV) of the Act, the Federal rates in this final rule reflect an update to the rates that we published in the final rule for FY

2008 (72 FR 43412, August 3, 2007) and the associated correction notices published on September 28, 2007 (72 FR 55085) and November 30, 2007 (72 FR 67652), equal to the full change in the SNF market basket index. A more detailed discussion of the SNF market basket index and related issues appears in sections I.F.2. and IV. of this final rule.

2. Rate Updates Using the Skilled Nursing Facility Market Basket Index

Section 1888(e)(5) of the Act requires us to establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. We use the SNF market basket index to update the Federal rates on an annual basis. In the FY 2008 SNF PPS final rule (72 FR 43425 through 43430, August 3, 2007), we revised and rebased the market basket, which included updating the base year from FY 1997 to FY 2004. The proposed FY 2009 market basket increase was 3.1 percent. The final FY 2009 market basket increase is 3.4 percent.

In addition, as explained in the SNF PPS final rule for FY 2004 (66 FR 46058, August 4, 2003) and in section IV.B. of this final rule, the annual update of the payment rates includes, as appropriate, an adjustment to account for market basket forecast error. As described in the SNF PPS final rule for FY 2008 (72 FR 43425, August 3, 2007), the threshold

percentage that serves to trigger an adjustment to account for market basket forecast error is 0.5 percentage point effective for FY 2008 and subsequent years. This adjustment takes into account the forecast error from the most recently available FY for which there is final data, and applies whenever the difference between the forecasted and actual change in the market basket exceeds a 0.5 percentage point threshold. For FY 2007 (the most recently available FY for which there is final data), the estimated increase in the market basket index was 3.1 percentage points, while the actual increase was 3.1 percentage points, resulting in no difference. Accordingly, as the difference between the estimated and actual amount of change does not exceed the 0.5 percentage point threshold, the payment rates for FY 2009 do not include a forecast error adjustment. Table 1 below shows the forecasted and actual market basket amounts for FY 2007.

Table 1 - Difference Between the Forecasted and Actual Market Basket Increases for FY 2007

Index	Forecasted FY 2007 Increase*	Actual FY 2007 Increase**	FY 2007 Difference***
SNF	3.1	3.1	0.0

*Published in Federal Register; based on second quarter 2006 Global Insight Inc. forecast (97 index).
**Based on the second quarter 2008 Global Insight forecast (97 index).
***The FY 2007 forecast error correction will be applied to the FY 2009 PPS update recommendations. Any forecast error less than 0.5 percentage points will not be reflected in the update recommendation.

Requirements for Issuance of Regulations

Section 902 of the Medicare Prescription Drug,

Improvement, and Modernization Act of 2003 (MMA) amended section 1871(a) of the Act and requires the Secretary, in consultation with the Director of the Office of Management and Budget, to establish and publish timelines for the publication of Medicare final regulations based on the previous publication of a Medicare proposed or interim final regulation. Section 902 of the MMA also states that the timelines for these regulations may vary but shall not exceed 3 years after publication of the preceding proposed or interim final regulation except under exceptional circumstances.

This final rule finalizes provisions proposed in the May 7, 2008 proposed rule. In addition, this final rule has been published within the 3-year time limit imposed by section 902 of the MMA. Therefore, we believe that the final rule is in accordance with the Congress' intent to ensure timely publication of final regulations.

II. Summary of the Provisions of the FY 2009 Proposed Rule

In the FY 2009 proposed rule (73 FR 25918, May 7, 2008), we proposed to update the Federal payment rates used under the SNF PPS for FY 2009. We also proposed to recalibrate the case-mix indexes so that they would more accurately reflect parity in expenditures related to the implementation of case-mix refinements in January 2006. In addition, we discussed our ongoing analysis of nursing home staff time measurement

data collected in the Staff Time and Resource Intensity Verification (STRIVE) project. We also proposed to make technical corrections in the regulations text with respect to Medicare bad debt payments to SNFs and the reference to the definition of urban and rural as applied to SNFs.

III. Analysis and Response to Public Comments on the FY 2009 Proposed Rule

In response to the publication of the FY 2009 proposed rule, we received over 100 timely items of correspondence from the public. The comments originated primarily from various trade associations and major organizations, but also from individual providers, corporations, government agencies, and private citizens.

Brief summaries of each proposed provision, a summary of the public comments that we received, and our responses to the comments appear below.

A. General Comments on the FY 2009 Proposed Rule

In addition to the comments that we received on the proposed rule's discussion of specific aspects of the SNF PPS (which we address later in this final rule), commenters also submitted the following, more general observations on the payment system.

Comment: We received comments similar to those discussed previously in the SNF PPS final rule for FY 2008 (72 FR 43415

through 43416, August 3, 2007) regarding the need to address certain perceived inadequacies in payment for non-therapy ancillary (NTA) services, including those services relating to the provision of ventilator care in SNFs. We also received comments recommending that we continue to monitor ongoing research, and that we consider alternative case-mix methodologies such as the recent MedPAC proposal that appears on the MedPAC web site (see www.MedPAC.gov.)

Response: As we noted in the August 3, 2007 FY 2008 final rule (72 FR 43416), we anticipate that the findings from our current Staff Time and Resource Intensity Verification (STRIVE) project will assist us in reviewing and addressing these types of concerns. However, as noted in our December 2006 Report to Congress, our analysis of NTA utilization has been hindered by a lack of data. All Medicare institutional providers except SNFs are required to submit detailed line item billing that shows each ancillary service furnished during a Part A stay. SNFs currently submit summary data that shows total dollar amounts for each ancillary service category, such as radiology and pharmacy. As we examine the data collected through the STRIVE project, we will be evaluating whether our current data requirements are sufficient to move forward with additional program enhancements. We will also consider whether collecting more

detailed claims information on a regular basis will allow us to establish more accurate payment rates for NTA services.

We also believe it is important to monitor ongoing research activities, and work with all stakeholders, including MedPAC, to identify opportunities for future program enhancements. At the same time, we note that the SNF PPS reimbursement structure will be completely examined as part of the Post Acute Care Payment Reform Demonstration (PAC-PRD) project. Under this major CMS initiative, we intend to analyze the payment structure currently used for all post-acute care providers, and establish an integrated payment model centered on beneficiary needs and service utilization (including the use of non-therapy ancillaries) across settings. In considering future changes to the SNF PPS, it will be important to evaluate how shorter term enhancements contribute to our integrated post acute care strategy.

A discussion of the public comments that we received on the STRIVE project itself appears in section III.B.7.a of this final rule.

B. Annual 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, 2008. The schedule incorporates per diem Federal rates that provide Part A payment for all costs of services furnished to a beneficiary in a SNF during a Medicare-covered stay.

a. Costs and Services Covered by the Federal Rates

In accordance with section 1888(e)(2)(B) of the Act, the Federal rates apply to all costs (routine, ancillary, and capital-related) of covered SNF services other than costs associated with approved educational activities as defined in §413.85. Under section 1888(e)(2)(A)(i) of the Act, covered SNF services include post-hospital SNF services for which benefits are provided under Part A (the hospital insurance program), as well as all items and services (other than those services excluded by statute) that, before July 1, 1998, were paid under Part B (the supplementary medical insurance program) but furnished to Medicare beneficiaries in a SNF during a Part A covered stay. (These excluded service categories are discussed in greater detail in section V.B.2. of the May 12, 1998 interim final rule (63 FR 26295 through

26297).)

b. Methodology Used for the Calculation of the Federal Rates

The FY 2009 rates reflect an update using the full amount of the latest market basket index. The FY 2009 market basket increase factor is 3.4 percent. A complete description of the multi-step process used to calculate Federal rates initially appeared in the May 12, 1998 interim final rule (63 FR 26252), as further revised in subsequent rules. We note that in accordance with section 101(c)(2) of the BBRA, the previous temporary increases in the per diem adjusted payment rates for certain designated RUGs, as specified in section 101(a) of the BBRA and section 314 of the BIPA, are no longer in effect due to the implementation of case-mix refinements as of January 1, 2006. However, the temporary increase of 128 percent in the per diem adjusted payment rates for SNF residents with AIDS, enacted by section 511 of the MMA (and discussed previously in section I.E of this final rule), remains in effect.

We used the SNF market basket to adjust each per diem component of the Federal rates forward to reflect cost increases occurring between the midpoint of the Federal FY beginning October 1, 2007, and ending September 30, 2008, and the midpoint of the Federal FY beginning October 1, 2008, and ending September 30, 2009, to which the payment rates

apply. In accordance with section 1888(e)(4)(E)(ii)(IV) of the Act, we update the payment rates for FY 2009 by a factor equal to the full market basket index percentage increase. (We note, that the FY 2009 President's Budget includes a provision that would establish a zero percent market basket update for FYs 2009 through 2011, contingent upon the enactment of legislation by the Congress to adopt that proposal.) We further adjust the rates by a wage index budget neutrality factor, described later in this section. Tables 2 and 3 below reflect the updated components of the unadjusted Federal rates for FY 2009.

Table 2
FY 2009 Unadjusted Federal Rate Per Diem
Urban

Rate Component	Nursing - Case-Mix	Therapy - Case-Mix	Therapy - Non-Case-mix	Non-Case-Mix
Per Diem Amount	$151.74	$114.30	$15.05	$77.44

Table 3
FY 2009 Unadjusted Federal Rate Per Diem
Rural

Rate Component	Nursing - Case-Mix	Therapy - Case-Mix	Therapy - Non-Case-mix	Non-Case-Mix
Per Diem Amount	$144.97	$131.80	$16.08	$78.87

2. Case-Mix Adjustments

a. Background

Section 1888(e)(4)(G)(i) of the Act requires the Secretary to make an adjustment to account for case-mix. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the relative resource use of different patient types, as well as resident assessment and other data that the Secretary considers appropriate. In first implementing the SNF PPS (we refer readers to the May 12, 1998 interim final rule (63 FR 26252)), we developed the Resource Utilization Groups, version III (RUG-III) case-mix classification system, which tied the amount of payment to resident resource use in combination with resident characteristic information. Staff time measurement (STM) studies conducted in 1990, 1995, and 1997 provided information on resource use (time spent by staff members on residents) and resident characteristics that enabled us not only to establish RUG-III, but also to create case-mix indexes.

Under the BBA, each update of the SNF PPS payment rates must include the case-mix classification methodology applicable for the coming Federal FY. As indicated previously in section I.F.1, the payment rates set forth in this final rule reflect the use of the refined RUG-53 system that we discussed in detail in the proposed and final rules for FY 2006.

When we introduced a new refined RUG-53 classification model in January 2006, we used our authority for establishing an appropriate case-mix structure to construct a new case-mix index for use with the RUG-53 model. We calculated the new case-mix indexes using the STM study data that were collected during the 1990s and originally used in creating the SNF PPS case-mix classification system and case-mix indexes. As explained in greater detail below, we then performed a budget neutrality analysis, and increased the RUG-53 case-mix weights so that overall payments under the two models (the original 44-group model and the refined 53-group model) could be expected to be equal.

In the following section of this final rule, we discuss the adjustments to the RUG-53 case-mix indexes structure that we proposed in our FY 2009 proposed rule.

b. Development of the Case-Mix Indexes

In the August 4, 2005 SNF PPS final rule for FY 2006 (70 FR 45032), we introduced two refinements to the SNF PPS: (1) nine new case-mix groups to account for the care needs of beneficiaries requiring both extensive medical and rehabilitation services; and (2) an adjustment to reflect the variability in the use of non-therapy ancillaries (NTAs). We made these refinements by using the resource minute data from the original 44-group model to create a new set of relative

weights, or case-mix indexes (CMIs), for the refined 53-group model. We then compared the two models to ensure that estimated total payments under the 53-group model would not be greater or less than the aggregate payments that would have been made under the 44-group model.

As explained in the FY 2009 proposed rule (73 FR 25923), in conducting this analysis for the FY 2006 final rule, we used FY 2001 claims data (the most current data available at the time) to compare estimated aggregate payments under the 44-group and 53-group models. For each model, we multiplied the estimated case-mix adjusted base rate by the number of Medicare paid days attributable to each RUG group. For the 44-group RUG model, we used the actual 2001 paid claims data to determine the distribution of paid days. For the 53-group RUG model, we did not have any actual claims data, and had to estimate the number of days that would be distributed across the 53 groups. Using our estimated distribution, we found that payments under the new 53-group model would be lower than under the original 44-group model. As the purpose of the refinement was to better allocate payment and not to reduce overall expenditures, we adjusted the new CMIs upward by applying a parity adjustment factor. In this way, we attempted to ensure that the RUG-III model was expanded in a budget-neutral manner (that is, one that would not cause any

change in the overall level of expenditures). We then applied a second adjustment to the CMIs to account for the variability in the use of NTA services. These two adjustments resulted in a combined 17.9 percent increase in the CMIs that went into effect on January 1, 2006, as part of the case-mix refinement implementation. A detailed description of the methods used to make these two adjustments to the CMIs appears in the SNF PPS proposed rule for FY 2006 (70 FR 29077 through 29078, May 19, 2005).

While we took all reasonable precautions to establish an appropriate, budget neutral conversion from the 44-group to the 53-group classification model, we recognized that the analyses we used to compute the budget neutrality adjustment were based solely on estimated data and that actual experience could be significantly different. For this reason, in the SNF PPS final rule for FY 2006 (70 FR 45031, August 4, 2005), we committed to monitoring the accuracy and effectiveness of the CMIs used in the 53-group model.

In monitoring recent claims data, we observed that actual expenditures were significantly higher than what we had projected using the 2001 data. In particular, the proportion of dollars paid for patients who grouped in the highest paying RUG categories--combining high therapy with extensive services--greatly exceeded our projections. To determine why

expenditures so greatly exceeded our projections, we repeated the budget neutrality analyses described earlier in this section (and as described in the FY 2006 SNF PPS proposed rule (70 FR 29077 through 29078, May 19, 2005)), using actual 2006 claims data to determine the distribution of paid days across the 53-group RUG model. For this analysis, we compared simulated calendar year (CY) 2006 payments (the first time period for which RUG-53 paid days data were available) to payments that would have been made under the RUG-44 model. As the introduction of the 9 new groups had not required a change to the MDS used to classify beneficiaries, we also had all of the data necessary to calculate accurately the distribution of paid days under the RUG-44 model. We found that estimated payments under the RUG-44 model were still higher than under the RUG-53 model, but that our original projections had overstated the difference. In addition, as the original budget neutrality adjustment was overestimated, the percentage adjustment made to the case-mix weights (after the budget neutrality adjustment was made) to account for NTA variability also needed to be recalibrated. Using the actual 2006 data, we found that the adjustment necessary to achieve budget neutrality was an increase of 9.68 percent rather than the 17.9 percent increase that had been in effect since January 2006. Thus, from January 2006 to the present, using the 17.9

percent adjustment to the case-mix weights resulted in overpayments far exceeding our intention of paying in a budget neutral manner. For FY 2009, we estimate the amount of overpayment at $780 million.

