DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 410, 411, 413, 424, 482, and 489

[HCFA–1163–P]

RIN 0938–AK47

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

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

ACTION: Proposed rule.

SUMMARY: This proposed rule updates the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2002, as required by statute. Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act (the Act), as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA 1999), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000), relating to Medicare payments and consolidated billing for SNFs. As part of this annual update, we are rebasing and revising the routine SNF market basket to reflect 1997 total cost data (the latest available complete data on the structure of SNF costs), and modifying certain variables for some of the cost categories. In addition, we propose to implement the transition of swing-bed facilities to the SNF PPS, as required by section 1888(e)(7) of the Act.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on July 9, 2001.

ADDRESSES: Mail written comments (one original and three copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1163–P, P.O. Box 8013, Baltimore, MD 21244–8013.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses: Hubert H. Humphrey Building, Room 443–G, 200 Independence Avenue, SW., Washington, DC 20201, or Health Care Financing Administration, Room C5–15–03, 7500 Security Boulevard, Baltimore, MD 21244–8150.

Comments mailed to those addresses designated for courier delivery may be delayed and could be considered late. Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Please refer to file code HCFA–1163–P on each comment. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of this document, in Room C5–12–08 of the Health Care Financing Administration, 7500 Security Boulevard, Baltimore, Maryland, Monday through Friday of each week from 8:30 a.m. to 5 p.m. Please call (410) 786–7197 to make an appointment to view comments.

FOR FURTHER INFORMATION CONTACT:

Dana Burley, (410) 786–4547 or Sheila Lambowitz, (410) 786–7605 (for information related to the case-mix classification methodology)

John Davis, (410) 786–0008 (for information related to the Wage Index)

Bill Ullman, (410) 786–5667 (for information related to consolidated billing)

Susan Burris, (410) 786–6655 (for information related to payment)

Sheila Lambowitz, (410) 786–7605 (for information related to swing-bed providers)

Bill Ullman, (410) 786–5667 or Susan Burris, (410) 786–6655 (for general information)

SUPPLEMENTARY INFORMATION:

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

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

ADL Activity of Daily Living
AHE Average Hourly Earnings
ARD Assessment Reference Date
BBA 1997 Balanced Budget Act of 1997, Pub. L. 105–33
BBRA 1999 Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BEA (U.S.) Bureau of Economic Analysis
BIPA 2000 The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
BES (U.S.) Business Expenditures Survey
BLS (U.S.) Bureau of Labor Statistics
CAH Critical Access Hospital
CFR Code of Federal Regulations
CPI Consumer Price Index
CPI–U Consumer Price Index-All Urban Consumers
CPT (Physicians') Current Procedural Terminology
DRG Diagnosis Related Group
ECI Employment Cost Index
FI Fiscal Intermediary
FR Federal Register
FY Fiscal Year
GAO General Accounting Office
HCFA Health Care Financing Administration
HCPCS HCFA Common Procedure Coding System
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IFC Interim Final Rule with Comment Period
MDS Minimum Data Set
MEDPAR Medicare Provider Analysis and Review File
MIP Medicare Integrity Program
MSA Metropolitan Statistical Area
NECMA New England County Metropolitan Area
OIG Office of the Inspector General
OMRA Other Medicare Required Assessment
PCE Personal Care Expenditures
PPI Producer Price Index
PPS Prospective Payment System
PRM Provider Reimbursement Manual
RAI Resident Assessment Instrument
RAP Resident Assessment Protocol
RAVEN Resident Assessment Validation Entry
RUG Resource Utilization Groups
SCHIP State Children's Health Insurance Program
SNF Skilled Nursing Facility
STM Staff Time Measure

I. Background

On July 31, 2000, we published in the **Federal Register** (65 FR 46770), a final rule that set forth updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2001. Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act (the Act), as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA 1999) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000), relating to Medicare payments and consolidated billing for SNFs.

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

Section 4432 of the Balanced Budget Act of 1997 (BBA 1997) 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) of covered SNF services furnished to beneficiaries under Part A of the Medicare program, effective for cost reporting periods beginning on or after July 1, 1998. We propose to update the per diem payment rates for SNFs, for FY 2002. Major elements of the SNF PPS include:

• *Rates.* Per diem Federal rates were established for urban and rural areas using allowable costs from FY 1995 cost reports. These rates also included an estimate of the cost of services that, before July 1, 1998, had been paid under Part B but furnished to Medicare beneficiaries in a SNF during a Part A covered stay. The rates were adjusted annually using a SNF market basket index. Rates were case-mix adjusted using a classification system (Resource Utilization Groups, version III (RUG–III)) based on beneficiary assessments (using the Minimum Data Set (MDS) 2.0). The rates were also adjusted by the hospital wage index to account for geographic variation in wages. (In section II.C of this preamble, we discuss the wage index adjustment in detail, including an examination of the feasibility of developing a wage index based on SNF-specific wage data.) At this time, data for the FY 2002 hospital wage index are not yet available; therefore, the index applied in this proposed rule is the same index used in the July 31, 2000 final rule. A correction notice was published on January 16, 2001 (66 FR 3497) that announced corrections to several of the wage factors. Additionally, as noted in the July 31, 2000 final rule (65 FR 46770), section 101 of BBRA 1999 also affects the payment rate. Finally, sections 311, 312, and 314 of BIPA 2000 affect the Part A PPS payment rates for SNFs. These new provisions are discussed in detail in section I.D. of this proposed rule.

• *Transition.* The SNF PPS includes an initial 3-year, phased transition that blended a facility-specific payment rate with the Federal case-mix adjusted rate. For each cost reporting period after a facility migrated to the new system, the facility-specific portion of the blend decreased and the Federal portion increased in 25 percentage point increments. For most facilities, the facility-specific rate was based on allowable costs from FY 1995; however, since the last year of the transition is FY 2001, all facilities will be paid at the full Federal rate by the coming fiscal year (FY 2002), for which we are now proposing updated rates. Therefore, unlike previous years, this proposed rule does not include adjustment factors related to facility-specific rates for the coming fiscal year.

• *Coverage.* Medicare's fundamental requirements for SNF coverage were not changed by BBA 1997; however, because RUG–III classification is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have attempted, where possible, to coordinate claims review procedures with the outputs of beneficiary assessment and RUG–III classifying activities.

• *Consolidated Billing.* BBA 1997 included a billing provision that required a SNF to submit consolidated Medicare bills for its residents for almost all services that are covered under either Part A or Part B (the statute excluded a small list of services, primarily those of physicians and certain other types of practitioners). With the exception of physical therapy, occupational therapy, and speech-language therapy, section 313 of BIPA 2000 has now limited the scope of this

provision to apply only to those services that are furnished during the course of a resident's covered Part A stay in the SNF, as discussed later in this proposed 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. Part A currently pays for SNF services furnished by swing-bed hospitals on a cost-related basis. Section 1888(e)(7) of the Act requires the SNF PPS to encompass these services no earlier than cost reporting periods beginning on July 1, 1999, and no later than the end of the SNF PPS transition period described in section 1888(e)(2)(E) of the Act.

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

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

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

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

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

In 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.

Along with a number of other revisions discussed later in this preamble, this proposed 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 1999)

There were several provisions in BBRA 1999 that resulted in adjustments to the PPS for SNFs. The provisions were described in the final rule that we published on July 31, 2000 (65 FR 46770). In particular, section 101 provided for a temporary, 20 percent increase in the per diem adjusted payment rates for 15 specified RUG–III groups (SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, CA1, RHC, RMC, and RMB). Section 101 also included a 4 percent across-the-board increase in the adjusted Federal per diem payment rates each year for FYs 2001 and 2002, exclusive of the 20 percent increase.

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

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

The following highlights the major provisions in BIPA 2000 that result in adjustments to the PPS for SNFs:

• *Section 203—Exemption of Critical Access Hospital (CAH) Swing-beds from SNF PPS.* This provision exempts swing-beds in CAHs from section 1888(e)(7) of the Act (as enacted by section 4432(a) of BBA 1997) which applies the SNF PPS to SNF services furnished by swing-bed hospitals. Accordingly, this provision enables CAHs to be paid for their swing-bed SNF services on a reasonable cost basis. This provision is effective with cost reporting periods beginning on or after December 21, 2000, the date of the enactment of this Act. We include further information on this provision in Program Memorandum A–01–09 (January 16, 2001).

• *Section 311—Elimination of Reduction in SNF Market Basket Update in 2001.* This provision eliminates the one percent reduction reflected in the update formula for the Federal rates for FY 2001 that was required by BBA 1997. In implementing this change, this provision modifies the schedule and rates according to which Federal per diem payments are updated. For FY 2002 and FY 2003, the updates would be the market basket index increase minus 0.5 percentage points. This provision also provides a special rule that, for purposes of making payments under the SNF PPS for FY 2001, for the first half of FY 2001 (the period beginning October 1, 2000, and ending March 31, 2001), the market basket update remains at market basket minus 1, and for the second half of the fiscal year (the period beginning on April 1, 2001, and ending on September 30, 2001), the market basket update changes from market basket minus 1 to market basket plus 1.

In addition, this provision requires the General Accounting Office (GAO) to submit a report to Congress by July 1, 2002, on the adequacy of SNF payment rates. It also requires the Secretary to conduct a study of the different systems for categorizing patients in SNFs in a manner that accounts for the relative resource utilization of different patient types, and to submit a report to Congress not later than January 1, 2005.

• *Section 312—Increase in Nursing Component of PPS Federal Rate.* This provision requires the Secretary to increase by 16.66 percent the nursing component of the case-mix adjusted Federal rate specified in the July 31, 2000 final rule (65 FR 46770) for services furnished on or after April 1, 2001, and before October 1, 2002. This provision also requires the GAO to conduct an audit of SNF nursing staff ratios, and to submit a report to Congress by August 1, 2002, including a recommendation on whether the temporary 16.66 percent increase in the nursing component should be continued.

• *Section 313—Application of SNF Consolidated Billing Requirement Limited to Part A Covered Stays.* This provision repeals the consolidated billing requirement for services (other than physical therapy, occupational therapy, and speech-language therapy) furnished to those SNF residents who are in non-covered stays, effective January 1, 2001. It also directs the Secretary to monitor Part B payments for such services, in order to guard against duplicate billing and the excessive provision of services.

• *Section 314—Adjustment of Rehabilitation RUGs to Correct Anomaly in Payment Rates.* For services furnished from April 1, 2001, until the date that RUG refinements are implemented, this provision requires the Secretary to increase by 6.7 percent the adjusted Federal per diem rate for all of the following RUG–III rehabilitation groups: RUC, RUB, RUA, RVC, RVB, RVA, RHC, RHB, RHA, RMC, RMB, RMA, RLB, and RLA. This provision amends section 101(b) of BBRA 1999 and supersedes the 20 percent increase that BBRA 1999 had previously established for the RHC, RMC, and RMB rehabilitation groups, and corrects the resulting anomaly under which the payment rates for these particular groups were actually higher than the rates for some other, more intensive rehabilitation RUGs. This provision also requires the Office of Inspector General (OIG) to review whether the RUG payment structure in effect under BBRA 1999 included incentives for the delivery of inadequate care and report to the Congress by October 1, 2001.

• *Section 315—Establishment of Process for Geographic Reclassification.* This provision explicitly permits the Secretary to establish a geographic reclassification procedure that is specific to SNFs, for purposes of payment for covered SNF services under the PPS. The Secretary may not implement this procedure until the

Secretary has collected data necessary to establish a SNF wage index that is based on wage data from nursing homes.

We include further information on several of these provisions in Program Memorandum A–01–08 (January 16, 2001).

E. Skilled Nursing Facility Prospective Payment—General Overview

The Medicare SNF PPS was implemented for cost reporting periods beginning on or after July 1, 1998. Under the PPS, SNFs are paid through prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services. These payment rates cover all the costs of furnishing covered skilled nursing services (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 BBA 1997) but furnished to Medicare beneficiaries in a SNF during a Part A covered stay. A complete discussion of these provisions appears in the May 12, 1998 interim final rule (63 FR 26252).

1. Payment Provisions—Federal Rate

The 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 who were receiving Part A covered services in a SNF.

In developing the rates for the initial period, we updated costs to the first effective year of PPS (15-month period beginning July 1, 1998) using a SNF market basket index, and then standardized for the costs of facility differences in case-mix and for geographic variations in wages. Providers that received new provider exemptions from the routine cost limits were excluded from the database used to compute the Federal payment rates, as well as costs related to payments for exceptions to the routine cost limits. In accordance with the formula prescribed in BBA 1997, 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. This classification system, RUG–III, utilizes beneficiary assessment data from the Minimum Data Set (MDS) completed by SNFs to assign beneficiaries to one of 44 groups. The May 12, 1998 interim final rule (63 FR 26252) included a complete and detailed description of the RUG–III classification system.

The Federal rates in this proposed rule reflect an update to the rates in the July 31, 2000 update notice (65 FR 46770) equal to the SNF market basket index minus 0.5 percent, as well as the elimination of the 1 percent reduction reflected in the update formula for the FY 2001 payment rates under section 311 of BIPA 2000. According to section 311 of BIPA 2000, for FY 2002, we will update the rate by adjusting the current rates by the SNF market basket change minus 0.5 percent.

2. Payment Provisions—Transition Period

The SNF PPS includes an initial, phased transition from a facility-specific rate (which reflects the individual facility's historical cost experience) to the Federal case-mix adjusted rate. The transition extends through the facility's first three cost reporting periods under the PPS, up to and including the one that begins in FY 2001. Accordingly, starting with cost reporting periods that begin in FY 2002, we will base payments entirely on the Federal rates.

F. Skilled Nursing Facility Market Basket Index

Section 1888(e)(5) of the Act requires the Secretary 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 the covered SNF services. The SNF market basket index is used to update the Federal rates on an annual basis. We are proposing a revised and rebased SNF market basket index that consists of the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses. A complete discussion concerning the design and application of the proposed SNF market basket index is presented in Section III.

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

A. Federal Prospective Payment System

This proposed rule sets forth a schedule of Federal prospective payment rates applicable to Medicare Part A SNF services beginning October 1, 2001. 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.

1. Costs and Services Covered by the Federal Rates

The Federal rates apply to all costs (routine, ancillary, and capital-related costs) of covered SNF services other than costs associated with approved educational activities as defined in § 413.85. Under section 1888(e)(2) 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 26295–97)).

2. Methodology Used for the Calculation of the Federal Rates

The proposed FY 2002 rates would reflect an update using the latest market basket index minus 0.5 percentage point. The FY 2002 market basket update factor is 2.9 percent, and subtracting 0.5 percentage points yields an update of 2.4 percent. For a complete description of the multi-step process, see the May 12, 1998 interim final rule (63 FR 26252). In accordance with section 101 of BBRA 1999 and section 314 of BIPA 2000, we have provided for a temporary increase in the per diem adjusted payment rates of 20 percent for certain specified RUGs, and 6.7 percent for certain others. These temporary increases of 20 percent and 6.7 percent for certain specified RUGs will continue until implementation of case-mix refinements, as described in section 101 of BBRA 1999 and section 314 of BIPA 2000. Also, in accordance with section 101 of BBRA 1999, we are providing a 4 percent increase in the adjusted Federal rate for FY 2002. These temporary adjustments (that is, 20

percent, 6.7 percent, or 4 percent) are not reflected in the rate tables (Tables 1, 2, 3, 4, 5, and 6 of this proposed rule). Rather, in accordance with the statute, they are applied only after all other adjustments (wage and case-mix) have been made. Further, several provisions of BIPA 2000 affect the payment rates for SNFs, as described in the previous section.

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, 2000, and the midpoint of the Federal FY beginning October 1, 2001 and ending September 30, 2002, to which the payment rates apply. In accordance with section 311 of BIPA 2000, the payment rates are updated for FY 2002 by a factor equal to the annual market basket index percentage increase minus 0.5 percentage point. However, we note that section 311 of BIPA 2000 has also eliminated the one percent reduction in the market basket associated with the establishment of the FY 2001 payment rates. Therefore, in establishing the payment rates for FY 2002, we would update from the FY 2001 payment rates determined using the full market basket amount for that year rather than the rates as they appeared in the July 31, 2000 final rule (65 FR 46770), that were determined using the one percent reduction. As modified in this manner to reflect section 311 of BIPA 2000, the FY 2001 rates would be updated using the latest market basket minus 0.5 percentage point to determine the payment rates for FY 2002. The nursing case-mix component of the proposed rates, both urban and rural, includes the 16.66 percent increase provided by section 312 of BIPA 2000. The rates are further adjusted by a wage index budget neutrality factor, described later in this section. Tables 1 and 2 reflect the updated components of the unadjusted Federal rates (including both the market basket adjustment and the 16.66 percent increase in the nursing case-mix component).

TABLE 1.—UNADJUSTED FEDERAL RATE PER DIEM, URBAN

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$137.89	$89.03	$11.73	$60.33

TABLE 2.—UNADJUSTED FEDERAL RATE PER DIEM, RURAL

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$131.76	$102.67	$12.53	$61.44

B. Case-Mix Adjustment

For FY 2002, we are not proposing to modify the case-mix classification system. The payment rates set forth in this proposed rule reflect the continued use of the existing 44-group RUG–III classification system discussed in the May 12, 1998 interim final rule (63 FR 26252). Consequently, we will also maintain the add-ons to the Federal rates for specified RUG–III groups, as required by section 101 of BBRA 1999 and subsequently modified by section 314 of BIPA 2000. The case-mix adjusted payment rates are listed separately for urban and rural SNFs in Tables 3 and 4, with the corresponding case-mix index values. These tables do not reflect the add-ons (that is, 20 percent, 6.7 percent, or 4 percent) provided for in BBRA 1999 and BIPA 2000, which are applied only after all other adjustments (wage and case-mix) have been made.

TABLE 3.—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
RUC	1.30	2.25	179.26	200.32	.....	60.33	439.91
RUB	0.95	2.25	131.00	200.32	.....	60.33	391.65
RUA	0.78	2.25	107.55	200.32	.....	60.33	368.20
RVC	1.13	1.41	155.82	125.53	.....	60.33	341.68
RVB	1.04	1.41	143.41	125.53	.....	60.33	329.27
RVA	0.81	1.41	111.69	125.53	.....	60.33	297.55
RHC	1.26	0.94	173.74	83.69	.....	60.33	317.76
RHB	1.06	0.94	146.16	83.69	.....	60.33	290.18
RHA	0.87	0.94	119.96	83.69	.....	60.33	263.98
RMC	1.35	0.77	186.15	68.55	.....	60.33	315.03
RMB	1.09	0.77	150.30	68.55	.....	60.33	279.18
RMA	0.96	0.77	132.37	68.55	.....	60.33	261.25
RLB	1.11	0.43	153.06	38.28	.....	60.33	251.67
RLA	0.80	0.43	110.31	38.28	.....	60.33	208.92
SE3	1.70	.....	234.41	.....	11.73	60.33	306.47
SE2	1.39	.....	191.67	.....	11.73	60.33	263.73
SE1	1.17	.....	161.33	.....	11.73	60.33	233.39
SSC	1.13	.....	155.82	.....	11.73	60.33	227.88
SSB	1.05	.....	144.78	.....	11.73	60.33	216.84
SSA	1.01	.....	139.27	.....	11.73	60.33	211.33
CC2	1.12	.....	154.44	.....	11.73	60.33	226.50

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

RUG III category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp.	Non-case mix component	Total rate
CC1	0.99	.....	136.51	.....	11.73	60.33	208.57
CB2	0.91	.....	125.48	.....	11.73	60.33	197.54
CB1	0.84	.....	115.83	.....	11.73	60.33	187.89
CA2	0.83	.....	114.45	.....	11.73	60.33	186.51
CA1	0.75	.....	103.42	.....	11.73	60.33	175.48
IB2	0.69	.....	95.14	.....	11.73	60.33	167.20
IB1	0.67	.....	92.39	.....	11.73	60.33	164.45
IA2	0.57	.....	78.60	.....	11.73	60.33	150.66
IA1	0.53	.....	73.08	.....	11.73	60.33	145.14
BB2	0.68	.....	93.77	.....	11.73	60.33	165.83
BB1	0.65	.....	89.63	.....	11.73	60.33	161.69
BA2	0.56	.....	77.22	.....	11.73	60.33	149.28
BA1	0.48	.....	66.19	.....	11.73	60.33	138.25
PE2	0.79	.....	108.93	.....	11.73	60.33	180.99
PE1	0.77	.....	106.18	.....	11.73	60.33	178.24
PD2	0.72	.....	99.28	.....	11.73	60.33	171.34
PD1	0.70	.....	96.52	.....	11.73	60.33	168.58
PC2	0.65	.....	89.63	.....	11.73	60.33	161.69
PC1	0.64	.....	88.25	.....	11.73	60.33	160.31
PB2	0.51	.....	70.32	.....	11.73	60.33	142.38
PB1	0.50	.....	68.95	.....	11.73	60.33	141.01
PA2	0.49	.....	67.57	.....	11.73	60.33	139.63
PA1	0.46	.....	63.43	.....	11.73	60.33	135.49