Although the 2001 data were the best source available at the time the FY 2006 refinements were introduced, the distribution of paid days, a key component in adjusting the RUG-53 case-mix weights, was based solely on estimated utilization. The 2006 data provide a more recent and a more accurate source of RUG-53 utilization based on actual utilization, and are an appropriate source to use for case-mix adjustment.

We received a number of comments questioning our legal authority to recalibrate the case-mix weights, as well as questions on the methodology used to make the case-mix weight adjustments. In the following discussion, we present the concerns that the commenters raised on this issue, and we also take the opportunity to address a number of misconceptions about the proposed recalibration that the comments reflected. However, in view of the potential ramifications of this proposal and the complexity of the issues involved, we believe that it would be prudent to take additional time to evaluate the proposal in order to further consider consequences that may result from it. Accordingly, we are not proceeding with

the proposed recalibration at this time, pending further analysis. We note that as we continue to evaluate this issue, we fully expect to implement such an adjustment in the future. The comments that we received on this issue, and our responses, are as follows:

Comment: Several commenters stated that the need for the recalibration arose because CMS initial projections of utilization under the refined case-mix system proved to be inaccurate once actual utilization data became available. They then asserted that in view of this, the proposed recalibration represents a "forecast error adjustment" that is not covered under the statutory authority to provide for an appropriate adjustment to account for case mix (section 1888(e)(4)(G)(i) of the Act).

Response: It would be incorrect to characterize the proposed recalibration as a "forecast error adjustment," as that term refers solely to an adjustment that compensates for an inaccurate forecast of the annual inflation factor in the SNF market basket. By contrast, the proposed recalibration would serve to ensure that the 2006 case-mix refinements are implemented as intended. As such, it would be integral to the process of providing ". . . for an appropriate adjustment to account for case mix" that is based upon appropriate data in accordance with section 1888(e)(4)(G)(i) of the Act.

Comment: A number of comments included references to the discussion of the 2006 case-mix refinements in the SNF PPS proposed rule for FY 2006 (70 FR 29079, May 19, 2005), in which we explained that we were ". . . advancing these proposed changes under our authority in section 101(a) of the BBRA to establish case-mix refinements, and that the changes we are hereby proposing will represent the final adjustments made under this authority" (emphasis added). The commenters stated that this earlier description of the 2006 case-mix refinements as "final" effectively precludes CMS from proceeding with a recalibration, which they characterized as representing a further refinement. Similarly, several commenters also questioned our authority to recalibrate the case-mix system prior to the completion of the STRIVE staff time measurement (STM) project. In addition, several commenters questioned whether CMS has the authority to impose a budget neutrality requirement on the introduction of a new classification model.

Response: We wish to clarify that the actual "refinement" that we proposed and implemented in the FY 2006 rulemaking cycle consisted of our introduction of the 9 new Rehabilitation plus Extensive Services groups at the top of the previous, 44-group RUG hierarchy, along with the adjustment recognizing the variability of NTA use, which

together fulfilled the provisions of section 101(a) of the BBRA. The accompanying adjustment to the case-mix indexes (CMIs) was merely a vehicle through which we implemented that refinement. Rather than representing a new or further "refinement" in itself, the proposed recalibration merely serves to ensure that we correctly accomplish a revision to the CMIs that accompanied the FY 2006 case-mix refinements.

In the FY 2006 final rule (70 FR 45033, August 4, 2005), we addressed the introduction of the refinements within the broader context of ensuring payment accuracy and beneficiary access to care. We pointed out that

> . . . this incremental change is part of this ongoing process that will also include update activities such as the upcoming STM study and investigation of potential alternatives to the RUG system itself. However, the commitment to long term analysis and refinement should not preclude the introduction of more immediate methodological and policy updates.

Finally, the budget neutrality factor was applied to the unadjusted RUG 53 case-mix weights that were introduced in January 2006. As stated above, our initial analyses indicated that payments would be lower under the RUG-53 model. As the purpose of the refinement was to reallocate payments, and not to reduce expenditures, we believe that increasing the case-

mix weights to equalize payments under the two models is an appropriate exercise of our broad authority to establish an appropriate case-mix system. We further note that the FY 2006 refinement to the case-mix classification system using adjusted CMIs was implemented through the rulemaking process, and we received no comments on the use of a budget neutrality adjustment at that time.

We also received a number of technical comments on the potential effects of implementing this recalibration proposal on beneficiaries, providers, and the overall economy. These comments are summarized below.

Comment: Some commenters opposed the recalibration of the budget neutrality adjustment, believing that the change to the case-mix weights would "take back" payments to providers that had increased due to changes in case mix between 2001 and 2006. Specifically, several commenters expressed the belief that by proposing to recalibrate the case-mix weights put into place for the RUG-53 system, we are incorrectly identifying increased payments related to treatment of higher case-mix patients with an overpayment related to the use of an incorrect budget neutrality adjustment factor applied in January 2006. Another commenter believed that the proposed recalibration could be more accurately calculated using either 2005 data or a combination of 2005 and 2006 data.

Response: We agree that, on average, the case-mix indexes for current SNF patients are higher than they were in 2001. However, we believe this concern erroneously equates the introduction of a new classification model with the regular SNF PPS annual update process. Normally, changes in case mix are accommodated as the classification model identifies changes in case mix and assigns the appropriate RUG group. Actual payments will typically vary from projections since case-mix changes, which occur for a variety of reasons, cannot be anticipated in an impact analysis.

However, in January 2006, we did more than just update the payment rates; we introduced a new classification model, the RUG-53 case-mix system. As discussed above, the purpose of this refined model was to redistribute payments across the 53 groups while maintaining the same total expenditure level that we would have incurred had we retained the original 44-group RUG model.

In testing the two models, we used 2001 data because it was the best data we had available, and found that using the raw weights calculated for the RUG-53 model, we could expect aggregate payments to decrease as a result of introducing the refinement. To prevent this expected reduction in Medicare expenditures, we applied an adjustment to the RUG-53 case-mix weights as described in detail earlier in this section. Later

analysis using actual 2006 data showed that, rather than achieving budget neutrality between the two models, expenditures were significantly higher than intended. For FY 2009, expenditures are estimated to be $780 million higher than intended.

We do not agree that updating our analysis using CY 2006 data captured payments related to increased case mix rather than establishing budget neutrality between the two models. First, by using 2006 data to estimate expenditures under both models, the same case-mix changes are incorporated into the estimated expenditure levels for RUG-44 as well as for RUG-53. Second, we believe it is appropriate to standardize the new model for the time period in which it is being introduced. The only reason we used 2001 data in the original calculation is that it was the best data available at the time. The CY 2006 data allowed us to calibrate the RUG-53 model more precisely for its first year of operation.

One commenter recommended using alternative time periods in calculating the budget neutrality adjustment. However, while it might be possible to use CY 2005 rather than CY 2006 data, using CY 2005 data still requires us to use a projection of the distributional shift to the nine new groups in the RUG-53 group model. We also looked at a second recommended alternative, which involved comparing quarterly data periods

directly before and after implementation of the RUG-53 model; that is, October through December 2005 for the RUG-44 model and January through March 2006 for the RUG-53 model. Our preliminary analyses confirmed that the proposed recalibration would serve to ensure that the 2006 case-mix refinements are implemented as actually intended. However, we believe that using actual utilization data for CY 2006 is more accurate, since actual case mix during the calibration year is the basis for computing the case-mix adjustment. We have determined that using the 2006 data instead of the suggested alternatives are the most appropriate to adopt.

It is important to stress that this recalibration was not designed to adjust for aggregate payment differences that result from changes in the coding or classification of residents not reflective of real changes in case mix; that is, case-mix creep. Monitoring the changes in case mix under RUG-53 over the years since RUG-53 has been in place is part of a longer-term effort. If we find that a pattern of coding or the classification of residents does not reflect real changes in case mix over several years, we would propose a documentation and coding adjustment, pursuant to §1888(e)(4)(F) of the Act. By contrast, the original application of a budget neutrality factor and the recalibration of that factor discussed in this final rule

represented the mechanism that we used to establish the appropriate baseline for expenditures under the refined classification model (that is, the change from RUG-44 to RUG-53).

Comment: Some commenters argued against implementing the proposed recalibration, asserting that it is important to maintain Medicare SNF payments at their current levels in order to cross-subsidize what they characterized as inadequate payment rates for nursing facilities under the Medicaid program. Other commenters asserted that a shift in patients from Inpatient Rehabilitation Facilities (IRFs) to SNFs results in savings to the Medicare Trust Fund and that the current SNF spending levels are needed to treat the types of patients SNFs are now receiving.

Response: Even though we are not moving forward at this time with the proposed recalibration, we wish to be clear that it is not the appropriate role of the Medicare SNF benefit to cross-subsidize nursing home payments made under the Medicaid program. We note that MedPAC stated it is inappropriate for the Medicare program's SNF payments to cross-subsidize Medicaid nursing facility rates. Specifically, on page 152 of its March 2008 Report to the Congress on Medicare Payment Policy (which is available online at http://medpac.gov/documents/Mar08_EntireReport.pdf), MedPAC

stated:

> There are several reasons why Medicare cross-subsidization is not advisable policy for the Medicare program. On average, Medicare payments accounted for 21 percent of revenues to freestanding SNFs in 2006. As a result, the policy would use a minority of Medicare payments to subsidize a majority of Medicaid payments. If Medicare were to pay still higher rates, facilities with high shares of Medicare payments—-presumably the facilities that need revenues the least—-would receive the most in subsidies from the higher Medicare payments. In other words, the subsidy would be poorly targeted. Given the variation among states in the level and method of nursing home payments, the impact of the subsidy would be highly variable; in states where Medicaid payments were adequate, it would have no positive impact. In addition, increasing Medicare's payment rates could encourage states to reduce Medicaid payments further and, in turn, result in pressure to again raise Medicare rates. It could also encourage providers to select patients based on payer source or to rehospitalize dual-eligible patients so that they qualified for a Medicare-covered, and higher payment, stay.
>
> We agree with MedPAC and, therefore, do not agree with

the commenters that cited cross-subsidizing Medicaid as a justification for maintaining Medicare SNF payments at any specific level.

Regarding the comments about a shift of patients from IRFs to SNFs producing savings to the Medicare Trust Fund, and the need to maintain current SNF spending levels to treat the types of patients SNFs are now receiving, we note that a basic principle of the SNF PPS is to pay appropriately for the services provided. CMS data are consistent with the commenters' assertions that many patients formerly being treated in IRFs are now being treated in SNFs or Home Health Agencies. In fact, the CY 2006 distribution used to recalibrate the case-mix adjustments indicates that there are more patients in the 9 new RUGs than we originally anticipated and patients shifting from IRFs could be a partial explanation.

Patients who shifted to SNFs or other settings from IRFs due to "75 Percent Rule" compliance percentage requirements represent a population that was not appropriate for IRF care, and CMS payments for those IRF stays would represent an overpayment to IRFs. For those former IRF patients who are appropriate for SNF care, we must pay the appropriate rate for the SNF services provided, and cannot use a reduction in IRF overpayments as a reason to increase payments under the SNF

PPS. SNF patients with more intensive therapy and extensive service needs will be paid the higher amounts associated with the 9 new groups. While we are not moving forward with the proposed recalibration at this time, it is still important to understand that recalibrating CMIs would not change the relative nature of higher payments for patients using more staff resources and services.

Comment: One commenter claimed that CMS did not make the data and analysis underlying the proposed recalibration of the budget neutrality adjustment publicly available.

Response: We do not agree with the commenter's assertion. The methodology used to establish the case-mix adjustments is the same as that described in detail in the FY 2006 SNF PPS proposed rule (70 FR 29077 through 29078, May 19, 2005). In addition, the data used to calculate the adjustments are publicly available on the CMS Web site. We used the CY 2006 days of service (available in the downloads section of our Web site at http://www.cms.hhs.gov/SNFPPS/02_Highlights.asp#TopOfPage) for both the RUG-44 and RUG-53 systems. We multiplied the CY 2006 days of service by the FY 2008 unadjusted Federal per diem payment rate components (72 FR 43416) multiplied by the unadjusted case-mix indexes (available in the Downloads section of our Web site at

http://www.cms.hhs.gov/SNFPPS/09_RUGRefinement.asp#TopOfPage) to establish expenditures under the RUG-44 and RUG-53 systems. The budget neutrality adjustment was determined as the percentage increase necessary for the nursing CMIs to generate estimated expenditure levels under the RUG-53 system that were equal to estimated expenditure levels under the RUG-44 system. We then calculated a second adjustment factor to increase the baseline by an amount that served to offset the variability in NTA utilization.

As discussed above, we are confident that we employed the correct methodology to evaluate the accuracy with which we implemented the 2006 refinements. However, in view of the widespread industry concern that a recalibration could potentially have adverse effects on beneficiaries and SNF clinical staff, and could negatively affect the quality of SNF care, we believe that the most prudent course is to continue to evaluate these issues carefully before proceeding. Thus, we will not proceed with the recalibration for FY 2009, but will instead continue to evaluate the data, and further consider consequences that may result from the recalibration. We note that as we continue to evaluate this issue, we fully expect to implement such an adjustment in the future. Therefore, for FY 2009, the case-mix indexes shown in Tables 4 and 5 below remain the same as those adopted in FY 2006. As

always, we list the case-mix adjusted payment rates separately for urban and rural SNFs, with the corresponding case-mix values. We note that these tables do not reflect the AIDS add-on enacted by section 511 of the MMA, which we apply only after making all other adjustments (wage and case-mix).