TABLE 4.—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
RUC	1.30	2.25	171.29	231.01	.....	61.44	463.74
RUB	0.95	2.25	125.17	231.01	.....	61.44	417.62
RUA	0.78	2.25	102.77	231.01	.....	61.44	395.22
RVC	1.13	1.41	148.89	144.76	.....	61.44	355.09
RVB	1.04	1.41	137.03	144.76	.....	61.44	343.23
RVA	0.81	1.41	106.73	144.76	.....	61.44	312.93
RHC	1.26	0.94	166.02	96.51	.....	61.44	323.97
RHB	1.06	0.94	139.67	96.51	.....	61.44	297.62
RHA	0.87	0.94	114.63	96.51	.....	61.44	272.58
RMC	1.35	0.77	177.88	79.06	.....	61.44	318.38
RMB	1.09	0.77	143.62	79.06	.....	61.44	284.12
RMA	0.96	0.77	126.49	79.06	.....	61.44	266.99
RLB	1.11	0.43	146.25	44.15	.....	61.44	251.84
RLA	0.80	0.43	105.41	44.15	.....	61.44	211.00
SE3	1.70	.....	223.99	.....	12.53	61.44	297.96
SE2	1.39	.....	183.15	.....	12.53	61.44	257.12
SE1	1.17	.....	154.16	.....	12.53	61.44	228.13
SSC	1.13	.....	148.89	.....	12.53	61.44	222.86
SSB	1.05	.....	138.35	.....	12.53	61.44	212.32
SSA	1.01	.....	133.08	.....	12.53	61.44	207.05
CC2	1.12	.....	147.57	.....	12.53	61.44	221.54
CC1	0.99	.....	130.44	.....	12.53	61.44	204.41
CB2	0.91	.....	119.90	.....	12.53	61.44	193.87
CB1	0.84	.....	110.68	.....	12.53	61.44	184.65
CA2	0.83	.....	109.36	.....	12.53	61.44	183.33
CA1	0.75	.....	98.82	.....	12.53	61.44	172.79
IB2	0.69	.....	90.91	.....	12.53	61.44	164.88
IB1	0.67	.....	88.28	.....	12.53	61.44	162.25
IA2	0.57	.....	75.10	.....	12.53	61.44	149.07
IA1	0.53	.....	69.83	.....	12.53	61.44	143.80
BB2	0.68	.....	89.60	.....	12.53	61.44	163.57
BB1	0.65	.....	85.64	.....	12.53	61.44	159.61
BA2	0.56	.....	73.79	.....	12.53	61.44	147.76
BA1	0.48	.....	63.24	.....	12.53	61.44	137.21
PE2	0.79	.....	104.09	.....	12.53	61.44	178.06
PE1	0.77	.....	101.46	.....	12.53	61.44	175.43
PD2	0.72	.....	94.87	.....	12.53	61.44	168.84
PD1	0.70	.....	92.23	.....	12.53	61.44	166.20

TABLE 4.—CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES, RURAL—Continued

RUG III category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
PC2	0.65		85.64		12.53	61.44	159.61
PC1	0.64		84.33		12.53	61.44	158.30
PB2	0.51		67.20		12.53	61.44	141.17
PB1	0.50		65.88		12.53	61.44	139.85
PA2	0.49		64.56		12.53	61.44	138.53
PA1	0.46		60.61		12.53	61.44	134.58

We remain committed to efforts to monitor the RUG–III classification system and to pursue refinements in SNF payment. In the proposed rule associated with the FY 2001 SNF PPS update published April 10, 2000 (65 FR 19188), we had discussed options for refinements to the RUG–III classification system to account more accurately for the services provided to medically complex patients. The refinement approaches discussed had a particular focus on ancillary services other than rehabilitation (physical, occupational, and speech-language therapy), such as prescription drugs and respiratory therapy. We described our ongoing research and analyses in this area and shared the initial results that we proposed be incorporated into the Medicare SNF PPS system effective October 1, 2000. In that proposed rule, we cautioned that the proposed RUG–III refinements were based on limited data from seven states from periods prior to the implementation of the SNF PPS (1996 and 1997). Consequently, we indicated our plan to validate the findings using more current data from a broad national sample before issuing a final rule.

As discussed in the final rule published on July 31, 2000 (65 FR 46770), we conducted the validation analyses to determine the predictive power of the proposed case-mix models in identifying variations in non-therapy ancillary costs, using national data from a current period (that is, after the implementation of the SNF PPS). Based on these analyses, we determined that the refinement models developed using the pre-PPS sample were not effective in predicting resource use in the post-PPS environment. We identified several important variations in the post-PPS volume and distribution of beneficiaries and ancillary services costs using the 1999 national data, which appear to have affected the performance of the case-mix refinement models described in the proposed rule. We noted our belief that the introduction of the PPS and consolidated billing provisions for covered Part A SNF stays may have caused changes in facility practice patterns and billing. These changes, as well as the use of the broader national data sample, likely diminished the effectiveness of the models. Accordingly, in the final rule, we indicated our decision not to proceed with the implementation of case-mix refinements for FY 2001.

However, this decision did not in any way reflect a lack of commitment to pursuing appropriate case-mix refinements, and we remain dedicated to achieving this objective as quickly as possible. While the language in section 101 of BBRA 1999 does not directly mandate that we make case-mix refinements, we believe it nonetheless reflects a clear expectation that refinements will occur, by establishing payment adjustments that will expire upon the implementation of case-mix refinements, and by characterizing those adjustments as temporary. Accordingly, we are continuing our active efforts in this area, with the expectation that we will, over the next 12 months, develop case-mix refinements.

The inability of the specific case-mix refinement models based on a pre-PPS study sample (as described in the FY 2001 proposed rule) to explain behavior adequately in the post-PPS data does not warrant the conclusion that further efforts to improve the payment system's ability to allocate payments based on expected ancillary use would be unproductive. In fact, we believe there may well be the potential to establish meaningful refinements in the short term based on the results of a deliberate, comprehensive analysis using the extensive MDS 2.0, claims, and other administrative data now available. Moreover, this research will also provide an important foundation for a longer term analysis which seeks to identify alternative classification approaches in the SNF setting. The analysis we propose to conduct will be included in the report to Congress mandated by section 311 of BIPA 2000. This section requires us to submit the report no later than January 1, 2005. This work may also support a longer term goal, supported by HCFA and MedPAC, of developing more integrated approaches for the payment and delivery system for Medicare post acute services generally.

Therefore, we are currently proceeding with efforts to develop refinements to the RUG–III system, and are in the process of initiating a research contract in this area. We plan to look broadly for alternative refinement approaches that will improve the payment system's ability to account for the variation in resources associated with SNF patients generally, as well as medically complex patients and non-therapy ancillary services more specifically. This may include further analysis to develop a non-therapy ancillary index, similar to that proposed in the FY 2001 proposed rule, as well as exploration of other potential refinement approaches that could utilize information related to service use, function, diagnosis, and co-morbidities. In exploring possible refinement approaches, it is necessary to consider the potential effect of the refinements on aggregate SNF payments, as well as on access to and quality of care. In addition, we recognize the utility of using administrative data (such as claims) in the construction of the case-mix indexes and may, as MedPAC has recommended in the past, examine the potential for using this data to accomplish the tasks we are undertaking. Such an approach would facilitate annual updates to the case-mix indexes similar to the inpatient hospital PPS. In continuing this research, we will carefully consider the comments we received pursuant to the FY 2001 proposed rule. In addition, we specifically solicit comments in this proposed rule regarding possible approaches to refining the case-mix system.

While we recognize the need to seek improvements in the payment system, we are not aware of any substantive findings that demonstrate, as has been

suggested at recent MedPAC meetings, that the RUG–III system has proven to be unworkable. In fact, several recent reports indicate that quality and access do not appear to be impaired. This may be more a function of overall revenues available to SNFs under the PPS, especially considering recent increases in funding under BBRA 1999 and BIPA 2000. Even though they do not affect the current case-mix classification structure, a number of these recent payment increases are nonetheless intended to ensure that facilities continue to be paid appropriately until RUG refinements can be made. We also note that it may be premature to make assumptions regarding the effect of case-mix on provider behavior based on currently available data (which, at this point, still reflect only payments made during the transition period when SNFs received a blend of the Federal rate and facility-specific rate), since provider behavior may change significantly once payment is made under the fully case-mix adjusted Federal rates.

Further, it is worth noting that in research conducted to support the implementation of the SNF PPS, the RUG–III case-mix system was shown to predict approximately 55 percent of the overall variation in nursing and therapy staff time costs across total facility population (that includes both Medicare and Medicaid, as well as other patients). The level of variance explanation is somewhat less across the Medicare population due to its greater homogeneity. While we have not measured this directly, an examination of the 1997 staff time data focusing on patients in Medicare certified units that specialize in medically complex care or intensive rehabilitation found that RUG–III predicted 41 percent of nursing and rehabilitation staff time costs across total facility population (which includes Medicare, Medicaid, and private pay patients). We believe that it continues to be highly effective in this area. While we have found that pharmacy costs are correlated somewhat with the nursing case-mix indexes in RUG–III, it is important to note that such costs are, by and large, difficult to account for in case-mix systems because drug costs do not necessarily follow physical condition, resource use, or functional and clinical pathways.

We look forward to addressing this important issue through the study of alternative case-mix systems required under BIPA 2000, which provides an opportunity for a deliberate analytical approach to the question of how best to refine the current classification system or to redirect Medicare's payment system to produce more equitable payments for providers and best support access and quality of care for Medicare beneficiaries. Similarly, we look forward to the study required under section 545 of BIPA 2000 (required to be completed by January 1, 2005), which requires us to submit a report on the development of standard instruments for the assessment of the health and functional status of patients. We also invite comments on possible approaches to refining the current case-mix classification system, as well as on identifying and studying alternatives to the current system. With regard to the MDS 2.0, we continue to believe that the MDS is an accurate and effective assessment tool, which meets program objectives related to its major purposes of supporting quality of care and providing patient status and treatment information needed to support payment. We are currently engaged in a number of activities that support accurate completion of the MDS. These include expanded provider training, clearer definitions of certain MDS elements and coding instructions, and funding of program safeguard contractor activities to undertake auditing and verification of the MDS. We also note our concern that the OIG's recent reports related to the accuracy of the MDS contained a number of methodological limitations (as acknowledged in the reports) that limit their utility for drawing conclusions about the MDS.

However, we recognize the increased financial incentives that BIPA creates for the rehabilitation categories and the potential for upcoding under the SNF PPS to gain higher payments. In fact, the potential for inappropriate upcoding exists in any prospective payment system that uses coding of clinical information as the basis for determining payment amounts due to providers, and the SNF PPS (which bases payment amounts on the clinical information entered on the MDS) is no exception. In this context, we note that fiscal intermediaries (FIs) will continue reviewing SNF PPS bills. As with current practice, the FIs will focus on identifying instances in which inappropriate services were provided or where the beneficiary did not meet the requirements for Medicare Part A coverage in an SNF. As part of this review, the MDS and the medical record is assessed to verify that the reported information supports the RUG category billed.