Table 4
RUG-53
CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES
URBAN

RUG-III Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RUX	1.9	2.25	288.31	257.18		77.44	622.93
RUL	1.4	2.25	212.44	257.18		77.44	547.06
RVX	1.54	1.41	233.68	161.16		77.44	472.28
RVL	1.33	1.41	201.81	161.16		77.44	440.41
RHX	1.42	0.94	215.47	107.44		77.44	400.35
RHL	1.37	0.94	207.88	107.44		77.44	392.76
RMX	1.93	0.77	292.86	88.01		77.44	458.31
RML	1.68	0.77	254.92	88.01		77.44	420.37
RLX	1.31	0.43	198.78	49.15		77.44	325.37
RUC	1.28	2.25	194.23	257.18		77.44	528.85
RUB	0.99	2.25	150.22	257.18		77.44	484.84
RUA	0.84	2.25	127.46	257.18		77.44	462.08
RVC	1.23	1.41	186.64	161.16		77.44	425.24
RVB	1.09	1.41	165.40	161.16		77.44	404.00
RVA	0.82	1.41	124.43	161.16		77.44	363.03
RHC	1.22	0.94	185.12	107.44		77.44	370.00
RHB	1.11	0.94	168.43	107.44		77.44	353.31
RHA	0.94	0.94	142.64	107.44		77.44	327.52
RMC	1.15	0.77	174.50	88.01		77.44	339.95
RMB	1.09	0.77	165.40	88.01		77.44	330.85
RMA	1.04	0.77	157.81	88.01		77.44	323.26
RLB	1.14	0.43	172.98	49.15		77.44	299.57
RLA	0.85	0.43	128.98	49.15		77.44	255.57
SE3	1.86		282.24		15.05	77.44	374.73
SE2	1.49		226.09		15.05	77.44	318.58
SE1	1.26		191.19		15.05	77.44	283.68
SSC	1.23		186.64		15.05	77.44	279.13
SSB	1.13		171.47		15.05	77.44	263.96
SSA	1.1		166.91		15.05	77.44	259.40

CC2	1.22		185.12		15.05	77.44	277.61
CC1	1.06		160.84		15.05	77.44	253.33
CB2	0.98		148.71		15.05	77.44	241.20
CB1	0.91		138.08		15.05	77.44	230.57
CA2	0.9		136.57		15.05	77.44	229.06
CA1	0.8		121.39		15.05	77.44	213.88
IB2	0.74		112.29		15.05	77.44	204.78
IB1	0.72		109.25		15.05	77.44	201.74
IA2	0.61		92.56		15.05	77.44	185.05
IA1	0.56		84.97		15.05	77.44	177.46
BB2	0.73		110.77		15.05	77.44	203.26
BB1	0.69		104.70		15.05	77.44	197.19
BA2	0.6		91.04		15.05	77.44	183.53
BA1	0.52		78.90		15.05	77.44	171.39
PE2	0.85		128.98		15.05	77.44	221.47
PE1	0.82		124.43		15.05	77.44	216.92
PD2	0.78		118.36		15.05	77.44	210.85
PD1	0.76		115.32		15.05	77.44	207.81
PC2	0.71		107.74		15.05	77.44	200.23
PC1	0.69		104.70		15.05	77.44	197.19
PB2	0.55		83.46		15.05	77.44	175.95
PB1	0.54		81.94		15.05	77.44	174.43
PA2	0.53		80.42		15.05	77.44	172.91
PA1	0.5		75.87		15.05	77.44	168.36

Table 5
RUG-53
CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES
RURAL

RUG-III Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RUX	1.9	2.25	275.44	296.55		78.87	650.86
RUL	1.4	2.25	202.96	296.55		78.87	578.38
RVX	1.54	1.41	223.25	185.84		78.87	487.96
RVL	1.33	1.41	192.81	185.84		78.87	457.52
RHX	1.42	0.94	205.86	123.89		78.87	408.62
RHL	1.37	0.94	198.61	123.89		78.87	401.37
RMX	1.93	0.77	279.79	101.49		78.87	460.15
RML	1.68	0.77	243.55	101.49		78.87	423.91
RLX	1.31	0.43	189.91	56.67		78.87	325.45
RUC	1.28	2.25	185.56	296.55		78.87	560.98
RUB	0.99	2.25	143.52	296.55		78.87	518.94
RUA	0.84	2.25	121.77	296.55		78.87	497.19
RVC	1.23	1.41	178.31	185.84		78.87	443.02

RVB	1.09	1.41	158.02	185.84		78.87	422.73
RVA	0.82	1.41	118.88	185.84		78.87	383.59
RHC	1.22	0.94	176.86	123.89		78.87	379.62
RHB	1.11	0.94	160.92	123.89		78.87	363.68
RHA	0.94	0.94	136.27	123.89		78.87	339.03
RMC	1.15	0.77	166.72	101.49		78.87	347.08
RMB	1.09	0.77	158.02	101.49		78.87	338.38
RMA	1.04	0.77	150.77	101.49		78.87	331.13
RLB	1.14	0.43	165.27	56.67		78.87	300.81
RLA	0.85	0.43	123.22	56.67		78.87	258.76
SE3	1.86		269.64		16.08	78.87	364.59
SE2	1.49		216.01		16.08	78.87	310.96
SE1	1.26		182.66		16.08	78.87	277.61
SSC	1.23		178.31		16.08	78.87	273.26
SSB	1.13		163.82		16.08	78.87	258.77
SSA	1.1		159.47		16.08	78.87	254.42
CC2	1.22		176.86		16.08	78.87	271.81
CC1	1.06		153.67		16.08	78.87	248.62
CB2	0.98		142.07		16.08	78.87	237.02
CB1	0.91		131.92		16.08	78.87	226.87
CA2	0.9		130.47		16.08	78.87	225.42
CA1	0.8		115.98		16.08	78.87	210.93
IB2	0.74		107.28		16.08	78.87	202.23
IB1	0.72		104.38		16.08	78.87	199.33
IA2	0.61		88.43		16.08	78.87	183.38
IA1	0.56		81.18		16.08	78.87	176.13
BB2	0.73		105.83		16.08	78.87	200.78
BB1	0.69		100.03		16.08	78.87	194.98
BA2	0.6		86.98		16.08	78.87	181.93
BA1	0.52		75.38		16.08	78.87	170.33
PE2	0.85		123.22		16.08	78.87	218.17
PE1	0.82		118.88		16.08	78.87	213.83
PD2	0.78		113.08		16.08	78.87	208.03
PD1	0.76		110.18		16.08	78.87	205.13
PC2	0.71		102.93		16.08	78.87	197.88
PC1	0.69		100.03		16.08	78.87	194.98
PB2	0.55		79.73		16.08	78.87	174.68
PB1	0.54		78.28		16.08	78.87	173.23
PA2	0.53		76.83		16.08	78.87	171.78
PA1	0.5		72.49		16.08	78.87	167.44

3. Wage Index Adjustment to Federal Rates

Section 1888(e)(4)(G)(ii) of the Act requires that we adjust the Federal rates to account for differences in area

wage levels, using a wage index that we find appropriate. Since the inception of a PPS for SNFs, we have used hospital wage data in developing a wage index to be applied to SNFs. In the FY 2009 proposed rule, we proposed to continue that practice, as we continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index is appropriate and reasonable for the SNF PPS. As explained in the SNF PPS update notice for FY 2005 (69 FR 45786, July 30, 2004), the SNF PPS does not use the hospital area wage index's occupational mix adjustment, as this adjustment serves specifically to define the occupational categories more clearly in a hospital setting; moreover, the collection of the occupational wage data also excludes any wage data related to SNFs. Therefore, we believe that using the updated wage data exclusive of the occupational mix adjustment continues to be appropriate for SNF payments.

Since the implementation of the SNF PPS, as set forth in §413.337(a)(1)(ii), a SNF's wage index is determined based on the location of the SNF in an urban or rural area as defined in §413.333 and further defined in §412.62(f)(1)(ii) and §412.62(f)(1)(iii) as urban and rural areas, respectively. In the SNF PPS final rule for FY 2006 (70 FR 45041, August 4, 2005), we adopted revised labor market area definitions based on Core-Based Statistical Area (CBSAs).

At the time, we noted that these were the same labor market area definitions (based on OMB's new CBSA designations) implemented under the Hospital Inpatient Prospective Payment System (IPPS) at §412.64(b), which were effective for those hospitals beginning October 1, 2004, as discussed in the IPPS final rule for FY 2005 (69 FR at 49026 through 49034, August 11, 2004). In the FY 2006 SNF PPS final rule, we inadvertently omitted making a conforming regulation text change to §413.333. However, this did not alter our decision to follow the IPPS definitions of urban and rural. In the FY 2009 proposed rule, we proposed to make that conforming regulation text change to revise the definitions for rural and urban areas effective for services provided on or after October 1, 2005, to reference the regulations at §§412.64(b)(1)(ii)(A) through (C), consistent with the revision under the IPPS.

Comments on the wage index adjustment to the Federal rates, and our responses to those comments, are as follows:

Comment: A few commenters recommended that CMS develop a SNF-specific wage index. Other commenters asked CMS to consider adopting certain wage index policies in use under the acute IPPS, because SNFs compete in a similar labor pool as acute care hospitals. The commenters indicated that adoption of these measures under the SNF PPS would allow SNFs to

benefit from the IPPS geographic reclassification and/or rural floor policies. (A discussion of the IPPS reclassification and floor policies appears on our Web site at http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp.)

Response: The regulations that govern the SNF PPS currently do not provide a mechanism for allowing providers to seek geographic reclassification. Moreover, as we have explained in the past (most recently, in the SNF PPS final rule for FY 2008 (72 FR 43420, August 3, 2007), while section 315 of the Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) does authorize us to establish such a reclassification methodology under the SNF PPS, it additionally stipulates that such reclassification cannot be implemented until we have collected the data necessary to establish a SNF-specific wage index. This, in turn, has proven to be infeasible due to ". . . the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data" (72 FR 43420, August 3, 2007). We continue to believe that these factors make it unlikely for such an approach to yield meaningful improvements in our ability to determine facility payments, or to justify the significant increase in administrative resources as well as burden on providers that this type of data collection would involve.

In addition, we reviewed the Medicare Payment Advisory Commission's (MedPAC) wage index recommendations as discussed in MedPAC's June 2007 report entitled, "Report to Congress: Promoting Greater Efficiency in Medicare." Although some commenters recommend that we adopt the IPPS wage index policies such as reclassification and floor policies, we note that MedPAC's June 2007 report to Congress recommends that Congress "repeal the existing hospital wage index statute, including reclassification and exceptions, and give the Secretary authority to establish new wage index systems." We believe that adopting the IPPS wage index policies (such as reclassification or floor) would not be prudent at this time, because MedPAC suggests that the reclassification and exception policies in the IPPS wage index alters the wage index values for one-third of IPPS hospitals. In addition, MedPAC found that the exceptions may lead to anomalies in the wage index. By adopting the IPPS reclassification and exceptions at this time, the SNF PPS wage index could become vulnerable to problems similar to those that MedPAC identified in their June 2007 Report to Congress. However, we will continue to review and consider MedPAC's recommendations on a refined or alternative wage index methodology for the SNF PPS in future years.

We also note that section 106(b)(2) of the Medicare Improvements and Extension Act (MIEA) of 2006 (which is Division B of the Tax Relief and Health Care Act (TRHCA) of 2006, Pub. L. 109-432, collectively referred to as "MIEA-TRHCA") required the Secretary of Health and Human Services, taking into account MedPAC's recommendations on the Medicare wage index classification system, to include in the FY 2009 IPPS proposed rule one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS. To assist CMS in meeting the requirements of section 106(b)(2) of MIEA-TRHCA, in February 2008, CMS awarded a Task Order under its Expedited Research and Demonstration Contract, to Acumen, LLC. A comparison of the current IPPS wage index and MedPAC's are presented in the FY 2009 IPPS final rule. We plan to continue monitoring wage index research efforts and the impact or influence they may have for the SNF PPS wage index. Moreover, in light of all of the pending research and review of wage index issues in general, we believe that it would be premature at this time to initiate review of a SNF-specific wage index.

a. Clarification of New England Deemed Counties

As we discussed in the SNF PPS proposed rule for FY 2009 (73 FR 25926, May 7, 2008), two New England counties (Litchfield County, CT and Merrimack County, NH) are deemed to

be urban areas under section 601(g) of the Social Security Amendments of 1983, yet are considered rural by OMB definitions. We proposed to clarify the treatment of these two New England counties in accordance with the FY 2008 IPPS final rule with comment period (72 FR 47337 through 47338, August 22, 2007), which revised the regulations at §412.64(b)(1)(ii)(B) so that these counties are no longer considered urban, effective for discharges occurring on or after October 1, 2007. A more detailed discussion of this proposal appears in the SNF PPS proposed rule for FY 2009 (73 FR 24926). We note that all post-acute care payment systems are clarifying this policy to create consistency among provider types.

We received no comments on this aspect of the proposed rule, and we are proceeding with this technical clarification as proposed with no change. Therefore, we are treating these counties as rural for purposes of the SNF PPS.

b. Multi-Campus Hospital Wage Index Data

When a multi-campus hospital has campuses located in different labor market areas, wages and hours are reported in a single labor market area (CBSA) even though the hospital's staff is working at campuses in more than one labor market area. Currently, the wage data are reported in the labor market area of the hospital campus associated with the

provider number. In the SNF PPS proposed rule for FY 2009 (73 FR 25926, May 7, 2008), we described a change in the way wage data for multi-campus hospitals located in different labor market areas (CBSAs) would be apportioned, consistent with a FY 2008 change in the IPPS rule. The IPPS wage data used to determine the FY 2009 SNF wage index apportion the wage data for multi-campus hospitals located in different labor market areas (CBSAs) to each CBSA where the campuses are located (72 FR 47317 through 47320, August 22, 2007). A more detailed discussion of this proposal appears in the SNF PPS proposed rule for FY 2009 (73 FR 24926). Adopting the treatment of this data is consistent with our use of the pre-floor, pre-reclassified IPPS wage data.

We received no comments on this aspect of the proposed rule and we are adopting this policy as proposed without change, consistent with our use of IPPS wage data. The wage index values for the FY 2009 SNF PPS are affected by this policy.

We also proposed to continue using the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in which there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the FY 2009 SNF PPS wage index. For rural geographic areas that do not have hospitals and,

therefore, lack hospital wage data on which to base an area wage adjustment, we would use the average wage index from all contiguous CBSAs as a reasonable proxy. This methodology is used to construct the wage index for rural Massachusetts. However, as discussed in the FY 2008 SNF PPS proposed rule (72 FR 25539, May 4, 2007), we are not applying this methodology to rural Puerto Rico due to the distinct economic circumstances that exist there, but instead will continue using the most recent wage index previously available for that area. For urban areas without specific hospital wage index data, we will use the average wage indexes of all of the urban areas within the State to serve as a reasonable proxy for the wage index of that urban CBSA. The only urban area without wage index data available is CBSA (25980) Hinesville-Fort Stewart, GA. We received no comments on this issue and are finalizing our policy as proposed without change.

In summary, in the FY 2009 proposed rule, we proposed to use the FY 2009 wage index data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2005) to adjust SNF PPS payments beginning October 1, 2008. We also proposed to continue our policies for calculating wage indexes for areas without hospitals. We are finalizing the wage index and associated policies as proposed for the SNF PPS for FY 2009 without change. These

data reflect the multi-campus and New England deemed counties policies discussed above.

To calculate the SNF PPS wage index adjustment, we apply the wage index adjustment to the labor-related portion of the Federal rate, which is 69.783 percent of the total rate. This percentage reflects the labor-related relative importance for FY 2009, using the revised and rebased FY 2004-based market basket. The labor-related relative importance for FY 2008 was 70.249, as shown in Table 11. We calculate the labor-related relative importance from the SNF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2009. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Accordingly, the relative importance figure more closely reflects the cost share weights for FY 2009 than the base year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2009 in four steps. First, we compute the FY 2009 price index level for the total market basket and each cost category of the market basket. Second, we calculate a ratio for each cost category by dividing the FY 2009 price index level for

that cost category by the total market basket price index level. Third, we determine the FY 2009 relative importance for each cost category by multiplying this ratio by the base year (FY 2004) weight. Finally, we add the FY 2009 relative importance for each of the labor-related cost categories (wages and salaries, employee benefits, non-medical professional fees, labor-intensive services, and a portion of capital-related expenses) to produce the FY 2009 labor-related relative importance. Tables 6 and 7 below show the Federal rates by labor-related and non-labor-related components.