We believe that the practice of FIs using a data driven approach to focus medical review efforts will help address the incentive for upcoding. Once bills have been targeted for review, the FIs will identify instances in which inappropriate services were provided or where the beneficiary did not meet the requirements for Medicare Part A coverage in a SNF. As part of this review, the medical record (which includes the MDS) is assessed to verify that the reported information supports the RUG category billed.

To lend further support to program safeguard efforts, we are in the process of awarding a contract to a Medicare Integrity Program (MIP) contractor to provide an ongoing centralized data surveillance process to assess the accuracy and reliability of MDS data particular to the health care furnished by SNFs, and payment for these services. This includes ensuring appropriate payment and payment denial decisions. The findings will produce evidence for further actions at national, regional, and State levels in addressing concerns in the areas of program integrity, beneficiary health and safety, and quality improvement. The contractor is also expected to perform monitoring and data analyses to determine if there are variations over time in the case-mix intensity, and whether those differences represent changes in actual or real case status of beneficiaries rather than changes that reflect improper provider behavior. Through the MIP contractor and the FIs, we will address instances of improper billing through recoupment of improper payments, intensified reviews, and provider education.

Further, in the context of our ongoing efforts to ensure accurate payment for appropriate care, we note a situation regarding rehabilitation therapy that is being provided in SNFs in a manner that conflicts with Medicare coverage guidelines. This issue involves providers that refuse to employ therapists who are unwilling to perform, on a routine basis, concurrent therapy. Concurrent therapy is the practice of one professional therapist treating more than one Medicare beneficiary at a time—in some cases, many more than one individual at a time.

Concurrent therapy is distinguished from group therapy, because all participants in group therapy are working on some common skill development and the ratio of participants to therapist may be no higher than 4 to 1. In addition, in the July 30, 1999 SNF PPS final rule (64 FR 41662), we specified that the minutes of group therapy received by the beneficiary may account for no more than 25 percent of the therapy (per discipline) received in a 7 day period. By contrast, a beneficiary who is receiving concurrent therapy with one or more other beneficiaries likely is not

receiving services that relate to those needed by any of the other participants. Although each beneficiary may be receiving care that is prescribed in his individual plan of treatment, it is not being delivered according to Medicare coverage guidelines; that is, the therapy is not being provided individually, and it is unlikely that the services being delivered are at the complex skill level required for coverage by Medicare.

The Medicare SNF benefit provides coverage of therapy services only when the services are of such a level of complexity and sophistication (or the beneficiary's condition is such) that the services can be safely and effectively performed only by or under the supervision of a qualified professional therapist. Therapy services that are concurrently being delivered by one treating therapist to many beneficiaries would not appear to meet these criteria. If the therapist or therapy assistant can provide distinct services to several beneficiaries at once, then it is unlikely that the services are sufficiently complex and sophisticated to qualify for coverage under the Medicare guidelines.

We note that there have always been isolated instances in which a professional therapist has been allowed to have some overlap in the time of concluding treatment to one individual and the time of commencing the treatment of another, even to the point of briefly providing therapy concurrently in certain cases. However, the key principle here is that Medicare relies on the professional judgment of the therapist to determine when, based on the complexity of the services to be delivered and the condition of the beneficiary, it is appropriate to deliver care to more than one beneficiary at the same time. Our concern now is that in some areas of the country, concurrent therapy is becoming a standard practice rather than the exception, and is being dictated by facility management personnel rather than according to the professional judgment of the therapists involved.

We believe that it is important to heighten the SNF and therapy industries' awareness of the applicable Medicare policy in this regard. Medicare policy has not, until now, specifically addressed coverage of skilled rehabilitation therapy in situations in which a single professional therapist (or therapy assistant under the supervision of the professional therapist) simultaneously provides different treatments to multiple beneficiaries. As noted above, we have relied on the professional therapist's judgment as to when it is appropriate for an individual therapist to provide services to more than one beneficiary. We now wish to advise the providers of care of our concern about the potentially adverse effect of this practice on the quality of the therapy provided to beneficiaries in Part A SNF stays, as well as our concern about the implications of making payments in such situations. We solicit public comments regarding the scope and magnitude of this problem, and possible approaches for addressing this issue.

C. 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 an appropriate wage index, as determined by the Secretary. Section 315 of BIPA 2000 authorizes the Secretary to establish a reclassification system for SNFs, similar to the hospital methodology. This reclassification system cannot be implemented until the Secretary has collected data necessary to establish an area wage index for SNFs based on wage data from such facilities. Pursuant to section 106(a) of the Social Security Act Amendments of 1994 (P.L. 103–432), the Secretary was directed to begin to collect data on employee compensation and paid hours of employment in SNFs for the purpose of constructing a SNF wage index. Since the inception of a PPS for SNFs, we have utilized hospital wage data in developing a wage index to be applied to SNFs.

The computation of the proposed wage index is similar to past years because we incorporate the latest data and methodology used to construct the hospital wage index (see the discussion in the May 12, 1998 interim final rule (63 FR 26274)). The wage index adjustment is applied to the proposed labor-related portion of the Federal rate, which is 75.374 percent of the total rate. This percentage reflects the labor-related relative importance for FY 2002. The labor-related relative importance is calculated from the SNF market basket, and approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2002. 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 2002 than the base year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2002 in four steps. First, we compute the FY 2002 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 2002 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2002 relative importance for each cost category by multiplying this ratio by the base year (FY 1997) weight. Finally, we sum the FY 2002 relative importance for each of the labor-related cost categories (that is, wages and salaries; employee benefits; nonmedical professional fees; labor-intensive services; and, capital-related) to produce the FY 2002 labor-related relative importance. Tables 5 and 6 show the Federal rates by labor-related and non-labor-related components.

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

RUG III category	Total rate	Labor portion	Non-labor portion
RUC	439.91	331.58	108.33
RUB	391.65	295.20	96.45
RUA	368.20	277.53	90.67
RVC	341.68	257.54	84.14
RVB	329.27	248.18	81.09
RVA	297.55	224.28	73.27
RHC	317.76	239.51	78.25
RHB	290.18	218.72	71.46
RHA	263.98	198.97	65.01
RMC	315.03	237.45	77.58
RMB	279.18	210.43	68.75
RMA	261.25	196.91	64.34
RLB	251.67	189.69	61.98
RLA	208.92	157.47	51.45
SE3	306.47	231.00	75.47
SE2	263.73	198.78	64.95
SE1	233.39	175.92	57.47
SSC	227.88	171.76	56.12
SSB	216.84	163.44	53.40
SSA	211.33	159.29	52.04
CC2	226.50	170.72	55.78
CC1	208.57	157.21	51.36
CB2	197.54	148.89	48.65
CB1	187.89	141.62	46.27
CA2	186.51	140.58	45.93
CA1	175.48	132.27	43.21
IB2	167.20	126.03	41.17
IB1	164.45	123.95	40.50
IA2	150.66	113.56	37.10
IA1	145.14	109.40	35.74
BB2	165.83	124.99	40.84
BB1	161.69	121.87	39.82
BA2	149.28	112.52	36.76
BA1	138.25	704.20	34.05
PE2	780.99	136.42	44.57
PE1	178.24	134.35	43.89
PD2	171.34	129.15	42.19
PD1	168.58	127.07	41.51
PC2	161.69	121.87	39.82
PC1	160.31	120.83	39.48
PB2	142.38	107.32	35.06
PB1	141.01	106.28	34.73

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

RUG III category	Total rate	Labor portion	Non-labor portion
PA2	139.63	105.24	34.39
PA1	135.49	102.12	33.37

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

RUG III category	Total rate	Labor portion	Non-labor portion
RUC	463.74	349.54	114.20
RUB	417.62	314.78	102.84
RUA	395.22	297.89	97.33
RVC	355.09	267.65	87.44
RVB	343.23	258.71	84.52
RVA	312.93	235.87	77.06
RHC	323.97	244.19	79.78
RHB	297.62	224.33	73.29
RHA	272.58	205.45	67.13
RMC	318.38	239.98	78.40
RMB	284.12	214.15	69.97
RMA	266.99	201.24	65.75
RLB	251.84	189.82	62.02
RLA	211.00	159.04	51.96
SE3	297.96	224.58	73.38
SE2	257.12	193.80	63.32
SE1	228.13	171.95	56.18
SSC	222.86	167.98	54.88
SSB	212.32	160.03	52.29
SSA	207.05	156.06	50.99
CC2	221.54	166.98	54.56
CC1	204.41	154.07	50.34
CB2	193.87	146.13	47.74
CB1	184.65	139.18	45.47
CA2	183.33	138.18	45.15
CA1	172.79	130.24	42.55
IB2	164.88	124.28	40.60
IB1	162.25	122.29	39.96
IA2	149.07	112.36	36.71
IA1	143.80	108.39	35.41
BB2	163.57	123.29	40.28
BB1	159.61	120.30	39.31
BA2	147.76	111.37	36.39
BA1	137.21	103.42	33.79
PE2	178.06	134.21	43.85
PE1	175.43	132.23	43.20
PD2	168.84	127.26	41.58
PD1	166.20	125.27	40.93
PC2	159.61	120.30	39.31
PC1	158.30	119.32	38.98
PB2	141.17	106.41	34.76
PB1	139.85	105.41	34.44

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

RUG III category	Total rate	Labor portion	Non-labor portion
PA2	138.53	104.42	34.11
PA1	134.58	101.44	33.14

Section 1888(e)(4)(G)(ii) of the Act also requires that the application of this wage index be made in a manner that does not result in aggregate payments that are greater or lesser than would otherwise be made in the absence of the wage adjustment. In this fourth PPS year (Federal rates effective October 1, 2001), we are updating the wage index applicable to SNF payments using the most recent hospital wage data and applying an adjustment to fulfill the budget neutrality requirement. This requirement will be met by multiplying each of the components of the unadjusted Federal rates by a factor equal to the ratio of the volume weighted mean wage adjustment factor (using the wage index from the previous year) to the volume weighted mean wage adjustment factor, using the wage index for the FY beginning October 1, 2001. The same volume weights are used in both the numerator and denominator and will be derived from 1997 Medicare Provider Analysis and Review File (MEDPAR) data. The wage adjustment factor used in this calculation is defined as the labor share of the rate component multiplied by the wage index plus the non-labor share. The proposed budget neutrality factor for FY 2002 is .99939.

Over the past few years, we have received many comments asking that we evaluate a SNF-specific wage index, which would be based solely on wage and hourly data from SNFs. To develop this analysis, a schedule was added to the cost report to gather wage and hourly data from each SNF. In this proposed rule we are publishing a wage index prototype based on SNF data, along with the wage index based on the hospital wage data that was used in the FY 2001 final rule published July 31, 2000 in the **Federal Register** (65 FR 46770).

The wage index computations for the SNF prototype were done in the same manner as the current wage index based on hospital data, except that SNFs use one of three cost reports to report their data: Freestanding SNFs use the HCFA–2540, Worksheet S–3; hospital-based SNFs use the HCFA–2552, Worksheet S–3; and low-volume SNF providers use the HCFA–2540-S, Worksheet S–3.

The SNF-specific wage indexes illustrated in Table 7 include the following categories of data associated with costs paid under the SNF PPS:

- Salaries and hours from freestanding and hospital-based SNFs.
- Home office costs and hours.
- Certain contract labor costs and hours.
- Wage-related costs.

Consistent with the wage index methodology used in the development of the hospital wage index, the wage indexes published here would also continue to exclude the direct and overhead costs of salaries and hours for services not paid through the SNF PPS, such as home health services, and other sub-provider components that are not subject to the PPS. In addition, as is done in computing the hospital wage index, we would phase out costs associated with graduate medical education (GME) (teaching physicians and residents). For purposes of illustrating the wage indexes shown in Table 7, the SNF wage index is based on a blend of 60 percent of an average hourly wage including the GME costs, and 40 percent of an average hourly wage excluding these costs.

Table 7 shows a side by side comparison of the wage index. Column A shows the Metropolitan Statistical Area (MSA); Column B shows the wage index, utilizing data derived from SNFs with cost reporting periods ending during FY 1998; Column C shows the wage index developed using SNF data from cost reporting periods ending during FY 1999; and Column D shows the wage index from the FY 2001 final rule, as revised by the correction notice published on January 16, 2001 (66 FR 3497).

TABLE 7.—WAGE INDEX FOR URBAN AREAS

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
0040 Abilene, TX Taylor, TX	0.7354	0.8162	0.8240
0060 Aguadilla, PR Aguada, PR	0.0000	0.0000	0.4391

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
Aguadilla, PR Moca, PR			
0080 Akron, OH Portage, OH Summit, OH	0.9636	1.0553	0.9736
0120 Albany, GA Dougherty, GA Lee, GA	0.6203	0.7460	0.9933
0160 Albany-Schenectady-Troy, NY Albany, NY Montgomery, NY Rensselaer, NY Saratoga, NY Schenectady, NY Schoharie, NY	1.0860	1.0809	0.8549
0200 Albuquerque, NM Bernalillo, NM Sandoval, NM Valencia, NM	0.7892	0.7980	0.9136
0220 Alexandria, LA Rapides, LA	0.7849	0.6318	0.8123
0240 Allentown-Bethlehem-Easton, PA Carbon, PA Lehigh, PA Northampton, PA	1.1553	1.0749	0.9925
0280 Altoona, PA Blair, PA	0.9559	0.9712	0.9346
0320 Amarillo, TX Potter, TX Randall, TX	0.8377	0.8338	0.8715
0380 Anchorage, AK Anchorage, AK	1.5003	1.4716	1.2793
0440 Ann Arbor, MI Lenawee, MI Livingston, MI Washtenaw, MI	1.0845	1.1059	1.1254
0450 Anniston, AL Calhoun, AL	0.7619	0.9226	0.8284
0460 Appleton-Oshkosh-Neenah, WI Calumet, WI Outagamie, WI Winnebago, WI	1.0962	1.0662	0.9052
0470 Arecibo, PR Arecibo, PR Camuy, PR Hatillo, PR	0.0000	0.0000	0.4525
0480 Asheville, NC Buncombe, NC Madison, NC	0.9090	0.9482	0.9516
0500 Athens, GA Clarke, GA Madison, GA Oconee, GA	0.9653	0.9264	0.9739
0520 Atlanta, GA Barrow, GA Bartow, GA Carroll, GA Cherokee, GA Clayton, GA Cobb, GA Coweta, GA De Kalb, GA Douglas, GA Fayette, GA Forsyth, GA Fulton, GA Gwinnett, GA Henry, GA Newton, GA Paulding, GA Pickens, GA Rockdale, GA Spalding, GA Walton, GA	0.9733	0.9474	1.0096
0560 Atlantic City-Cape May, NJ Atlantic City, NJ Cape May, NJ	1.1443	1.1406	1.1182

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
0580 Auburn-Opelika, AL	0.9892	0.8857	0.8106
Lee, AL			
0600 Augusta-Aiken, GA-SC	0.7831	0.7898	0.9160
Columbia, GA			
McDuffie, GA			
Richmond, GA			
Aiken, SC			
Edgefield, SC			
0640 Austin-San Marcos, TX	0.8694	0.8826	0.9577
Bastrop, TX			
Caldwell, TX			
Hays, TX			
Travis, TX			
Williamson, TX			
0680 Bakersfield, CA	1.0005	1.0059	0.9678
Kern, CA			
0720 Baltimore, MD	1.0144	0.9797	0.9365
Anne Arundel, MD			
Baltimore, MD			
Baltimore City, MD			
Carroll, MD			
Harford, MD			
Howard, MD			
Queen Annes, MD			
0733 Bangor, ME	1.0358	0.8851	0.9561
Penobscot, ME			
0743 Barnstable-Yarmouth, MA	1.2663	1.2722	1.3839
Barnstable, MA			
0760 Baton Rouge, LA	0.7459	0.7803	0.8842
Ascension, LA			
East Baton Rouge, LA			
Livingston, LA			
West Baton Rouge, LA			
0840 Beaumont-Port Arthur, TX	0.8049	0.7895	0.8744
Hardin, TX			
Jefferson, TX			
Orange, TX			
0860 Bellingham, WA	0.9121	0.8984	1.1439
Whatcom, WA			
0870 Benton Harbor, MI	0.8766	0.9098	0.8671
Berrien, MI			
0875 Bergen-Passaic, NJ	1.3811	1.2739	1.1848
Bergen, NJ			
Passaic, NJ			
0880 Billings, MT	0.9429	0.9017	0.9585
Yellowstone, MT			
0920 Biloxi-Gulfport-Pascagoula, MS	0.8023	0.9676	0.8236
Hancock, MS			
Harrison, MS			
Jackson, MS			
0960 Binghamton, NY	0.9400	0.9231	0.8690
Broome, NY			
Tioga, NY			
1000 Birmingham, AL	0.8846	0.9155	0.8452
Blount, AL			
Jefferson, AL			
St. Clair, AL			
Shelby, AL			
1010 Bismarck, ND	0.8939	0.8745	0.7705
Burleigh, ND			
Morton, ND			
1020 Bloomington, IN	0.8272	0.9108	0.8733
Monroe, IN			
1040 Bloomington-Normal, IL	0.8547	0.9268	0.9095
McLean, IL			
1080 Boise City, ID	1.0779	0.9592	0.9006
Ada, ID			
Canyon, ID			
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.2273	1.1947	1.1160
Bristol, MA			
Essex, MA			
Middlesex, MA			
Norfolk, MA			
Plymouth, MA			
Suffolk, MA			
Worcester, MA			
Hillsborough, NH			

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
Merrimack, NH Rockingham, NH Strafford, NH			
1125 Boulder-Longmont, CO Boulder, CO	1.1414	0.9062	0.9731
1145 Brazoria, TX Brazoria, TX	0.7869	0.7187	0.8658
1150 Bremerton, WA Kitsap, WA	0.9945	0.9732	1.0975
1240 Brownsville-Harlingen-San Benito, TX Cameron, TX	0.8226	0.7991	0.8722
1260 Bryan-College Station, TX Brazos, TX	0.8326	0.6742	0.8237
1280 Buffalo-Niagara Falls, NY Erie, NY Niagara, NY	1.0114	0.9494	0.9580
1303 Burlington, VT Chittenden, VT Franklin, VT Grand Isle, VT	1.0690	1.0145	1.0735
1310 Caguas, PR Caguas, PR Cayey, PR Cidra, PR Gurabo, PR San Lorenzo, PR	0.0000	0.0000	0.4562
1320 Canton-Massillon, OH Carroll, OH Stark, OH	0.9343	0.8839	0.8584
1350 Casper, WY Natrona, WY	0.7798	0.8405	0.8724
1360 Cedar Rapids, IA Linn, IA	0.8652	0.9390	0.8736
1400 Champaign-Urbana, IL Champaign, IL	0.9478	1.0588	0.9198
1440 Charleston-North Charleston, SC Berkeley, SC Charleston, SC Dorchester, SC	0.7764	0.7695	0.9038
1480 Charleston, WV Kanawha, WV Putnam, WV	0.9525	0.9975	0.9240
1520 Charlotte-Gastonia-Rock Hill, NC–SC Cabarrus, NC Gaston, NC Lincoln, NC Mecklenburg, NC Rowan, NC Stanly, NC Union, NC York, SC	1.0230	0.9661	0.9407
1540 Charlottesville, VA Albemarle, VA Charlottesville City, VA Fluvanna, VA Greene, VA	0.9619	0.9943	1.0789
1560 Chattanooga, TN–GA Catoosa, GA Dade, GA Walker, GA Hamilton, TN Marion, TN	0.9186	0.8876	0.9833
1580 Cheyenne, WY Laramie, WY	1.0743	0.9800	0.8308
1600 Chicago, IL Cook, IL De Kalb, IL Du Page, IL Grundy, IL Kane, IL Kendall, IL Lake, IL McHenry, IL Will, IL	0.9358	0.9860	1.1146
1620 Chico-Paradise, CA Butte, CA	0.9238	0.9565	0.9918

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
1640 Cincinnati, OH–KY–IN	0.9579	0.9615	0.9415
Dearborn, IN			
Ohio, IN			
Boone, KY			
Campbell, KY			
Gallatin, KY			
Grant, KY			
Kenton, KY			
Pendleton, KY			
Brown, OH			
Clermont, OH			
Hamilton, OH			
Warren, OH			
1660 Clarksville-Hopkinsville, TN–KY	0.7928	0.7668	0.8204
Christian, KY			
Montgomery, TN			
1680 Cleveland-Lorain-Elyria, OH	1.0330	1.0271	0.9597
Ashtabula, OH			
Geauga, OH			
Cuyahoga, OH			
Lake, OH			
Lorain, OH			
Medina, OH			
1720 Colorado Springs, CO	0.8972	0.9387	0.9697
El Paso, CO			
1740 Columbia, MO	0.9174	0.8050	0.8961
Boone, MO			
1760 Columbia, SC	0.9423	0.9195	0.9554
Lexington, SC			
Richland, SC			
1800 Columbus, GA–AL	0.7897	0.8062	0.8568
Russell, AL			
Chattanoochee, GA			
Harris, GA			
Muscogee, GA			
1840 Columbus, OH	1.0294	1.0288	0.9619
Delaware, OH			
Fairfield, OH			
Franklin, OH			
Licking, OH			
Madison, OH			
Pickaway, OH			
1880 Corpus Christi, TX	0.8333	0.8573	0.8726
Nueces, TX			
San Patricio, TX			
1890 Corvallis, OR	0.7759	0.8492	1.1326
Benton, OR			
1900 Cumberland, MD–WV	0.8879	0.9957	0.8369
Allegany, MD			
Mineral, WV			
1920 Dallas, TX	0.8943	0.9558	0.9913
Collin, TX			
Dallas, TX			
Denton, TX			
Ellis, TX			
Henderson, TX			
Hunt, TX			
Kaufman, TX			
Rockwall, TX			
1950 Danville, VA	0.7390	0.7589	0.8589
Danville City, VA			
Pittsylvania, VA			
1960 Davenport-Moline-Rock Island, IA–IL	0.8633	0.8694	0.8898
Scott, IA			
Henry, IL			
Rock Island, IL			
2000 Dayton-Springfield, OH	0.9102	0.9455	0.9442
Clark, OH			
Greene, OH			
Miami, OH			
Montgomery, OH			
2020 Daytona Beach, FL	0.8922	0.9231	0.9200
Flagler, FL			
Volusia, FL			
2030 Decatur, AL	0.9186	0.8669	0.8534
Lawrence, AL			
Morgan, AL			