Table 6
RUG-53
Case-Mix Adjusted Federal Rates for Urban SNFs
By Labor and Non-Labor Component

RUG-III Category	Total Rate	Labor Portion	Non-Labor Portion
RUX	622.93	434.70	188.23
RUL	547.06	381.75	165.31
RVX	472.28	329.57	142.71
RVL	440.41	307.33	133.08
RHX	400.35	279.38	120.97
RHL	392.76	274.08	118.68
RMX	458.31	319.82	138.49
RML	420.37	293.35	127.02
RLX	325.37	227.05	98.32
RUC	528.85	369.05	159.80
RUB	484.84	338.34	146.50
RUA	462.08	322.45	139.63
RVC	425.24	296.75	128.49
RVB	404.00	281.92	122.08
RVA	363.03	253.33	109.70
RHC	370.00	258.20	111.80
RHB	353.31	246.55	106.76
RHA	327.52	228.55	98.97
RMC	339.95	237.23	102.72
RMB	330.85	230.88	99.97
RMA	323.26	225.58	97.68
RLB	299.57	209.05	90.52
RLA	255.57	178.34	77.23
SE3	374.73	261.50	113.23
SE2	318.58	222.31	96.27
SE1	283.68	197.96	85.72
SSC	279.13	194.79	84.34
SSB	263.96	184.20	79.76
SSA	259.40	181.02	78.38
CC2	277.61	193.72	83.89
CC1	253.33	176.78	76.55
CB2	241.20	168.32	72.88
CB1	230.57	160.90	69.67
CA2	229.06	159.84	69.22
CA1	213.88	149.25	64.63
IB2	204.78	142.90	61.88
IB1	201.74	140.78	60.96
IA2	185.05	129.13	55.92
IA1	177.46	123.84	53.62
BB2	203.26	141.84	61.42

BB1	197.19	137.61	59.58
BA2	183.53	128.07	55.46
BA1	171.39	119.60	51.79
PE2	221.47	154.55	66.92
PE1	216.92	151.37	65.55
PD2	210.85	147.14	63.71
PD1	207.81	145.02	62.79
PC2	200.23	139.73	60.50
PC1	197.19	137.61	59.58
PB2	175.95	122.78	53.17
PB1	174.43	121.72	52.71
PA2	172.91	120.66	52.25
PA1	168.36	117.49	50.87

Table 7
RUG-53
Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component

RUG-III Category	Total Rate	Labor Portion	Non-Labor Portion
RUX	650.86	454.19	196.67
RUL	578.38	403.61	174.77
RVX	487.96	340.51	147.45
RVL	457.52	319.27	138.25
RHX	408.62	285.15	123.47
RHL	401.37	280.09	121.28
RMX	460.15	321.11	139.04
RML	423.91	295.82	128.09
RLX	325.45	227.11	98.34
RUC	560.98	391.47	169.51
RUB	518.94	362.13	156.81
RUA	497.19	346.95	150.24
RVC	443.02	309.15	133.87
RVB	422.73	294.99	127.74
RVA	383.59	267.68	115.91
RHC	379.62	264.91	114.71
RHB	363.68	253.79	109.89
RHA	339.03	236.59	102.44
RMC	347.08	242.20	104.88
RMB	338.38	236.13	102.25
RMA	331.13	231.07	100.06
RLB	300.81	209.91	90.90
RLA	258.76	180.57	78.19
SE3	364.59	254.42	110.17
SE2	310.96	217.00	93.96

SE1	277.61	193.72	83.89
SSC	273.26	190.69	82.57
SSB	258.77	180.58	78.19
SSA	254.42	177.54	76.88
CC2	271.81	189.68	82.13
CC1	248.62	173.49	75.13
CB2	237.02	165.40	71.62
CB1	226.87	158.32	68.55
CA2	225.42	157.30	68.12
CA1	210.93	147.19	63.74
IB2	202.23	141.12	61.11
IB1	199.33	139.10	60.23
IA2	183.38	127.97	55.41
IA1	176.13	122.91	53.22
BB2	200.78	140.11	60.67
BB1	194.98	136.06	58.92
BA2	181.93	126.96	54.97
BA1	170.33	118.86	51.47
PE2	218.17	152.25	65.92
PE1	213.83	149.22	64.61
PD2	208.03	145.17	62.86
PD1	205.13	143.15	61.98
PC2	197.88	138.09	59.79
PC1	194.98	136.06	58.92
PB2	174.68	121.90	52.78
PB1	173.23	120.89	52.34
PA2	171.78	119.87	51.91
PA1	167.44	116.84	50.60

Section 1888(e)(4)(G)(ii) of the Act also requires that we apply this wage index 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. For FY 2009 (Federal rates effective October 1, 2008), we apply an adjustment to fulfill the budget neutrality requirement. We meet this requirement by multiplying each of the components of the unadjusted Federal rates by a budget neutrality factor equal to the ratio of the weighted average wage adjustment

factor for FY 2008 to the weighted average wage adjustment factor for FY 2009. For this calculation, we use the same 2006 claims utilization data for both the numerator and denominator of this ratio. We define the wage adjustment factor used in this calculation as the labor share of the rate component multiplied by the wage index plus the non-labor share of the rate component. The final budget neutrality factor for this year is 1.0009. The wage index applicable to FY 2009 appears in Tables 8 and 9, which are included in the Addendum of this final rule.

In the FY 2006 SNF PPS final rule (70 FR 45026, August 4, 2005), we adopted the changes discussed in the Office of Management and Budget (OMB) Bulletin No. 03-04 (June 6, 2003), available online at www.whitehouse.gov/omb/bulletins/b03-04.html, which announced revised definitions for Metropolitan Statistical Areas (MSAs), and the creation of Micropolitan Statistical Areas and Combined Statistical Areas. In addition, OMB published subsequent bulletins regarding CBSA changes, including changes in CBSA numbers and titles. As indicated in the FY 2008 SNF PPS final rule (72 FR 43423, August 3, 2007), this and all subsequent SNF PPS rules and notices are considered to incorporate the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage data used to determine the current SNF PPS wage

index. The OMB bulletins may be accessed online at http://www.whitehouse.gov/omb/bulletins/index.html.

In adopting the OMB CBSA geographic designations, we provided for a 1-year transition with a blended wage index for all providers. For FY 2006, the wage index for each provider consisted of a blend of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index (both using FY 2002 hospital data). We referred to the blended wage index as the FY 2006 SNF PPS transition wage index. As discussed in the SNF PPS final rule for FY 2006 (70 FR 45041), subsequent to the expiration of this 1-year transition on September 30, 2006, we used the full CBSA-based wage index values, as now presented in Tables 8 and 9 in the Addendum to this final rule.

4. Updates to the Federal Rates

In accordance with section 1888(e)(4)(E) of the Act, as amended by section 311 of the BIPA, the payment rates in this final rule reflect an update equal to the full SNF market basket, estimated at 3.4 percentage points. We continue to disseminate the rates, wage index, and case-mix classification methodology through the **Federal Register** before the August 1 that precedes the start of each succeeding FY.

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

As discussed in §413.345, we include in each update of the Federal payment rates in the **Federal Register** the designation of those specific RUGs under the classification system that represent the required SNF level of care, as provided in §409.30. This designation reflects an administrative presumption under the refined RUG-53 classification system that beneficiaries who are correctly assigned to one of the upper 35 of the RUG-53 groups on the initial 5-day, Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date on that assessment.

A beneficiary assigned to any of the lower 18 groups is not automatically classified as either meeting or not meeting the definition, but instead receives an individual level of care determination using the existing administrative criteria. This presumption recognizes the strong likelihood that beneficiaries assigned to one of the upper 35 groups during the immediate post-hospital period require a covered level of care, which would be significantly less likely for those beneficiaries assigned to one of the lower 18 groups.

In this final rule, we are continuing the designation of

the upper 35 groups for purposes of this administrative presumption, consisting of the following RUG-53 classifications: all groups within the Rehabilitation plus Extensive Services category; 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.

6. Example of Computation of Adjusted PPS Rates and SNF Payment

Using the hypothetical SNF XYZ described in Table 10 below, the following shows the adjustments made to the Federal per diem rate to compute the provider's actual per diem PPS payment. SNF XYZ's 12-month cost reporting period begins October 1, 2008. SNF XYZ's total PPS payment would equal $30,968. The Labor and Non-labor columns are derived from Table 6.

Table 10
RUG-53
SNF XYZ: Located in Cedar Rapids, IA (Urban CBSA 16300)
Wage Index: 0.8924

RUG Group	Labor	Wage index	Adj. Labor	Non-Labor	Adj. Rate	Percent Adj	Medicare Days	Payment
RVX	$329.57	0.8919	$293.94	$142.71	$436.65	$436.65	14	$6,113.00
RLX	$227.05	0.8919	$202.51	$98.32	$300.83	$300.83	30	$9,025.00
RHA	$228.55	0.8919	$203.84	$98.97	$302.81	$302.81	16	$4,845.00
CC2	$193.72	0.8919	$172.78	$83.89	$256.67	$585.21*	10	$5,852.00
IA2	$129.13	0.8919	$115.17	$55.92	$171.09	$171.09	30	$5,133.00
							100	$30,968.00

*Reflects a 128 percent adjustment from section 511 of the MMA.

7. Other Issues

In the SNF PPS proposed rule for FY 2009 (73 FR 25930, May 7, 2008), we discussed several issues that relate to the SNF PPS for which we made no specific proposals, but solicited comments. These issues are noted below.

a. Staff Time and Resource Intensity Verification (STRIVE) Project

The SNF PPS proposed rule for FY 2009 (73 FR 25930, May 7, 2008) included a more detailed discussion of the current status of the STRIVE project. Specific comments on this issue, and our responses to those comments, are as follows:

Comment: Specifically referencing the STRIVE Technical Expert Panel (TEP) described in the proposed rule, one commenter expressed concern about whether registered nurses (RNs) have been adequately represented in the STRIVE process.

Response: We understand that nurses have been well represented as the STRIVE contractor has sought input from a variety of individual stakeholders. Two RNs directly

representing nursing associations have attended STRIVE TEPs as observers, who not only observe the proceedings, but can also offer comments and ask questions of the STRIVE team. Other people with backgrounds as RNs constitute a significant percentage of TEP attendees overall. In fact, the STRIVE contractor has received insights from RNs attending not only as observers, but as participants, who directly interact with the STRIVE team during TEP presentations.

Comment: One commenter voiced concerns regarding whether STRIVE collected the RN staff time associated with residents separately from that of other personnel; for example, LPNs and nursing aides.

Response: STRIVE collected all nursing staff time over 2 days using personal digital assistants (PDAs). In each PDA, the name of each nursing staff member was linked to his or her individual job title (including RN, LPN, and CNA). STRIVE does not represent the first instance in which CMS (or, rather, its predecessor, HCFA) has separately tracked different nursing staff positions as it collected time data. In the FY 2006 refinements that added nine new RUG categories, CMS calculated case-mix indexes based on nursing staff time collected in the prior time studies. That data accounted for three different disciplines: RNs, LPNs, and Aides. In fact, CMS published on its website a spreadsheet containing

population-weighted time for each of those three positions. These data appear on the RUG refinement page of the SNF PPS website: http://www.cms.hhs.gov/SNFPPS/09_RUGRefinement.asp#TopOfPage. Under "Downloads" near the bottom of the page, that data can be unzipped after linking to Unadjusted nursing weights [Zip, 15kb].

b. Minimum Data Set (MDS) 3.0

The SNF PPS proposed rule for FY 2009 (73 FR 25931, May 7, 2008) included a more detailed discussion of the new version (3.0) of the MDS that is currently under development. Specific comments, and our responses to those comments, are as follows:

Comment: One commenter was concerned that because CMS does not currently require a resident assessment instrument to be completed at admission and at discharge, the changes in a patient's condition cannot be accurately measured and outcomes assessed, making it more difficult to tie Medicare's payments to patient outcomes.

Response: We note that the current SNF PPS is based upon the amount of resources used by a particular patient due to their unique clinical needs, and that it is not an outcome-based system. However, as noted in section III.B.7.c. of this final rule, we are currently evaluating the appropriateness of

introducing certain pay for performance initiatives in the SNF setting. In the interim, although the current SNF PPS design does not provide for the completion of an assessment at admission and then again at discharge, the current Post Acute Care Payment Reform Demonstration (PAC-PRD) does provide for this. It is our intention to monitor this particular aspect of the PAC-PRD to determine both its administrative and financial impact, in order to understand the effect it could have on SNFs should it be adopted under the SNF PPS.

Comment: A commenter recommended revising the MDS to gather information solely about services furnished during the SNF stay, so that payments to SNFs are not based on services provided during the preceding hospital stay. Another stated that the draft MDS 3.0 represents an excellent modification of the current MDS, and applauded CMS for retaining the critically necessary look-back periods that, in their view, help clinicians more thoroughly evaluate and follow-up on conditions and treatments related to the hospital stay.

Response: The development of the MDS 3.0 has been and will continue to be a collaborative effort designed to maximize the quality of care provided to Medicare beneficiaries and to ensure proper payment under the SNF PPS. Under the STRIVE project, we are currently assessing each of the data elements used in the payment methodology, as well as

other items that may affect resource utilization. We appreciate the commenter's concern and also recognize the role of clinicians in ensuring proper care, and will take these comments into consideration as we finalize the design of the MDS 3.0.

Comment: One commenter recommended that CMS change the look back period for therapies in Section O on the MDS 3.0 from 5 days to 7 days, as it is currently on the MDS 2.0. The same commenter suggested that we continue to collect minutes for respiratory therapy on the MDS 3.0.

Response: We note that, contrary to the commenter's impression, CMS did not change the look back for therapy services on the MDS 3.0 to 5 days. In fact, the instructions for Section O4 – Therapies states "Record the number of days each of the following therapies was administered for at least 15 minutes a day in the last 7 Days" (emphasis added). The January draft version of the MDS 3.0 appears at the following link: http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30DraftVersion.pdf. We will post the CMS Draft MDS 2.0/3.0 Crosswalk on the CMS web site. This draft version contains all of the items that potentially may appear in the final version of the MDS 3.0. We have added an item to collect the minutes of respiratory therapy services, as well as other

items. The CMS Draft MDS 2.0/3.0 Crosswalk (July 2008) will be available on the MDS 3.0 web site, which appears at the following link: http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp.

c. Integrated Post Acute Care Payment

In the proposed rule, we discussed our ongoing examination of possible steps toward achieving a more seamless system for the delivery and payment of post-acute care (PAC) services in various care settings. These include the PAC Payment Reform Demonstration (PAC-PRD) and its standardized patient assessment tool, the Continuity Assessment Record and Evaluation (CARE) tool. In the related area of value-based purchasing (VBP) initiatives, we described the IPPS preventable hospital-acquired conditions (HAC) payment provision, which is designed to ensure that the occurrence of selected, preventable conditions during hospitalization does not have the unintended effect of generating higher Medicare payments under the IPPS. We then discussed the potential application of this same underlying principle to other care settings in addition to IPPS hospitals. For a more detailed discussion of this issue as it pertains to the SNF setting, we refer readers to the SNF PPS proposed rule for FY 2009 (73 FR 25932, May 7, 2008).

The comments that we received, and our responses to those comments, are as follows:

Comment: We received several comments concerning the use of the CARE tool. While most of these comments acknowledged that the CARE tool holds long-term promise in terms of potentially facilitating the efficient flow of secure electronic patient information, they also cautioned that it would be far too premature at this point in time to draw any definitive conclusions about its use, given the very early stage of the research currently being conducted in this area.

Response: We agree with the commenters' observations about the CARE tool, both in terms of its significant future potential and the need to await the results of ongoing research before reaching any specific conclusions about its use. We will continue to evaluate the CARE tool closely during the remainder of the current demonstration, and we plan to keep the commenters' concerns in mind as we proceed with our research in this area.

Comment: A number of commenters stressed the need for external research in the area of PAC payment reform, as well as the importance of obtaining input from the stakeholder community.

Response: We agree with the commenters regarding the value of obtaining stakeholder input, and believe that this

is, in fact, crucial to the success of our PAC payment reform efforts. We also recognize the importance of obtaining the benefit of all available findings from any research that is currently underway. We note that our own activities in this regard primarily involve applied research through our demonstration projects and internal analysis of changes in program policy. However, we also encourage interested parties to engage in external research projects on PAC payment reform.

Comment: We received a number of comments regarding the HAC payment provision under the IPPS, and the possible adoption of a similar approach in care settings other than IPPS hospitals. The commenters recommended that CMS conduct a thorough evaluation of the HAC policy's implementation under the IPPS to determine its actual impact and efficacy before considering whether to adopt this type of approach in other care settings. Some commenters also questioned the legal authority under existing Medicare law to expand the HAC payment provision beyond the IPPS hospital setting. Other commenters raised concerns about the specific implications of applying this type of policy to the SNF setting. They cited hospital-acquired infections, dementia, and falls as examples of things that might be less appropriately characterized as "never events" in long-term care settings than in the acute setting. These commenters also observed that it would be

unfair to penalize a SNF financially for a condition that actually developed during the preceding hospital stay but was not detected until after transfer to the SNF.

One commenter specifically noted that a SNF should not be expected to assume the financial liability for the care of a resident's decubitus ulcer if it was acquired during the preceding hospital stay. In addition, the commenters indicated that it may be difficult to differentiate a preventable healthcare-acquired complication from a normal, unavoidable aspect of a terminal illness, and also asserted that it is difficult to define the extent to which an adverse event is "reasonably preventable."

Response: We appreciate the commenters' thoughtful input about application of the principal embodied in the IPPS HAC payment provision to the SNF setting. While we acknowledge that infections, dementia, and falls are among the selected HACs in the IPPS acute care setting that potentially have relevance for the SNF setting as well, we agree that these and other conditions may have different implications in the SNF setting. We agree with the commenters that it would be unfair to penalize a SNF financially for a condition that developed in another care setting. We note that the IPPS HAC payment provision uses Present on Admission (POA) indicator data to exclude from payment those conditions that develop outside of

the IPPS acute care stay, and a similar mechanism would be needed to apply this type of payment provision to the SNF setting should such an approach be adopted there. Regarding the commenters' concerns about the difficulty of determining which adverse events are "reasonably preventable," we would expect to work closely with stakeholders to determine which conditions could reasonably be prevented through the application of evidence-based guidelines. With regard to the comments that questioned the existing legal authority for expanding the HAC payment provision beyond the IPPS hospital setting, we note that in this final rule, we are not establishing any new Medicare policies in this area. However, we will keep the commenters' concerns in mind as our implementation of VBP for all Medicare payment systems proceeds. We look forward to working with stakeholders in continuing to explore possible ways to reduce the occurrence of these preventable conditions in various care settings. Finally, we note that in addition to the comments on those aspects of PAC payment reform and VBP that we discussed in the proposed rule, we also received some comments on the current Nursing Home VBP Demonstration (referenced previously in the SNF PPS update notice for
FY 2007 (71 FR 43172, July 31, 2006); however, those comments, which offered specific suggestions about the design and

conduct of the demonstration, are beyond the scope of this rulemaking.

8. Miscellaneous Technical Corrections and Clarifications

In the FY 2009 proposed rule, we set forth certain technical corrections and clarifications, as discussed below.

a. Bad Debt Payments

In the SNF PPS proposed rule for FY 2009 (73 FR 25932, May 7, 2008), we proposed to make a technical revision in the regulations text at §413.335(b), in order to reflect our longstanding policy regarding Medicare bad debt payments to SNFs.

We received no comments on this aspect of the proposed rule. We are proceeding with this technical correction as proposed with no change.

b. Additional Clarifications

In the FY 2009 proposed rule (73 FR 25932 through 25933, May 7, 2008), we also discussed the following clarifications in two other areas:

- The circumstances under which a SNF is paid at the "default rate," a reduced payment made in lieu of the full SNF PPS rate that would have been payable had the SNF's resident been assessed in a timely manner; and
- The role of rehabilitation services evaluations in SNFs.

The comments that we received, and our responses, are as follows:

Comment: One commenter asserted that in some of the circumstances that we specified as triggering payment of the default rate (for example, when the SNF does not receive timely notification of a Medicare Secondary Payer denial, or of the revocation of a payment ban), the SNF is not at fault and, accordingly, should be permitted to complete an assessment retroactively.

Response: We note that SNFs are not permitted to backdate any portion of the medical record, including the resident assessment. It is for precisely this reason that we strongly encourage SNFs to follow the Medicare-required assessment schedule in any instance where there is even a possibility of Medicare payment; otherwise, the SNF risks being paid at the default rate. We also note that if a SNF has performed an "OBRA" assessment (that is, one conducted to meet the basic assessment schedule prescribed in the nursing home reform provisions of OBRA 1987 rather than the supplemental SNF PPS schedule for Medicare-required assessments) during this period which also happens to fall within the window for a Medicare-required assessment, the OBRA assessment can be used for Medicare payment purposes as well.

Comment: One commenter was concerned that CMS did not

allow the billing of the default code when a SNF PPS assessment is inadvertently omitted, referring to an instruction in the Resident Assessment Instrument (RAI) regarding the use of the default code when an assessment was not completed. The commenter also asked whether there is a time limit on the filing of a late assessment.

Response: To bill for Part A services provided under the SNF PPS, the SNF is required to submit a HIPPS rate code and the assessment reference date (ARD) associated with the applicable RAI on the claim, except as provided in the five specific circumstances described in the FY 2009 proposed rule (73 FR 25933), under which payment is available at the default rate. In order to obtain the HIPPS code, the SNF is required to submit the RAI to the State RAI database, and to receive a Final Validation Report prior to filing the claim in order to establish the correct RUG code for billing purposes. For these reasons, the SNF cannot simply bill the default code if it misses a Medicare-required assessment. Instead, we have always provided for payment at the default rate for what is referred to as a "late assessment." A late assessment occurs when the ARD for the Medicare-required assessment is set outside of the prescribed assessment window. In order to bill the default code, the SNF must prepare a late assessment that is completed prior to the date of discharge from Medicare Part

A. If no assessment is completed prior to discharge from Medicare Part A, no payment is made. The statement in the RAI that the commenter cited is more fully described in the situations set forth in Chapter 2, Section 2.9 of the RAI. We are currently in the process of revising the RAI instructions to ensure greater clarity.

Comment: One commenter expressed the belief that CMS was further penalizing SNFs for not completing Medicare-required assessments by having the SNF absorb all of the liability for SNF-level care provided to their beneficiaries, by limiting the use of the default code (outside of a late assessment) to the following situations:

- When the stay is less than 8 days within a spell of illness (that is, benefit period);
- The SNF is notified on an untimely basis or is unaware of a Medicare Secondary Payer denial;
- The SNF is notified on an untimely basis of the revocation of a payment ban;
- The beneficiary requests a demand bill; or,
- The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment form a Medicare Advantage program.

Response: As we stated in the FY 2009 proposed rule (73 FR 25933), program instructions have been issued through the

Provider Reimbursement Manual and the Medicare Claims Processing Manual since the inception of the SNF PPS to allow for the use of the default code in the first four situations described above. The proposed rule simply reiterated these policies in order to remind providers of the procedures on the use of the default code in circumstances other than that of a late assessment. We also took this opportunity to clarify that in those situations where a beneficiary was enrolled in a Medicare Advantage (MA) plan and the SNF was subsequently unaware or notified untimely of a beneficiary's disenrollment from an MA plan, the SNF could use the default code to receive payment for services provided.

Comment: One commenter asked that CMS explain why the default code is allowed to be billed when the stay is less than 8 days within a spell of illness (that is, benefit period) when the beneficiary dies or is discharged.

Response: In those situations where the beneficiary dies or is discharged before day 8 of the covered stay upon initial admission to the SNF following the qualifying three-day hospital stay, CMS has instructed SNFs either to complete an assessment to the best of their ability or to submit a claim using the default rate without the necessity of completing an assessment. The decision to allow for payment at the default rate without the completion of an assessment in this case is

predicated on the administrative presumption that the beneficiary meets the SNF level of care requirements through the ARD on the Medicare required 5-day assessment completed upon initial admission following the qualifying three-day hospital stay. The ARD on a Medicare required 5-day assessment must be set no later than the eighth day of the covered stay.

Comment: A commenter asked that CMS explain why the default code is allowed to be billed when a beneficiary requests that the SNF submit a demand bill.

Response: As stated above, a HIPPS rate code must be present on the claim in order to receive payment under the SNF PPS. However, a SNF is not required to assess a beneficiary to classify that beneficiary into a RUG using the RAI when the SNF determines that the care is noncovered, or where the beneficiary has not met the technical requirements for a SNF stay. Therefore, a SNF may submit a claim using the default code in order to ensure payment in the event that the SNF's determination of noncoverage is subsequently reversed.

Comment: A commenter requested clarification of the term "most recent clinical assessment," in the context of current program instructions that provide for payment at other than the default rate when the SNF is notified untimely or is unaware of a Medicare secondary payer (MSP) denial or the

revocation of a payment ban. The commenter also requested guidance on how to handle an untimely notification of a beneficiary's disenrollment from a Medicare Advantage program. The commenter additionally requested clear instructions on the proper way to use clinical assessments in place of Medicare PPS assessments when the "most recent clinical assessment" does not accurately represent the level of resources currently being utilized by the beneficiary (including, the number of days that can be billed using the "most recent clinical assessment").

Response: A SNF that finds itself in these circumstances had no reason to expect payment under the SNF PPS and is generally not required to perform Medicare-required assessments; as a result, the SNF is left without a HIPPS code that would be required to bill for payment under the SNF PPS. Instructions relating to MSP denials in the Provider Reimbursement Manual and revocation of payment bans in the Medicare Claims Processing Manual have allowed SNFs to use the most recent assessment that was completed in accordance with the schedule outlined in 42 CFR 483.20(b)(4) in order to receive payment under the Medicare program. However, the commenter makes a valid point in asking whether it is proper to submit an MDS that does not reflect the level of resources currently being utilized by beneficiaries.

After careful consideration of this question, we are revising our policy to allow the 14-day assessment required under 42 CFR 483.20(b)(4) to be used to bill for all days of covered care associated with a Medicare-required 5-day and 14-day assessment. This is the case even if the beneficiary is no longer receiving therapy services that were identified under the most recent clinical assessment. For covered days associated with the Medicare-required 30-, 60,- or 90-day assessment, the SNF must have an assessment that falls within the window of the Medicare-required assessment in order to receive full payment at the RUG level in which the resident grouped. If no assessment was completed, the SNF may submit a claim requesting payment at the default rate.

This revision recognizes that the level of resources used by a resident changes throughout the stay, and that the 14-day assessment required under §483.20(b)(4) is less likely to represent the beneficiary's clinical status later in the stay. We will also apply this policy to situations where the SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage program.

Comment: A commenter asked if guidance involving the "special payment modifiers" was forthcoming, noting that it was overdue.

Response: Instructions are currently being revised to

provide for the proper use of the "special payment modifiers."

Comment: One commenter wanted to know, if a SNF can demonstrate that an ARD was determined on a document other than the MDS, whether the SNF could use such documentation to "set" the ARD in order to avoid payment at the default rate.

Response: It is not acceptable to backdate an MDS or to use any documentation other than the MDS itself to establish the ARD.

Comment: In a situation where the SNF receives no payment under Part A because it fails to do Medicare-required assessment before the date of discharge from Medicare Part A, a commenter questioned whether the SNF could bill Medicare Part B for services rendered, as the SNF would receive no Part A reimbursement.

Response: In situations where the SNF fails to assess the beneficiary and fails to issue the proper Notification of Non-Coverage, the SNF is liable for all services normally covered under the Medicare Part A benefit. Since the beneficiary is receiving benefits, the days will be considered Part A days and charged against the beneficiary's benefit period. The SNF may collect any applicable copayment amounts. Services that would have been payable to the SNF as Part A benefits cannot be billed to either the FI or the carrier as Part B services.

Comment: A commenter questioned why CMS was issuing a technical clarification regarding the requirement for a therapy evaluation before therapy minutes can be counted in Section P and Section T of the MDS. The commenter was concerned that while the proposed change appears to be consistent with the practices of its therapy members, questions have been raised as to whether in making this clarification, CMS inadvertently may be changing the instructions for Subpart T as they relate to projected therapy services.

Response: Due to several recent inquiries on the need for therapy evaluations, we sought to ensure that SNFs and other non-therapy ancillary providers are clear as to the requirement for a therapy evaluation for each discipline before minutes can be included on the MDS on Section P and Section T. Moreover, in the case of section T, the projection must be based upon the evaluation performed for each discipline that reflects the needs of the patient.

IV. The Skilled Nursing Facility Market Basket Index

Section 1888(e)(5)(A) of the Act requires us to establish a 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. In the FY 2009 proposed rule, we stated that the proposed rule incorporated the latest

available projections of the SNF market basket index. In this final rule, we are updating projections based on the latest available projections at the time of publication. 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.

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 11 below summarizes the final updated labor-related share for FY 2009.

Table 11
Labor-related Relative Importance,
FY 2008 and FY 2009

	Relative importance, labor-related, FY 2008 (04 index) 07:2 forecast	Relative importance, labor-related, FY 2009 (04 index) 08:2 forecast
Wages and salaries	51.218	51.003
Employee benefits	11.720	11.547
Nonmedical professional fees	1.333	1.331
Labor-intensive services	3.456	3.434
Capital-related (.391)	2.522	2.468
Total	70.249	69.783

Source: Global Insight, Inc., formerly DRI-WEFA.