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
2040 Decatur, IL	0.8804	0.8322	0.8125
Macon, IL			
2080 Denver, CO	1.0833	1.0643	1.0181
Adams, CO			
Arapahoe, CO			
Denver, CO			
Douglas, CO			
Jefferson, CO			
2120 Des Moines, IA	0.9003	0.9712	0.9118
Dallas, IA			
Polk, IA			
Warren, IA			
2160 Detroit, MI	0.9798	0.9957	1.0510
Lapeer, MI			
Macomb, MI			
Monroe, MI			
Oakland, MI			
St. Clair, MI			
Wayne, MI			
2180 Dothan, AL	0.7485	0.8621	0.7943
Dale, AL			
Houston, AL			
2190 Dover, DE	1.1346	1.0334	1.0078
Kent, DE			
2200 Dubuque, IA	0.9533	1.0244	0.8746
Dubuque, IA			
2240 Duluth-Superior, MN–WI	0.9492	1.0842	1.0032
St. Louis, MN			
Douglas, WI			
2281 Dutchess County, NY	1.0745	1.1267	1.0249
Dutchess, NY			
2290 Eau Claire, WI	0.9402	0.9868	0.8790
Chippewa, WI			
Eau Claire, WI			
2320 El Paso, TX	0.7912	0.8687	0.9346
El Paso, TX			
2330 Elkhart-Goshen, IN	1.0718	0.9752	0.9145
Elkhart, IN			
2335 Elmira, NY	1.0063	1.0535	0.8546
Chemung, NY			
2340 Enid, OK	0.7874	0.7879	0.8610
Garfield, OK			
2360 Erie, PA	1.0605	1.0583	0.8985
Erie, PA			
2400 Eugene-Springfield, OR	0.8713	0.8417	1.0965
Lane, OR			
2440 Evansville-Henderson, IN–KY	0.9297	0.9342	0.8173
Posey, IN			
Vanderburgh, IN			
Warrick, IN			
Henderson, KY			
2520 Fargo-Moorhead, ND–MN	0.9621	1.0643	0.8749
Clay, MN			
Cass, ND			
2560 Fayetteville, NC	0.8495	0.8584	0.8655
Cumberland, NC			
2580 Fayetteville-Springdale-Rogers, AR	0.8193	0.8512	0.7910
Benton, AR			
Washington, AR			
2620 Flagstaff, AZ–UT	1.2591	1.0997	1.0686
Coconino, AZ			
Kane, UT			
2640 Flint, MI	0.9788	0.9726	1.1205
Genesee, MI			
2650 Florence, AL	0.9251	0.9031	0.7616
Colbert, AL			
Lauderdale, AL			
2655 Florence, SC	0.7684	0.7799	0.8777
Florence, SC			
2670 Fort Collins-Loveland, CO	0.9010	0.9680	1.0647
Larimer, CO			
2680 Ft. Lauderdale, FL	0.9681	0.9625	1.0121
Broward, FL			
2700 Fort Myers-Cape Coral, FL	0.9444	0.8951	0.9247
Lee, FL			
2710 Fort Pierce-Port St. Lucie, FL	1.0172	0.9880	0.9538
Martin, FL			

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
St. Lucie, FL			
2720 Fort Smith, AR–OK	0.7268	0.7499	0.8052
Crawford, AR			
Sebastian, AR			
Sequoyah, OK			
2750 Fort Walton Beach, FL	0.9440	0.9582	0.9607
Okaloosa, FL			
2760 Fort Wayne, IN .	0.9082	0.9763	0.8665
Adams, IN			
Allen, IN			
De Kalb, IN			
Huntington, IN			
Wells, IN			
Whitley, IN			
2800 Forth Worth-Arlington, TX	0.8821	0.9047	0.9527
Hood, TX			
Johnson, TX			
Parker, TX			
Tarrant, TX			
2840 Fresno, CA	0.8738	0.9823	1.0104
Fresno, CA			
Madera, CA			
2880 Gadsden, AL	0.9108	0.6287	0.8423
Etowah, AL			
2900 Gainesville, FL	0.9325	1.0300	1.0074
Alachua, FL			
2920 Galveston-Texas City, TX	0.7678	0.6821	0.9918
Galveston, TX			
2960 Gary, IN	0.9827	0.9807	0.9454
Lake, IN			
Porter, IN			
2975 Glens Falls, NY	0.9560	0.9772	0.8361
Warren, NY			
Washington, NY			
2980 Goldsboro, NC	0.9370	0.8740	0.8423
Wayne, NC			
2985 Grand Forks, ND–MN	0.8816	0.9022	0.8816
Polk, MN			
Grand Forks, ND			
2995 Grand Junction, CO	0.9539	0.9156	0.9109
Mesa, CO.			
3000 Grand Rapids-Muskegon-Holland, MI	0.9715	0.9978	1.0248
Allegan, MI			
Kent, MI			
Muskegon, MI			
Ottawa, MI			
3040 Great Falls, MT	0.9712	1.0019	0.9065
Cascade, MT			
3060 Greeley, CO	0.9253	0.8880	0.9814
Weld, CO			
3080 Green Bay, WI	0.9441	1.0262	0.9225
Brown, WI			
3120 Greensboro-Winston-Salem-High Point, NC	1.0166	0.9782	0.9131
Alamance, NC			
Davidson, NC			
Davie, NC			
Forsyth, NC			
Guilford, NC			
Randolph, NC			
Stokes, NC			
Yadkin, NC			
3150 Greenville, NC	0.8844	0.9400	0.9384
Pitt, NC			
3160 Greenville-Spartanburg-Anderson, SC	0.8362	0.9622	0.9003
Anderson, SC			
Cherokee, SC			
Greenville, SC			
Pickens, SC			
Spartanburg, SC			
3180 Hagerstown, MD	0.9318	0.9153	0.9409
Washington, MD			
3200 Hamilton-Middletown, OH	0.9739	0.9532	0.9061
Butler, OH			
3240 Harrisburg-Lebanon-Carlisle, PA	1.1052	1.0753	0.9386
Cumberland, PA			
Dauphin, PA			
Lebanon, PA			

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
Perry, PA			
3283 Hartford, CT	1.2733	1.1675	1.1373
Hartford, CT			
Litchfield, CT			
Middlesex, CT			
Tolland, CT			
3285 Hattiesburg, MS	0.8421	0.7540	0.7490
Forrest, MS			
Lamar, MS			
3290 Hickory-Morganton-Lenoir, NC	0.9086	0.9027	0.9008
Alexander, NC			
Burke, NC			
Caldwell, NC			
Catawba, NC			
3320 Honolulu, HI	1.2242	1.2838	1.1863
Honolulu, HI			
3350 Houma, LA	0.6694	0..6749	0.8086
Lafourche, LA			
Terrebonne, LA			
3360 Houston, TX	0.8506	0.8634	0.9732
Chambers, TX			
Fort Bend, TX			
Harris, TX			
Liberty, TX			
Montgomery, TX			
Waller, TX			
3400 Huntington-Ashland, WV–KY–OH	0.7948	0.8957	0.9876
Boyd, KY			
Carter, KY			
Greenup, KY			
Lawrence, OH			
Cabell, WV			
Wayne, WV			
3440 Huntsville, AL	0.9774	0.7569	0.8932
Limestone, AL			
Madison, AL			
3480 Indianapolis, IN	0.9932	1.0128	0.9787
Boone, IN			
Hamilton, IN			
Hancock, IN			
Hendricks, IN			
Johnson, IN			
Madison, IN			
Marion, IN			
Morgan, IN			
Shelby, IN			
3500 Iowa City, IA	0.9092	0.8611	0.9657
Johnson, IA			
3520 Jackson, MI	0.9393	1.0367	0.9134
Jackson, MI			
3560 Jackson, MS	0.8731	0.9642	0.8812
Hinds, MS			
Madison, MS			
Rankin, MS			
3580 Jackson, TN	0.9437	0.8032	0.8796
Chester, TN			
Madison, TN			
3600 Jacksonville, FL	0.9566	0.9309	0.9208
Clay, FL			
Duval, FL			
Nassau, FL			
St. Johns, FL			
3605 Jacksonville, NC	0.6554	0.8257	0.7777
Onslow, NC			
3610 Jamestown, NY	0.9276	0.8990	0.7818
Chautaqua, NY			
3620 Janesville-Beloit, WI	0.8899	0.9652	0.9585
Rock, WI			
3640 Jersey City, NJ	1.2879	0.8535	1.1502
Hudson, NJ			
3660 Johnson City-Kingsport-Bristol, TN–VA	0.8853	0.8303	0.8272
Carter, TN			
Hawkins, TN			
Sullivan, TN			
Unicoi, TN			
Washington, TN			
Bristol City, VA			

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
Scott, VA Washington, VA			
3680 Johnstown, PA Cambria, PA Somerset, PA	0.9877	0.9914	0.8846
3700 Jonesboro, AR Craighead, AR	0.6568	0.8322	0.7832
3710 Joplin, MO Jasper, MO Newton, MO	0.8112	0.8128	0.8148
3720 Kalamazoo-Battle Creek, MI Calhoun, MI Kalamazoo, MI Van Buren, MI	0.9773	0.9982	1.0453
3740 Kankakee, IL Kankakee, IL	0.8635	0.8886	0.9902
3760 Kansas City, KS–MO Johnson, KS Leavenworth, KS Miami, KS Wyandotte, KS Cass, MO Clay, MO Clinton, MO Jackson, MO Lafayette, MO Platte, MO Ray, MO	0.9439	0.9726	0.9527
3800 Kenosha, WI Kenosha, WI	1.1006	1.0354	0.9611
3810 Killeen-Temple, TX Bell, TX Coryell, TX	0.7996	0.8280	1.0119
3840 Knoxville, TN Anderson, TN Blount, TN Knox, TN Loudon, TN Sevier, TN Union, TN	0.9046	0.8712	0.8340
3850 Kokomo, IN Howard, IN Tipton, IN	1.0415	0.8785	0.9518
3870 La Crosse, WI–MN Houston, MN La Crosse, WI	0.9343	0.9838	0.9211
3880 Lafayette, LA Acadia, LA Lafayette, LA St. Landry, LA St. Martin, LA	0.7373	0.7000	0.8490
3920 Lafayette, IN Clinton, IN Tippecanoe, IN	1.0308	0.9298	0.8834
3960 Lake Charles, LA Calcasieu, LA	0.7437	0.7102	0.7399
3980 Lakeland-Winter Haven, FL Polk, FL	1.0545	1.0235	0.9239
4000 Lancaster, PA Lancaster, PA	1.0528	1.0114	0.9259
4040 Lansing-East Lansing, MI Clinton, MI Eaton, MI Ingham, MI	0.9933	1.0271	0.9934
4080 Laredo, TX Webb, TX	0.7832	0.8348	0.8168
4100 Las Cruces, NM Dona Ana, NM	0.6816	0.7263	0.8658
4120 Las Vegas, NV–AZ Mohave, AZ Clark, NV Nye, NV	1.0189	1.0278	1.0796
4150 Lawrence, KS Douglas, KS	0.9625	0.9352	0.8190
4200 Lawton, OK Comanche, OK	0.6546	0.7951	0.8996
4243 Lewiston-Auburn, ME	0.8717	0.9202	0.9036

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
Androscoggin, ME			
4280 Lexington, KY	0.9208	0.7549	0.8866
Bourbon, KY			
Clark, KY			
Fayette, KY			
Jessamine, KY			
Madison, KY			
Scott, KY			
Woodford, KY			
4320 Lima, OH	0.8609	0.9397	0.9320
Allen, OH			
Auglaize, OH			
4360 Lincoln, NE	1.0497	1.0192	0.9626
Lancaster, NE			
4400 Little Rock-North Little Rock, AR	0.9213	0.9210	0.8906
Faulkner, AR			
Lonoke, AR			
Pulaski, AR			
Saline, AR			
4420 Longview-Marshall, TX	0.7978	0.9291	0.8922
Gregg, TX			
Harrison, TX			
Upshur, TX			
4480 Los Angeles-Long Beach, CA	1.0083	1.0129	1.1996
Los Angeles, CA			
4520 Louisville, KY–IN	0.9433	0.9206	0.9350
Clark, IN			
Floyd, IN			
Harrison, IN			
Scott, IN			
Bullitt, KY			
Jefferson, KY			
Oldham, KY			
4600 Lubbock, TX	0.7676	0.7802	0.8838
Lubbock, TX			
4640 Lynchburg, VA	0.8673	0.8209	0.8867
Amherst, VA			
Bedford City, VA			
Bedford, VA			
Campbell, VA			
Lynchburg City, VA			
4680 Macon, GA	0.8420	0.7877	0.8974
Bibb, GA			
Houston, GA			
Jones, GA			
Peach, GA			
Twiggs, GA			
4720 Madison, WI	0.9982	1.0705	1.0271
Dane, WI			
4800 Mansfield, OH	0.8294	0.9051	0.8690
Crawford, OH			
Richland, OH			
4840 Mayaguez, PR	0.0000	0.0000	0.4589
Anasco, PR			
Cabo Rojo, PR			
Hormigueros, PR			
Mayaguez, PR			
Sabana Grande, PR			
San German, PR			
4880 McAllen-Edinburg-Mission, TX	0.8136	0.7935	0.8566
Hidalgo, TX			
4890 Medford-Ashland, OR	0.9732	0.9528	1.0344
Jackson, OR			
4900 Melbourne-Titusville-Palm Bay, FL	1.0452	1.0178	0.9688
Brevard, Fl			
4920 Memphis, TN–AR–MS	0.9554	0.9919	0.8723
Crittenden, AR			
De Soto, MS			
Fayette, TN			
Shelby, TN			
Tipton, TN			
4940 Merced, CA	0.7959	0.9022	0.9646
Merced, CA			
5000 Miami, FL	0.9359	0.9577	1.0059
Dade, FL			
5015 Middlesex-Somerset-Hunterdon, NJ	1.1283	1.2052	1.1075
Hunterdon, NJ			

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
Middlesex, NJ			
Somerset, NJ			
5080 Milwaukee-Waukesha, WI	1.0373	1.0397	0.9767
Milwaukee, WI			
Ozaukee, WI			
Washington, WI			
Waukesha, WI			
5120 Minneapolis-St Paul, MN–WI	1.2186	1.2375	1.1017
Anoka, MN			
Carver, MN			
Chisago, MN			
Dakota, MN			
Hennepin, MN			
Isanti, MN			
Ramsey, MN			
Scott, MN			
Sherburne, MN			
Washington, MN			
Wright, MN			
Pierce, WI			
St. Croix, WI			
5140 Missoula, MT	0.9197	0.8724	0.9274
Missoula, MT			
5160 Mobile, AL	0.8273	0.9284	0.8163
Baldwin, AL			
Mobile, AL			
5170 Modesto, CA	0.8732	0.9675	1.0396
Stanislaus, CA			
5190 Monmouth-Ocean, NJ	1.1251	1.0979	1.1278
Monmouth, NJ			
Ocean, NJ			
5200 Monroe, LA	0.7793	0.8161	0.8396
Ouachita, LA			
5240 Montgomery, AL	0.7738	0.8229	0.7653
Autauga, AL			
Elmore, AL			
Montgomery, AL			
5280 Muncie, IN	0.9597	0.9550	1.0969
Delaware, IN			
5330 Myrtle Beach, SC	0.9077	0.7922	0.8440
Horry, SC			
5345 Naples, FL	0.9628	1.0437	0.9661
Collier, FL			
5360 Nashville, TN	0.9408	0.9345	0.9490
Cheatham, TN			
Davidson, TN			
Dickson, TN			
Robertson, TN			
Rutherford, TN			
Sumner, TN			
Williamson, TN			
Wilson, TN			
5380 Nassau-Suffolk, NY	1.5592	1.5034	1.3932
Nassau, NY			
Suffolk, NY			
5483 New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2799	1.3446	1.2297
Fairfield, CT			
New Haven, CT			
5523 New London-Norwich, CT	1.2035	1.2438	1.2063
New London, CT			
5560 New Orleans, LA	0.8077	0.8436	0.9295
Jefferson, LA			
Orleans, LA			
Plaquemines, LA			
St. Bernard, LA			
St. Charles, LA			
St. James, LA			
St. John The Baptist, LA			
St. Tammany, LA			
5600 New York, NY	1.5638	1.4983	1.4651
Bronx, NY			
Kings, NY			
New York, NY			
Putnam, NY			
Queens, NY			
Richmond, NY			
Rockland, NY			

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
Westchester, NY			
5640 Newark, NJ	1.2344	1.1704	1.1837
Essex, NJ			
Morris, NJ			
Sussex, NJ			
Union, NJ			
Warren, NJ			
5660 Newburgh, NY–PA	1.2791	1.2347	1.0847
Orange, NY			
Pike, PA			
5720 Norfolk-Virginia Beach-Newport News, VA–NC	0.8084	0.7828	0.8412
Currituck, NC			
Chesapeake City, VA			
Gloucester, VA			
Hampton City, VA			
Isle of Wight, VA			
James City, VA			
Mathews, VA			
Newport News City, VA			
Norfolk City, VA			
Poquoson City, VA			
Portsmouth City, VA			
Suffolk City, VA			
Virginia Beach City, VA			
Williamsburg City, VA			
York, VA			
5775 Oakland, CA	1.0815	1.0616	1.4983
Alameda, CA			
Contra Costa, CA			
5790 Ocala, FL	0.9967	0.7345	0.9243
Marion, FL			
5800 Odessa-Midland, TX	0.7857	0.8858	0.9205
Ector, TX			
Midland, TX			
5880 Oklahoma City, OK	0.7911	0.7955	0.8822
Canadian, OK			
Cleveland, OK			
Logan, OK			
McClain, OK			
Oklahoma, OK			
Pottawatomie, OK			
5910 Olympia, WA	0.9888	0.9548	1.0677
Thurston, WA			
5920 Omaha, NE–IA	1.0212	1.0731	0.9572
Pottawattamie, IA			
Cass, NE			
Douglas, NE			
Sarpy, NE			
Washington, NE			
5945 Orange County, CA	1.0747	1.0649	1.1467
Orange, CA			
5960 Orlando, FL	0.9445	0.9566	0.9610
Lake, FL			
Orange, FL			
Osceola, FL			
Seminole, FL			
5990 Owensboro, KY	1.0374	0.8987	0.8159
Daviess, KY			
6015 Panama City, FL	0.9224	0.9344	0.9010
Bay, FL			
6020 Parkersburg-Marietta, WV–OH	0.9779	0.9064	0.8274
Washington, OH			
Wood, WV			
6080 Pensacola, FL	0.7929	0.8519	0.8176
Escambia, FL			
Santa Rosa, FL			
6120 Peoria-Pekin, IL	0.8375	0.9017	0.8645
Peoria, IL			
Tazewell, IL			
Woodford, IL			
6160 Philadelphia, PA–NJ	1.1553	1.1460	1.0937
Burlington, NJ			
Camden, NJ			
Gloucester, NJ			
Salem, NJ			
Bucks, PA			
Chester, PA			

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
Delaware, PA Montgomery, PA Philadelphia, PA			
6200 Phoenix-Mesa, AZ Maricopa, AZ Pinal, AZ	1.0176	1.0219	0.9669
6240 Pine Bluff, AR Jefferson, AR	0.6727	0.7983	0.7791
6280 Pittsburgh, PA Allegheny, PA Beaver, PA Butler, PA Fayette, PA Washington, PA Westmoreland, PA	1.0937	1.0574	0.9741
6323 Pittsfield, MA Berkshire, MA	1.1357	1.0739	1.0288
6340 Pocatello, ID Bannock, ID	0.7864	0.7717	0.9076
6360 Ponce, PR Guayanilla, PR Juana Diaz, PR Penuelas, PR Ponce, PR Villalba, PR Yauco, PR	0.7238	0.6854	0.5006
6403 Portland, ME Cumberland, ME Sagadahoc, ME York, ME	1.0594	1.0378	0.9748
6440 Portland-Vancouver, OR–WA Clackamas, OR Columbia, OR Multnomah, OR Washington, OR Yamhill, OR Clark, WA	1.0495	1.0048	1.0910
6483 Providence-Warwick-Pawtucket, RI Bristol, RI Kent, RI Newport, RI Providence, RI Washington, RI	1.0486	1.0120	1.0864
6520 Provo-Orem, UT Utah, UT	0.7640	0.9453	1.0029
6560 Pueblo, CO Pueblo, CO	0.8689	0.9305	0.8815
6580 Punta Gorda, FL Charlotte, FL	0.9549	0.9761	0.9613
6600 Racine, WI Racine, WI	1.1701	1.1432	0.9246
6640 Raleigh-Durham-Chapel Hill, NC Chatham, NC Durham, NC Franklin, NC Johnston, NC Orange, NC Wake, NC	1.0767	1.0122	0.9646
6660 Rapid City, SD Pennington, SD	0.7728	0.9584	0.8865
6680 Reading, PA Berks, PA	1.0531	1.1283	0.9152
6690 Redding, CA Shasta, CA	1.1269	1.0330	1.1664
6720 Reno, NV Washoe, NV	1.0926	1.2112	1.0550
6740 Richland-Kennewick-Pasco, WA Benton, WA Franklin, WA	1.0241	1.0334	1.1460
6760 Richmond-Petersburg, VA Charles City County, VA Chesterfield, VA Colonial Heights City, VA Dinwiddie, VA Goochland, VA Hanover, VA Henrico, VA	0.7927	0.8517	0.9617