A. 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 from the average of the previous FY to the

average of the current FY. For the Federal rates established in this final rule, we use the percentage increase in the SNF market basket index to compute the update factor for FY 2009. We use the Global Insight, Inc. (GII, formerly DRI-WEFA), 2nd quarter 2008 (2008q2) forecasted percentage increase in the FY 2004-based SNF market basket index for routine, ancillary, and capital-related expenses, described in the previous section, to compute the update factor. Finally, as discussed previously in section I.A. of this final rule, we no longer compute update factors to adjust a facility-specific portion of the SNF PPS rates because the initial three-phase transition period from facility-specific to full Federal rates that started with cost reporting periods beginning in July 1998 has expired.

B. Market Basket Forecast Error Adjustment

As discussed in the FY 2004 supplemental proposed rule (68 FR 34768, June 10, 2003) and finalized in the FY 2004 final rule (68 FR 46067, August 4, 2003), regulations at §413.337(d)(2) provide for an adjustment to account for market basket forecast error. The initial adjustment applied to the update of the FY 2003 rate for FY 2004, and took into account the cumulative forecast error for the period from FY 2000 through FY 2002. Subsequent adjustments in succeeding FYs take into account the forecast error from the most recently

available FY for which there is final data, and apply whenever the difference between the forecasted and actual change in the market basket exceeds a specified threshold. We originally used a 0.25 percentage point threshold for this purpose; however, for the reasons specified in the FY 2008 SNF PPS final rule (72 FR 43425, August 3, 2007), we adopted a 0.5 percentage point threshold effective with FY 2008. As discussed previously in section I.F.2. of this final rule, as the difference between the estimated and actual amounts of increase in the market basket index for FY 2007 (the most recently available FY for which there is final data) does not exceed the 0.5 percentage point threshold, the payment rates for FY 2009 do not include a forecast error adjustment.

The following is a specific comment that we received on the market basket forecast error adjustment, and our response:

Comment: A few commenters suggested that CMS apply a cumulative forecast error to account for all of the variations in the market basket forecasts since FY 2004 (that is, as of when CMS implemented the market basket forecast error correction policy.)

Response: For FY 2004, CMS applied a one-time, cumulative forecast error correction of 3.26 percent (68 FR 46036). Since that time, the forecast errors have been relatively small and clustered near zero. We believe the

forecast error correction should be applied only when the forecast error in any given year reflects a percentage such that the SNF PPS base payment rate does not adequately reflect the historical price changes faced by SNFs. We continue to believe that the forecast error adjustment mechanism should appropriately be reserved for the type of major, unexpected change that initially gave rise to this policy, rather than the minor variances that are a routine and inherent aspect of this type of statistical measurement.

C. Federal Rate Update Factor

Section 1888(e)(4)(E)(ii)(IV) of the Act requires that the update factor used to establish the FY 2009 Federal rates be at a level equal to the full market basket percentage change. Accordingly, to establish the update factor, we determined the total growth from the average market basket level for the period of October 1, 2007 through September 30, 2008 to the average market basket level for the period of October 1, 2008 through September 30, 2009. Using this process, the market basket update factor for FY 2009 SNF Federal rates is 3.4 percent. We used this update factor to compute the Federal portion of the SNF PPS rate shown in Tables 2 and 3.

We received one comment expressing support for our proposed full market basket increase for FY 2009. We thank

the commenter and again note that the final update factor for FY 2009 is 3.4 percent.

V. Consolidated Billing

Section 4432(b) of the BBA established a consolidated billing requirement that places with the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive, except for a small number of services that the statute specifically identifies as being excluded from this provision. Section 103 of the BBRA amended this provision by further excluding a number of individual "high-cost, low-probability" services, identified by the Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy and its administration, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA amendment in greater detail in the FY 2001 SNF PPS proposed rule (65 FR 19231 through 19232, April 10, 2000), and the FY 2001 SNF PPS final rule (65 FR 46790 through 46795, July 31, 2000), as well as in Program Memorandum AB-00-18 (Change Request #1070), issued March 2000, which is available online at www.cms.hhs.gov/transmittals/downloads/ab001860.pdf.

Section 313 of the BIPA further amended this provision by repealing its Part B aspect; that is, its applicability to

services furnished to a resident during a SNF stay that Medicare does not cover. (However, physical, occupational, and speech-language therapy remain subject to consolidated billing, regardless of whether the resident who receives these services is in a covered Part A stay.) We discuss this BIPA amendment in greater detail in the FY 2002 SNF PPS proposed rule (66 FR 24020 through 24021, May 10, 2001), and the FY 2002 SNF PPS final rule (66 FR 39587 through 39588, July 31, 2001).

In addition, section 410 of the MMA amended this provision by excluding certain practitioner and other services furnished to SNF residents by RHCs and FQHCs. We discuss this MMA amendment in greater detail in the SNF PPS update notice for FY 2005 (69 FR 45818 through 45819, July 30, 2004), as well as in Program Transmittal #390 (Change Request #3575), issued December 10, 2004, which is available online at www.cms.hhs.gov/transmittals/downloads/r390cp.pdf.

To date, the Congress has enacted no further legislation affecting the consolidated billing provision. However, as noted above and explained in the FY 2001 SNF PPS proposed rule (65 FR 19232, April 10, 2000), the amendments enacted in section 103 of the BBRA not only identified for exclusion from this provision a number of particular service codes within four specified categories (that is, chemotherapy items,

chemotherapy administration services, radioisotope services, and customized prosthetic devices), but also gave the Secretary ". . . the authority to designate additional, individual services for exclusion within each of the specified service categories." In the FY 2001 SNF PPS proposed rule, we also noted that the BBRA Conference report (H.R. Rep. No. 106-479 at 854 (1999) (Conf. Rep.)) characterizes the individual services that this legislation targets for exclusion as, ". . . high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment [SNFs] receive under the prospective payment system . . . .” According to the conferees, section 103(a) ". . . is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs . . . For example, . . . chemotherapy drugs [that] are not typically administered in a SNF, or are exceptionally expensive, or are given as infusions, thus requiring special staff expertise to administer.” By contrast, we noted that the Congress declined to designate for exclusion any of the remaining services within those four categories (thus leaving all of those services subject to SNF consolidated billing), because they “. . . are relatively inexpensive and are administered routinely in SNFs”.

As we further explained in the FY 2001 SNF PPS final rule

(65 FR 46790, July 31, 2000), any additional service codes that we might designate for exclusion under our discretionary authority must meet the same criteria that the Congress used in identifying the original codes excluded from consolidated billing under section 103(a) of the BBRA: our longstanding policy is that they must fall within one of the four service categories specified in the BBRA, and they also must meet the same standards of high cost and low probability in the SNF setting. Accordingly, we characterized this statutory authority to identify additional service codes for exclusion ". . . 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)" (65 FR 46791). In the FY 2009 proposed rule (73 FR 25934, May 7, 2008), we specifically invited public comments identifying codes in any of these four service categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) representing recent medical advances that might meet our criteria for exclusion from SNF consolidated billing.

Specific comments on this issue and our responses to those comments are as follows:

Comment: Several commenters submitted additional chemotherapy codes that they recommended for exclusion from consolidated billing.

Response: We note that the law (at section 1888(e)(2)(A)(iii)(II) of the Act) describes the chemotherapy code ranges that the BBRA identified for exclusion in terms of the version of the HCPCS codes that was in existence "as of July 1, 1999." In the SNF PPS final rule for FY 2006 (70 FR 45048, August 4, 2005), we reiterated our belief that the authority granted by the BBRA to identify additional codes for exclusion within this category was ". . . 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)" (emphasis added). Accordingly, we view this discretionary authority as applying only to codes that were created subsequent to that point, and not to those codes that were in existence as of July 1, 1999.

A review of the particular chemotherapy codes that commenters submitted in response to the proposed rule's solicitation for comment revealed that many of them were codes that had already been submitted for consideration in previous years, and that we had previously decided not to exclude.

Other codes that commenters submitted were themselves already in existence as of July 1, 1999, but did not fall within the specific code ranges statutorily designated for exclusion in the BBRA. As the statute does not specifically exclude these already-existing codes, we are not adding them to the exclusion list. Most of the other codes submitted represent services that, for various reasons, do not meet the statutory criteria for exclusion. For example, some represent oral medications that can be administered routinely in SNFs and are not reasonably characterized as "requiring special staff expertise to administer." Others represent drugs that are administered in conjunction with chemotherapy to address side effects such as nausea; however, as such drugs are not in themselves inherently chemotherapeutic in nature, they do not fall within the excluded chemotherapy category designated in the BBRA. Finally, some other codes that were submitted represent services that, in fact, are already excluded from consolidated billing under existing instructions.

Comment: Although the FY 2008 SNF PPS proposed rule specifically invited comments on possible exclusions within the particular service categories identified in the BBRA legislation, a number of commenters took this opportunity to reiterate concerns about other aspects of consolidated billing. For example, some commenters reiterated past

suggestions that CMS unbundle additional service categories such as specialized wound care procedures (including hyperbaric oxygen therapy) and ambulance services. Another commenter advocated the exclusion of custom fabricated orthotics, stating that in the absence of such an exclusion SNFs might deny access to needed orthotic treatments during the Medicare-covered portion of the stay.

Response: As we have consistently stated (most recently, in the SNF PPS final rule for FY 2008 (72 FR 43431, August 3, 2007)), the BBRA authorizes us to identify additional services for exclusion only within those particular service categories--chemotherapy and its administration; radioisotope services; and, customized prosthetic devices (a term which does not encompass orthotics)--that it has designated for this purpose, and does not give us the authority to create additional categories of excluded services beyond those specified in the law. Accordingly, as the particular services that these commenters recommended for exclusion do not fall within one of the specific service categories designated for this purpose in the statute itself, these services remain subject to consolidated billing. Regarding the concern about the possibility of a SNF withholding access to a needed item or service during the covered portion of a stay because it is bundled, we note that the requirements for program

participation at §483.25 require participating SNFs to provide the necessary care and services to attain or maintain each resident's ". . . highest practicable state of physical, mental, and psychosocial well-being . . . ." Thus, a SNF which delays or denies access to needed care could jeopardize its Medicare program certification.

Comment: One commenter stated that the existing exclusion of certain customized prosthetic devices should be expanded to encompass all prosthetics that are designated by an L code.

Response: When the Congress enacted the selective consolidated billing exclusion (by HCPCS code) of certain customized prosthetic devices in section 103 of the BBRA, it specifically identified certain designated L codes for exclusion, while omitting others from the exclusion list. Accordingly, we believe it is clear that the assignment of an L code to a particular prosthetic does not, in itself, automatically serve to qualify that item for exclusion from consolidated billing.

Comment: Several commenters took this opportunity to revisit the existing set of administrative exclusions for certain high-intensity outpatient hospital services under the regulations in 42 CFR §411.15(p)(3)(iii), and expressed the view that these exclusions should not be limited to only those

services that actually occur in the hospital setting, but rather, should also encompass services performed in other, non-hospital settings as well. As examples, they cited services such as magnetic resonance imaging (MRIs) and computerized axial tomography (CT) scans furnished in freestanding imaging centers, and radiation therapy furnished in physicians' clinics or ambulatory care centers, all of which may be less expensive and more accessible in certain particular localities (such as rural areas) than those furnished by hospitals.

Response: We believe the comments that reflect previous suggestions for expanding this administrative exclusion to encompass services furnished in non-hospital settings indicate a continued misunderstanding of the underlying purpose of this provision. As we have consistently noted in response to comments on this issue in previous years (most recently, in the SNF PPS final rule for FY 2008 (72 FR 43431, August 3, 2007), and as also explained in Medicare Learning Network (MLN) Matters article SE0432 (available online at www.cms.hhs.gov/MLNMattersArticles/downloads/SE0432.pdf), the rationale for establishing this exclusion was to address those types of services that are so far beyond the normal scope of SNF care that they require the intensity of the hospital setting in order to be furnished safely and effectively.

Moreover, we note that when the Congress enacted the consolidated billing exclusion for certain RHC and FQHC services in section 410 of the MMA, the accompanying legislative history's description of present law acknowledged that the existing exclusions for exceptionally intensive outpatient services are specifically limited to ". . . certain outpatient services from a Medicare-participating hospital or critical access hospital . . ." (emphasis added). (See the House Ways and Means Committee Report (H. Rep. No. 108-178, Part 2 at 209), and the Conference Report (H. Conf. Rep. No. 108-391 at 641).) Therefore, these services are excluded from SNF consolidated billing only when furnished in the outpatient hospital or CAH setting, and not when furnished in other, freestanding (non-hospital or non-CAH) settings. Accordingly, establishing a categorical exclusion for these services that would apply irrespective of the setting in which they are furnished would require the enactment of legislation by the Congress to amend the law itself.

Comment: Other commenters reiterated previous suggestions on expanding the existing chemotherapy exclusion to encompass related drugs that are commonly administered in conjunction with chemotherapy in order to treat the side effects of the chemotherapy drugs. The commenters cited examples such as anti-emetics (anti-nausea drugs),

erythropoietin (EPO), and Reclast, an osteoporosis drug administered via a once-yearly infusion.

Response: As we have noted previously in this final rule and in response to comments on this issue in the past (most recently, in the SNF PPS final rule for FY 2008 (72 FR 43432, August 3, 2007), the BBRA authorizes us to identify additional services for exclusion only within those particular service categories--chemotherapy and its administration; radioisotope services; and, customized prosthetic devices--that it has designated for this purpose, and does not give us the authority to exclude other services which, though they may be related, fall outside of the specified service categories themselves. Thus, while anti-emetics, for example, are commonly administered in conjunction with chemotherapy, they are not themselves inherently chemotherapeutic in nature and, consequently, do not fall within the excluded chemotherapy category designated in the BBRA. In the case of Reclast, in the FY 2008 SNF PPS final rule (72 FR 43432, August 3, 2007), we discussed the specific rationale for our decision not to exclude this particular drug, explaining that such an exclusion could not be accomplished administratively under our existing authority. We also explained in the FY 2008 final rule that the existing statutory exclusion from consolidated billing for EPO is effectively defined by the scope of

coverage under the Part B EPO benefit at section 1861(s)(2)(O) of the Act; that benefit, in turn, specifically limits EPO coverage to dialysis patients, and does not provide for such coverage in any other, non-dialysis situations such as chemotherapy (72 FR 43432).

VI. Application of the SNF PPS to SNF Services Furnished by Swing-Bed Hospitals

In accordance with section 1888(e)(7) of the Act, as amended by section 203 of the BIPA, Part A pays CAHs on a reasonable cost basis for SNF services furnished under a swing-bed agreement. However, effective with cost reporting periods beginning on or after July 1, 2002, the swing-bed services of non-CAH rural hospitals are paid under the SNF PPS. As explained in the FY 2002 SNF PPS final rule (66 FR 39562, July 31, 2001), we selected this effective date consistent with the statutory provision to integrate swing-bed rural hospitals into the SNF PPS by the end of the SNF transition period, June 30, 2002.

Accordingly, all non-CAH swing-bed rural hospitals have come under the SNF PPS as of June 30, 2003. Therefore, all rates and wage indexes outlined in earlier sections of this final rule, also apply to all non-CAH swing-bed rural hospitals. A complete discussion of assessment schedules, the MDS and the transmission software (RAVEN-SB for Swing Beds)

appears in the final rule for FY 2002 (66 FR 39562, July 31, 2001). The latest changes in the MDS for swing-bed rural hospitals appear on our SNF PPS website, www.cms.hhs.gov/snfpps.

We received no comments on this aspect of the proposed rule and are making no changes in this final rule.

VII. Provisions of the Final Rule

In this final rule, in addition to accomplishing the required annual update of the SNF PPS payment rates, we are making the following revisions in the regulations text:

- Revise the existing SNF PPS definitions of "urban" and "rural" areas that appear in §413.333 to include updated cross-references to the corresponding IPPS definitions in Part 412, subpart D.
- Make a technical revision at §413.335(b) to reflect Medicare bad debt payments to SNFs.

VIII. 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.).

IX. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (September 19, 1980, RFA, Pub. L. 96-354), section 1102(b) of the Social Security Act (the Act), the Unfunded Mandates Reform Act of 1995 (UMRA, Pub. L. 104-4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866, as amended, directs agencies to assess all costs and benefits of available regulatory alternatives and, if 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 in any 1 year). This final rule is a major rule, as defined in Title 5, United States Code, section 804(2), because we estimate the FY 2009 impact of the standard update will be to increase payments to SNFS by approximately $780 million dollars. We are also considering this an economically significant rule under Executive Order 12866.

The update set forth in this final rule would apply to payments in FY 2009. Accordingly, the analysis that follows only describes the impact of this single year. 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 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 small government jurisdictions. Most SNFs and most other providers and suppliers are small entities, either by their nonprofit status or by having revenues of $11.5 million or less in any 1 year. For purposes of the RFA, approximately 53 percent of SNFs are considered small businesses according to the Small Business Administration's latest size standards, with total revenues of $11.5 million or less in any 1 year (for further information, see 65 FR 69432, November 17, 2000). Individuals and States are not included in the definition of a small entity. In addition, approximately 29 percent of SNFs are nonprofit organizations.

This final rule updates the SNF PPS rates published in the FY 2008 SNF PPS final rule (72 FR 43412, August 3, 2007) and the associated correction notices published on September 28, 2007 (72 FR 55085) and on November 30, 2007 (72 FR 67652),

resulting in a net change in payments of an estimated $780 million for FY 2009. As indicated in Table 12, the effect on facilities will be a net positive impact of 3.4 percent. We note that while all providers will experience an overall net increase in payments, some providers may experience larger increases than others due to the distributional impact of the FY 2009 wage indexes and the degree of Medicare utilization.

The Department of Health and Human Services generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. While this final rule is considered major, its relative impact on SNFs overall is positive due to the application of the 3.4 percent market basket adjustment. Thus, while the overall impact is positive on the industry as a whole, and on small entities specifically, it is highly variable, with the majority of SNFs having significantly lower Medicare utilization. Therefore, for most facilities, the impact on total facility revenues, considering all payers, should be substantially less than those shown in Table 12. However, in view of the potential economic impact on small entities, we have considered regulatory alternatives.

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 100 beds. This final rule affects small rural hospitals that furnish SNF services under a swing-bed agreement, or that have a hospital-based SNF. We anticipate that the impact on small rural hospitals will be similar to the impact on SNF providers overall.

Section 202 of the UMRA also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2008, that threshold is approximately $130 million. This final rule will not have a substantial effect on State, local, or tribal governments, or on private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates regulations that impose substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. As stated above, this final rule will have no substantial effect on State and local governments.

B. Anticipated Effects

This final rule sets forth updates of the SNF PPS rates contained in the FY 2008 final rule (72 FR 43412, August 3,

2007) and the associated correction notices published on September 28, 2007 (72 FR 55085) and on November 30, 2008 (72 FR 67652). Based on the above, we estimate the FY 2009 impact would be a net increase of $780 million in payments to SNFs. The impact analysis of this final rule represents the projected effects of the changes in the SNF PPS from FY 2008 to FY 2009. We estimate the effects 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 these changes, and we do not make adjustments for future changes in such variables as days or case-mix.

We note that certain events may combine to limit the scope or accuracy of our impact analysis, because an analysis is future-oriented and, thus, very susceptible to changes in provider behavior related to such events as newly-legislated general Medicare program funding changes by the Congress. Although these changes may not be specific to the SNF PPS, the nature of the Medicare program is 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.

In accordance with section 1888(e)(4)(E) of the Act, we update the payment rates for FY 2008 by a factor equal to the

full market basket index percentage increase plus the FY 2007 forecast error adjustment to determine the payment rates for FY 2009. The special AIDS add-on established by section 511 of the MMA remains in effect until ". . . such date as the Secretary certifies that there is an appropriate adjustment in the case mix . . . ." We have not provided a separate impact analysis for this MMA provision. Our latest estimates indicate that there are less than 2,700 beneficiaries who qualify for the AIDS add-on payment. The impact on Medicare is included in the "total" column of Table 12. In updating the rates for FY 2009, we made a number of standard annual revisions and clarifications mentioned elsewhere in this final rule (for example, the update to the wage and market basket indexes used for adjusting the Federal rates). These revisions would increase payments to SNFs by approximately $780 million for FY 2009.

The impacts are shown in Table 12. The breakdown of the various categories of data in the table follows.

The first column shows the breakdown of all SNFs by urban or rural status, hospital-based or freestanding status, and census region.

The first row of figures in the first column describes the estimated effects of the various changes on all facilities. The next six rows show the effects on facilities

split by hospital-based, freestanding, urban, and rural categories. The urban and rural designations are based on the location of the facility under the CBSA designation. The next twenty-two rows show 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 of the table shows the effect of the annual update to the wage index. This represents the effect of using the most recent wage data available. The total impact of this change is zero percent; however, there are distributional effects of the change.

The fourth column shows the effect of all of the changes on the FY 2009 payments. The market basket increase of 3.4 percentage points is constant for all providers and, though not shown individually, is included in the total column. It is projected that aggregate payments will increase by 3.4 percent, assuming facilities do not change their care delivery and billing practices in response.

As can be seen from this table, the effects of the changes vary by specific types of providers and by location. For example, all facilities experience payment increases, however, some providers (for example, those in the urban Pacific region) show a greater increase. In fact, payment

increases for facilities in the urban and rural Pacific areas of the country are the highest for any of the provider categories at 4.9 percent and 4.5 percent, respectively.

Table 12
Projected Impact to the SNF PPS for FY 2009

	Number of facilities	Updated wage data	Total FY 2009 change
Total	**15,373**	0.0%	3.4%
Urban	10,497	0.0%	3.4%
Rural	4,876	0.0%	3.4%
Hospital based urban	1,528	-0.1%	3.3%
Freestanding urban	8,969	0.0%	3.4%
Hospital based rural	1,154	0.0%	3.4%
Freestanding rural	3,722	0.0%	3.4%
Urban by region			
New England	840	0.2%	3.6%
Middle Atlantic	1,490	-0.5%	2.9%
South Atlantic	1,734	-0.3%	3.1%
East North Central	2,010	-0.5%	2.9%
East South Central	530	0.0%	3.4%
West North Central	827	0.6%	4.0%
West South Central	1,166	0.2%	3.6%
Mountain	472	0.0%	3.4%
Pacific	1,420	1.5%	4.9%
Outlying	8	0.6%	4.0%
Rural by region			
New England	150	-1.8%	1.6%
Middle Atlantic	257	-0.2%	3.2%
South Atlantic	603	0.0%	3.4%
East North Central	940	-0.6%	2.8%
East South Central	552	0.3%	3.7%
West North Central	1,144	0.5%	4.0%
West South Central	821	0.5%	3.9%
Mountain	259	-0.1%	3.3%
Pacific	148	1.1%	4.5%
Outlying	2	0.4%	3.9%
Ownership			
Government	665	-0.1%	3.3%
Proprietary	11,286	0.0%	3.4%
Voluntary	3,422	-0.1%	3.3%

We received one comment on the regulatory impact section. The comment and our response to the comment is as follows:

Comment: One commenter asserted that the regulatory impact analysis understates the effects of the policy changes associated with the proposed recalibration of the case-mix weights (as discussed in the FY 2009 SNF PPS proposed rule) on state and local governments, as well as small entities. The commenter stated that the loss of tax revenues for State and local governments will be substantial.

Response: As we have decided not to pursue the recalibration of the case-mix weights at this time, SNFs will see an increase of approximately 3.4 percent in their payments. However, should we decide to recalibrate the case-mix weights in the future, we wish to make clear that the law and regulations that govern SNF payment rate updates do not provide for considering indirect effects, induced effects, or ripple effects on economic activity. Moreover, as such secondary effects, if any, would occur within the context of a dynamic, market-based economy, we expect that the market would properly adjust its economic resources in reaction to the appropriately recalibrated SNF PPS payments. For these reasons, we believe that the regulatory impact analysis adequately estimates the proposed rule's economic impact.

C. Alternatives Considered

Section 1888(e) of the Act establishes the SNF PPS for the payment of Medicare SNF services for cost reporting

periods beginning on or after July 1, 1998. This section of the statute prescribes a detailed formula for calculating payment rates under the SNF PPS, and does not provide for the use of any alternative methodology. It specifies that the base year cost data to be used for computing the SNF PPS payment rates must be from FY 1995 (October 1, 1994, through September 30, 1995.) In accordance with the statute, we also incorporated a number of elements into the SNF PPS (for example, case-mix classification methodology, the MDS assessment schedule, a market basket index, a wage index, and the urban and rural distinction used in the development or adjustment of the Federal rates). Further, section 1888(e)(4)(H) of the Act specifically requires us to disseminate the payment rates for each new FY through the **Federal Register**, and to do so before the August 1 that precedes the start of the new FY. Accordingly, we are not pursuing alternatives with respect to the payment methodology as discussed above.

In finalizing our decision on the proposed FY 2009 recalibration of the case-mix adjustment, we reviewed the options considered in the proposed rule and took into consideration comments received during the public comment period as discussed in the preamble.

Although the 2001 data were the best source available at

the time the FY 2006 refinements were introduced, the distribution of paid days, a key component in adjusting the RUG-53 case-mix weights, was based solely on estimated utilization. The 2006 data provide a more recent and a more accurate source of RUG-53 utilization based on actual utilization, and are an appropriate source to use for case-mix adjustment. However, in light of the potential ramifications of this proposal and the complexity of the issues involved, we believe that it would be prudent to take additional time to evaluate the proposal in order to further consider consequences that may result from it. Accordingly, we are not proceeding with the proposed recalibration at this time, pending further analysis. We note that as we continue to evaluate this issue, we fully expect to implement such an adjustment in the future.

D. Accounting Statement

As required by OMB Circular A-4 (available at www.whitehouse.gov/omb/circulars/a004/a-4.pdf), in Table 13 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. This table provides our best estimate of the change in Medicare payments under the SNF PPS as a result of the policies in this final rule based on the data for 15,373 SNFs in our database. All expenditures are

classified as transfers to Medicare providers (that is, SNFs).

Table 13
Accounting Statement: Classification of Estimated Expenditures, from the 2008 SNF PPS Fiscal Year to the 2009 SNF PPS Fiscal Year (in Millions)

Category	Transfers
Annualized Monetized Transfers	$780 million
From Whom To Whom?	Federal Government to SNF Medicare Providers

E. Conclusion

Overall estimated payments for SNFs in FY 2009 are projected to increase by $780 million dollars compared with those in FY 2008. We estimate that SNFs in urban areas will experience a positive change of 3.4 percent in estimated payments compared with FY 2008. We estimate that SNFs in rural areas will experience a 3.4 percent increase in estimated payments compared with FY 2008. Providers in the urban Pacific region and the rural Pacific region show the greatest increases in payments of 4.9 percent and 4.5 percent, respectively.

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

List of Subjects in 42 CFR Part 413

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

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

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

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

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Public Law 106–133 (113 Stat. 1501A–332).

Subpart J—Prospective Payment for Skilled Nursing Facilities

2. In §413.333, the definitions of the terms "rural area" and "urban area" are revised to read as follows:

§413.333 Definitions.

* * * * *

Rural area means, for services provided on or after July 1, 1998, but before October 1, 2005, an area as defined in §412.62(f)(1)(iii) of this chapter. For services provided on or after October 1, 2005, rural area means an

area as defined in §412.64(b)(1)(ii)(C) of this chapter.

Urban area means, for services provided on or after July 1, 1998, but before October 1, 2005, an area as defined in §412.62(f)(1)(ii) of this chapter. For services provided on or after October 1, 2005, urban area means an area as defined in §412.64(b)(1)(ii)(A) and §412.64(b)(1)(ii)(B) of this chapter.

§413.335 [Amended]

3. Section 413.335 is amended by revising paragraph (b) to read as follows:

§413.335 Basis of payment.

* * * * *

(b) Payment in full. (1) The payment rates represent payment in full (subject to applicable coinsurance as described in subpart G of part 409 of this chapter) for all costs (routine, ancillary, and capital-related) associated with furnishing inpatient SNF services to Medicare beneficiaries other than costs associated with approved educational activities as described in §413.85.

(2) In addition to the Federal per diem payment amounts, SNFs receive payment for bad debts of Medicare beneficiaries, as specified in §413.89 of this part.

CMS-1534-F

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

Dated: _____

_____

Kerry Weems,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Dated: _____

_____

Michael O. Leavitt,

Secretary.

BILLING CODE 4120-01-P

[Note: The following Addendum will not appear in the Code of Federal Regulations]

Addendum - FY 2009 CBSA Wage Index Tables

In this addendum, we provide the wage index tables referred to in the preamble to this final rule. Tables 8 and 9 display the CBSA-based wage index values for urban and rural providers.

Table 8 FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8097
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.3399
10420	Akron, OH Portage County, OH Summit County, OH	0.8917
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.8703

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8707
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9210
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8130
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9499
11020	Altoona, PA Blair County, PA	0.8521
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8927
11180	Ames, IA Story County, IA	0.9487
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.1931
11300	Anderson, IN Madison County, IN	0.8760

CBSA Code	Urban Area (Constituent Counties)	Wage Index
11340	Anderson, SC Anderson County, SC	0.9570
11460	Ann Arbor, MI Washtenaw County, MI	1.0445
11500	Anniston-Oxford, AL Calhoun County, AL	0.7927
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9440
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9142
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9591

CBSA Code	Urban Area (Constituent Counties)	Wage Index
12060	Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA	0.9754
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1973
12220	Auburn-Opelika, AL Lee County, AL	0.7544

CBSA Code	Urban Area (Constituent Counties)	Wage Index
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9615
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9536
12540	Bakersfield, CA Kern County, CA	1.1189
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0055
12620	Bangor, ME Penobscot County, ME	1.0174
12700	Barnstable Town, MA Barnstable County, MA	1.2643

CBSA Code	Urban Area (Constituent Counties)	Wage Index
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.8163
12980	Battle Creek, MI Calhoun County, MI	1.0120
13020	Bay City, MI Bay County, MI	0.9248
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8479
13380	Bellingham, WA Whatcom County, WA	1.1640
13460	Bend, OR Deschutes County, OR	1.1375
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0548
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8805
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8574

CBSA Code	Urban Area (Constituent Counties)	Wage Index
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.8792
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7148
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8155
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8979
14060	Bloomington-Normal, IL McLean County, IL	0.9323
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9268
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.1897
14500	Boulder, CO Boulder County, CO	1.0302

CBSA Code	Urban Area (Constituent Counties)	Wage Index
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8388
14600	Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	0.9900
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0770
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2868
15180	Brownsville-Harlingen, TX Cameron County, TX	0.8916
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9567
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9537
15500	Burlington, NC Alamance County, NC	0.8736
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9254
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1086
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0346
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8841

CBSA Code	Urban Area (Constituent Counties)	Wage Index
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9396
16180	Carson City, NV Carson City, NV	1.0128
16220	Casper, WY Natrona County, WY	0.9579
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8919
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9461
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8275
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9209
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9595

CBSA Code	Urban Area (Constituent Counties)	Wage Index
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9816
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.8878
16940	Cheyenne, WY Laramie County, WY	0.9276
16974	Chicago-Naperville-Joliet, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.0399
17020	Chico, CA Butte County, CA	1.0897

CBSA Code	Urban Area (Constituent Counties)	Wage Index
17140	Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH	0.9687
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8298
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.8010
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9241
17660	Coeur d'Alene, ID Kootenai County, ID	0.9322

CBSA Code	Urban Area (Constituent Counties)	Wage Index
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9346
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9977
17860	Columbia, MO Boone County, MO Howard County, MO	0.8540
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8933
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8739
18020	Columbus, IN Bartholomew County, IN	0.9739
18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	0.9943

CBSA Code	Urban Area (Constituent Counties)	Wage Index
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8598
18700	Corvallis, OR Benton County, OR	1.1304
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.7816
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	0.9945
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8705
19180	Danville, IL Vermilion County, IL	0.9374
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8395
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8435

CBSA Code	Urban Area (Constituent Counties)	Wage Index
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9203
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7803
19500	Decatur, IL Macon County, IL	0.8145
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8890
19740	Denver-Aurora, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.0818
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9535
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9958

CBSA Code	Urban Area (Constituent Counties)	Wage Index
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7613
20100	Dover, DE Kent County, DE	1.0325
20220	Dubuque, IA Dubuque County, IA	0.8380
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0363
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9732
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9668
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1283
20940	El Centro, CA Imperial County, CA	0.8746
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8525
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9568
21300	Elmira, NY Chemung County, NY	0.8247

CBSA Code	Urban Area (Constituent Counties)	Wage Index
21340	El Paso, TX El Paso County, TX	0.8694
21500	Erie, PA Erie County, PA	0.8713
21660	Eugene-Springfield, OR Lane County, OR	1.1061
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8690
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1297
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.4061
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8166
22140	Farmington, NM San Juan County, NM	0.8051
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9340
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8970
22380	Flagstaff, AZ Coconino County, AZ	1.1743

CBSA Code	Urban Area (Constituent Counties)	Wage Index
22420	Flint, MI Genesee County, MI	1.1425
22500	Florence, SC Darlington County, SC Florence County, SC	0.8130
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.7871
22540	Fond du Lac, WI Fond du Lac County, WI	0.9293
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9867
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	0.9946
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7697
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.8769
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9176
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9709
23420	Fresno, CA Fresno County, CA	1.1009

CBSA Code	Urban Area (Constituent Counties)	Wage Index
23460	Gadsden, AL Etowah County, AL	0.7983
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9312
23580	Gainesville, GA Hall County, GA	0.9109
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9250
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8473
24140	Goldsboro, NC Wayne County, NC	0.9143
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7565
24300	Grand Junction, CO Mesa County, CO	0.9812
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9184
24500	Great Falls, MT Cascade County, MT	0.8784
24540	Greeley, CO Weld County, CO	0.9684

CBSA Code	Urban Area (Constituent Counties)	Wage Index
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9709
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9011
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9448
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9961
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3249
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.9029
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.8997
25260	Hanford-Corcoran, CA Kings County, CA	1.0870
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9153

CBSA Code	Urban Area (Constituent Counties)	Wage Index
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.8894
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1069
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7337
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.8976
25980	Hinesville-Fort Stewart, GA[1] Liberty County, GA Long County, GA	0.9110
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9008
26180	Honolulu, HI Honolulu County, HI	1.1811
26300	Hot Springs, AR Garland County, AR	0.9113
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7758

CBSA Code	Urban Area (Constituent Counties)	Wage Index
26420	Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	0.9838
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9254
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9082
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9080
26900	Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	0.9908

CBSA Code	Urban Area (Constituent Counties)	Wage Index
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9483
27060	Ithaca, NY Tompkins County, NY	0.9614
27100	Jackson, MI Jackson County, MI	0.9309
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8067
27180	Jackson, TN Chester County, TN Madison County, TN	0.8523
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.8999
27340	Jacksonville, NC Onslow County, NC	0.8177
27500	Janesville, WI Rock County, WI	0.9662
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8775

CBSA Code	Urban Area (Constituent Counties)	Wage Index
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7971
27780	Johnstown, PA Cambria County, PA	0.7920
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7916
27900	Joplin, MO Jasper County, MO Newton County, MO	0.9406
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0801
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0485
28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	0.9610

CBSA Code	Urban Area (Constituent Counties)	Wage Index
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	0.9911
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.8765
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.7743
28740	Kingston, NY Ulster County, NY	0.9375
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.7881
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9349
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9758
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9221
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8374

CBSA Code	Urban Area (Constituent Counties)	Wage Index
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7556
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0389
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	0.9797
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8530
29540	Lancaster, PA Lancaster County, PA	0.9363
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	0.9931
29700	Laredo, TX Webb County, TX	0.8366
29740	Las Cruces, NM Dona Ana County, NM	0.8929
29820	Las Vegas-Paradise, NV Clark County, NV	1.1971
29940	Lawrence, KS Douglas County, KS	0.8343
30020	Lawton, OK Comanche County, OK	0.8211
30140	Lebanon, PA Lebanon County, PA	0.8954
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9465
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9200

CBSA Code	Urban Area (Constituent Counties)	Wage Index
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9110
30620	Lima, OH Allen County, OH	0.9427
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9759
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.8672
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8765
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8370
31020	Longview, WA Cowlitz County, WA	1.1207
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2208

CBSA Code	Urban Area (Constituent Counties)	Wage Index
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.9249
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8731
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8774
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9570
31460	Madera, CA Madera County, CA	0.7939

CBSA Code	Urban Area (Constituent Counties)	Wage Index
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.0967
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0359
31900	Mansfield, OH Richland County, OH	0.9330
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3940
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9009
32780	Medford, OR Jackson County, OR	1.0244
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9232
32900	Merced, CA Merced County, CA	1.2243
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	0.9830
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9159
33260	Midland, TX Midland County, TX	0.9827

CBSA Code	Urban Area (Constituent Counties)	Wage Index
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0080
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1150
33540	Missoula, MT Missoula County, MT	0.8973
33660	Mobile, AL Mobile County, AL	0.7908
33700	Modesto, CA Stanislaus County, CA	1.2194
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7900
33780	Monroe, MI Monroe County, MI	0.8941

CBSA Code	Urban Area (Constituent Counties)	Wage Index
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8283
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8528
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7254
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0292
34620	Muncie, IN Delaware County, IN	0.8489
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0055
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.8652
34900	Napa, CA Napa County, CA	1.4520
34940	Naples-Marco Island, FL Collier County, FL	0.9672

CBSA Code	Urban Area (Constituent Counties)	Wage Index
34980	Nashville-Davidson--—Murfreesboro--Franklin, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN	0.9504
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2453
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1731
35300	New Haven-Milford, CT New Haven County, CT	1.1742
35380	New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	0.9103

CBSA Code	Urban Area (Constituent Counties)	Wage Index
35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.2885
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9066
35980	Norwich-New London, CT New London County, CT	1.1398
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6092
36100	Ocala, FL Marion County, FL	0.8512
36140	Ocean City, NJ Cape May County, NJ	1.1496
36220	Odessa, TX Ector County, TX	0.9475
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9153

CBSA Code	Urban Area (Constituent Counties)	Wage Index
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.8724
36500	Olympia, WA Thurston County, WA	1.1537
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	0.9441
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9111
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9474
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8685
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.1951
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9332

CBSA Code	Urban Area (Constituent Counties)	Wage Index
37380	Palm Coast, FL Flagler County, FL	0.8963
37460	Panama City-Lynn Haven, FL Bay County, FL	0.8360
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7867
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8102
37764	Peabody, MA Essex County, MA	1.0747
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8242
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9038
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0979
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0379

CBSA Code	Urban Area (Constituent Counties)	Wage Index
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.7926
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8678
38340	Pittsfield, MA Berkshire County, MA	1.0445
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9343
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4289
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	0.9942
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.1456

CBSA Code	Urban Area (Constituent Counties)	Wage Index
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	0.9870
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.0920
39140	Prescott, AZ Yavapai County, AZ	1.0221
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.0696
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9381
39380	Pueblo, CO Pueblo County, CO	0.8713
39460	Punta Gorda, FL Charlotte County, FL	0.8976
39540	Racine, WI Racine County, WI	0.9054
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9817
39660	Rapid City, SD Meade County, SD Pennington County, SD	0.9598
39740	Reading, PA Berks County, PA	0.9242

CBSA Code	Urban Area (Constituent Counties)	Wage Index
39820	Redding, CA Shasta County, CA	1.3731
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0317
40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	0.9363
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1468

CBSA Code	Urban Area (Constituent Counties)	Wage Index
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.8660
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1214
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8811
40420	Rockford, IL Boone County, IL Winnebago County, IL	0.9835
40484	Rockingham County, NH Rockingham County, NH Strafford County, NH	0.9926
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9031
40660	Rome, GA Floyd County, GA	0.9134
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.3572

CBSA Code	Urban Area (Constituent Counties)	Wage Index
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.8702
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.0976
41100	St. George, UT Washington County, UT	0.9021
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0380
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9006
41420	Salem, OR Marion County, OR Polk County, OR	1.0884

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41500	Salinas, CA Monterey County, CA	1.4987
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9246
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9158
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8424
41700	San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.8856
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1538
41780	Sandusky, OH Erie County, OH	0.8870
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.5529
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.4756

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.6141

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	0.4393

CBSA Code	Urban Area (Constituent Counties)	Wage Index
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.2441
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.1993
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.1909
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.6429
42140	Santa Fe, NM Santa Fe County, NM	1.0610
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.5528
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9152
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8333
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1755
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9217
43100	Sheboygan, WI Sheboygan County, WI	0.8920
43300	Sherman-Denison, TX Grayson County, TX	0.9024
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8442

CBSA Code	Urban Area (Constituent Counties)	Wage Index
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.8915
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9354
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9761
43900	Spartanburg, SC Spartanburg County, SC	0.9025
44060	Spokane, WA Spokane County, WA	1.0559
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9102
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0405
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8424
44220	Springfield, OH Clark County, OH	0.8876
44300	State College, PA Centre County, PA	0.8937

CBSA Code	Urban Area (Constituent Counties)	Wage Index
44700	Stockton, CA San Joaquin County, CA	1.2015
44940	Sumter, SC Sumter County, SC	0.8257
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9787
45104	Tacoma, WA Pierce County, WA	1.1241
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8964
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.8852
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9085
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8144
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9407

CBSA Code	Urban Area (Constituent Counties)	Wage Index
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8756
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0604
46060	Tucson, AZ Pima County, AZ	0.9229
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8445
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8496
46340	Tyler, TX Smith County, TX	0.8804
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8404
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8027
46700	Vallejo-Fairfield, CA Solano County, CA	1.4359

CBSA Code	Urban Area (Constituent Counties)	Wage Index
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8124
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0366
47260	Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA	0.8884
47300	Visalia-Porterville, CA Tulare County, CA	1.0144
47380	Waco, TX McLennan County, TX	0.8596
47580	Warner Robins, GA Houston County, GA	0.8989
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9904

CBSA Code	Urban Area (Constituent Counties)	Wage Index
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.0827
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8490
48140	Wausau, WI Marathon County, WI	0.9615
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.8079
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	0.9544

CBSA Code	Urban Area (Constituent Counties)	Wage Index
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9757
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6955
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9069
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.8832
48700	Williamsport, PA Lycoming County, PA	0.8096
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0696
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9089
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	0.9801
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9016

CBSA Code	Urban Area (Constituent Counties)	Wage Index
49340	Worcester, MA Worcester County, MA	1.0836
49420	Yakima, WA Yakima County, WA	0.9948
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3432
49620	York-Hanover, PA York County, PA	0.9518
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8915
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1137
49740	Yuma, AZ Yuma County, AZ	0.9281

[1] At this time, there are no hospitals located in this urban area on which to base a wage index. We use the average wage index of all of the urban areas within the State to serve as a reasonable proxy.

Table 9 FY 2009 WAGE INDEX BASED ON CBSA LABOR MARKET AREAS FOR RURAL AREAS

State Code	Nonurban Area	Wage Index
1	Alabama	0.7587
2	Alaska	1.1898
3	Arizona	0.8453
4	Arkansas	0.7473
5	California	1.2275
6	Colorado	0.9570
7	Connecticut	1.1016
8	Delaware	0.9962
10	Florida	0.8504
11	Georgia	0.7612
12	Hawaii	1.0999
13	Idaho	0.7651
14	Illinois	0.8386
15	Indiana	0.8473
16	Iowa	0.8804
17	Kansas	0.8052
18	Kentucky	0.7803
19	Louisiana	0.7447
20	Maine	0.8644
21	Maryland	0.8883
22	Massachusetts[1]	1.1670
23	Michigan	0.8887
24	Minnesota	0.9059
25	Mississippi	0.7584
26	Missouri	0.7982
27	Montana	0.8658
28	Nebraska	0.8730
29	Nevada	0.9382
30	New Hampshire	1.0182
31	New Jersey[1]	-----

State Code	Nonurban Area	Wage Index
32	New Mexico	0.8812
33	New York	0.8145
34	North Carolina	0.8576
35	North Dakota	0.7205
36	Ohio	0.8588
37	Oklahoma	0.7732
38	Oregon	1.0218
39	Pennsylvania	0.8365
40	Puerto Rico1	0.4047
41	Rhode Island[1]	-----
42	South Carolina	0.8538
43	South Dakota	0.8603
44	Tennessee	0.7789
45	Texas	0.7894
46	Utah	0.8267
47	Vermont	1.0079
48	Virgin Islands	0.6971
49	Virginia	0.7861
50	Washington	1.0181
51	West Virginia	0.7503
52	Wisconsin	0.9373
53	Wyoming	0.9315
65	Guam	0.9611

[1] All counties within the State are classified as urban, with the exception of Massachusetts and Puerto Rico. Massachusetts and Puerto Rico have areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for FY 2009. The rural Massachusetts wage index is calculated as the average of all contiguous CBSAs. The Puerto Rico wage index is the same as FY 2008.