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
Hopewell City, VA			
New Kent, VA			
Petersburg City, VA			
Powhatan, VA			
Prince George, VA			
Richmond City, VA			
6780 Riverside-San Bernardino, CA	1.0127	1.0086	1.1239
Riverside, CA			
San Bernardino, CA			
6800 Roanoke, VA	0.7443	0.8052	0.8750
Botetourt, VA			
Roanoke, VA			
Roanoke City, VA			
Salem City, VA			
6820 Rochester, MN	1.1764	1.1235	1.1315
Olmsted, MN			
6840 Rochester, NY	1.0708	1.0488	0.9182
Genesee, NY			
Livingston, NY			
Monroe, NY			
Ontario, NY			
Orleans, NY			
Wayne, NY			
6880 Rockford, IL	0.8844	0.9617	0.8819
Boone, IL			
Ogle, IL			
Winnebago, IL			
6895 Rocky Mount, NC	0.9221	0.8247	0.8849
Edgecombe, NC			
Nash, NC			
6920 Sacramento, CA	1.0230	1.0580	1.1950
El Dorado, CA			
Placer, CA			
Sacramento, CA			
A6960 Saginaw-Bay City-Midland, MI	0.8510	0.9002	0.9575
Bay, MI			
Midland, MI			
Saginaw, MI			
6980 St. Cloud, MN	0.8480	0.9556	1.0016
Benton, MN			
Stearns, MN			
7000 St. Joseph, MO	1.1074	1.0774	0.9071
Andrews, MO			
Buchanan, MO			
7040 St. Louis, MO–IL	0.8900	0.9056	0.9049
Clinton, IL			
Jersey, IL			
Madison, IL			
Monroe, IL			
St. Clair, IL			
Franklin, MO			
Jefferson, MO			
Lincoln, MO			
St. Charles, MO			
St. Louis, MO			
St. Louis City, MO			
Warren, MO			
Sullivan City, MO			
7080 Salem, OR	0.9308	0.8379	1.0189
Marion, OR			
Polk, OR			
7120 Salinas, CA	1.0856	1.1224	1.4502
Monterey, CA			
7160 Salt Lake City-Ogden, UT	0.9984	0.9405	0.9807
Davis, UT			
Salt Lake, UT			
Weber, UT			
7200 San Angelo, TX	0.8222	0.7841	0.8083
Tom Green, TX			
7240 San Antonio, TX	0.8252	0.8159	0.8580
Bexar, TX			
Comal, TX			
Guadalupe, TX			
Wilson, TX			
7320 San Diego, CA	1.0177	1.0038	1.1784
San Diego, CA			
7360 San Francisco, CA	1.1958	1.1930	1.4156

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
Marin, CA			
San Francisco, CA			
San Mateo, CA			
7400 San Jose, CA	1.0787	1.1736	1.3652
Santa Clara, CA			
7440 San Juan-Bayamon, PR	0.5454	0.5070	0.4690
Aguas Buenas, PR			
Barceloneta, PR			
Bayamon, PR			
Canovanas, PR			
Carolina, PR			
Catano, PR			
Ceiba, PR			
Comerio, PR			
Corozal, PR			
Dorado, PR			
Fajardo, PR			
Florida, PR			
Guaynabo, PR			
Humacao, PR			
Juncos, PR			
Los Piedras, PR			
Loiza, PR			
Luguillo, PR			
Manati, PR			
Morovis, PR			
Naguabo, PR			
Naranjito, PR			
Rio Grande, PR			
San Juan, PR			
Toa Alta, PR			
Toa Baja, PR			
Trujillo Alto, PR			
Vega Alta, PR			
Vega Baja, PR			
Yabucoa, PR			
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.0873	0.9472	1.0673
San Luis Obispo, CA			
7480 Santa Barbara-Santa Maria-Lompoc, CA	0.9547	1.0338	1.0597
Santa Barbara, CA			
7485 Santa Cruz-Watsonville, CA	1.1349	0.9398	1.4040
Santa Cruz, CA			
7490 Santa Fe, NM	0.8636	1.3115	1.0537
Los Alamos, NM			
Santa Fe, NM			
7500 Santa Rosa, CA	1.0368	1.1709	1.2646
Sonoma, CA			
7510 Sarasota-Bradenton, FL	1.0006	1.0294	0.9809
Manatee, FL			
Sarasota, FL			
7520 Savannah, GA	0.8804	0.7861	0.9697
Bryan, GA			
Chatham, GA			
Effingham, GA			
7560 Scranton-Wilkes-Barre-Hazleton, PA	1.0313	1.0346	0.8421
Columbia, PA			
Lackawanna, PA			
Luzerne, PA			
Wyoming, PA			
7600 Seattle-Bellevue-Everett, WA	1.1078	1.0440	1.0996
Island, WA			
King, WA			
Snohomish, WA			
7610 Sharon, PA	1.0333	0.9605	0.7928
Mercer, PA			
7620 Sheboygan, WI	1.1775	1.2892	0.8379
Sheboygan, WI			
7640 Sherman-Denison, TX	0.8663	0.8372	0.8694
Grayson, TX			
7680 Shreveport-Bossier City, LA	0.7241	0.6735	0.8750
Bossier, LA			
Caddo, LA			
Webster, LA			
7720 Sioux City, IA–NE	0.9021	0.9063	0.8473
Woodbury, IA			
Dakota, NE			
7760 Sioux Falls, SD	0.8511	0.9286	0.8790

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
Lincoln, SD Minnehaha, SD			
7800 South Bend, IN St. Joseph, IN	1.0075	1.0621	1.0000
7840 Spokane, WA Spokane, WA	0.9486	0.9854	1.0513
7880 Springfield, IL Menard, IL Sangamon, IL	0.8276	0.9314	0.8685
7920 Springfield, MO Christian, MO Greene, MO Webster, MO	0.9289	0.9309	0.8488
8003 Springfield, MA Hampden, MA Hampshire, MA	1.2171	1.1537	1.0637
8050 State College, PA Centre, PA	1.0164	0.9558	0.9038
8080 Steubenville-Weirton, OH–WV Jefferson, OH Brooke, WV Hancock, WV	0.9182	0.9057	0.8548
8120 Stockton-Lodi, CA San Joaquin, CA	0.9860	1.0313	1.0629
8140 Sumter, SC Sumter, SC	0.7762	0.8687	0.8271
8160 Syracuse, NY Cayuga, NY Madison, NY Onondaga, NY Oswego, NY	1.0121	1.0499	0.9549
8200 Tacoma, WA Pierce, WA	0.9407	0.9441	1.1564
8240 Tallahassee, FL Gadsden, FL Leon, FL	0.9658	0.9761	0.8545
8280 Tampa-St. Petersburg-Clearwater, FL Hernando, FL Hillsborough, FL Pasco, FL Pinellas, FL	1.0177	1.0025	0.8982
8320 Terre Haute, IN Clay, IN Vermillion, IN Vigo, IN	0.8222	0.8286	0.8304
8360 Texarkana, AR-Texarkana, TX Miller, AR Bowie, TX	0.8290	0.8049	0.8363
8400 Toledo, OH Fulton, OH Lucas, OH Wood, OH	0.9963	0.9904	0.9832
8440 Topeka, KS Shawnee, KS	0.7969	0.8241	0.9117
8480 Trenton, NJ Mercer, NJ	1.1897	1.1835	1.0137
8520 Tucson, AZ Pima, AZ	0.9488	0.9534	0.8794
8560 Tulsa, OK Creek, OK Osage, OK Rogers, OK Tulsa, OK Wagoner, OK	0.8445	0.8104	0.8454
8600 Tuscaloosa, AL Tuscaloosa, AL	0.8490	0.8208	0.8064
8640 Tyler, TX Smith, TX	0.8607	0.8562	0.9404
8680 Utica-Rome, NY Herkimer, NY Oneida, NY	0.9634	0.9279	0.8560
8720 Vallejo-Fairfield-Napa, CA Napa, CA Solano, CA	1.1949	1.1287	1.2847
8735 Ventura, CA Ventura, CA	1.0838	1.0338	1.1030
8750 Victoria, TX	0.7002	0.7270	0.8154

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent Counties or County Equivalents)	Wage Index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
Victoria, TX			
8760 Vineland-Millville-Bridgeton, NJ	1.1806	1.1019	1.0501
Cumberland, NJ			
8780 Visalia-Tulare-Porterville, CA	0.9010	0.9027	0.9551
Tulare, CA			
8800 Waco, TX	0.8453	0.8291	0.8314
McLennan, TX			
8840 Washington, DC–MD–VA–WV	1.0430	1.0368	1.0755
District of Columbia, DC			
Calvert, MD			
Charles, MD			
Frederick, MD			
Montgomery, MD			
Prince Georges, MD			
Alexandria City, VA			
Arlington, VA			
Clarke, VA			
Culpepper, VA			
Fairfax, VA			
Fairfax City, VA			
Falls Church City, VA			
Fauquier, VA			
Fredericksburg City, VA			
King George, VA			
Loudoun, VA			
Manassas City, VA			
Manassas Park City, VA			
Prince William, VA			
Spotsylvania, VA			
Stafford, VA			
Warren, VA			
Berkeley, WV			
Jefferson, WV			
8920 Waterloo-Cedar Falls, IA	0.8201	0.8820	0.8404
Black Hawk, IA			
8940 Wausau, WI	1.1470	1.2648	0.9418
Marathon, WI			
8960 West Palm Beach-Boca Raton, FL	1.0131	0.9912	0.9682
Palm Beach, FL			
9000 Wheeling, OH–WV	0.9131	0.9078	0.7733
Belmont, OH			
Marshall, WV			
Ohio, WV			
9040 Wichita, KS	0.9211	0.9050	0.9544
Butler, KS			
Harvey, KS			
Sedgwick, KS			
9080 Wichita Falls, TX	0.7375	0.7385	0.7668
Archer, TX			
Wichita, TX			
9140 Williamsport, PA	0.9543	1.0264	0.8392
Lycoming, PA			
9160 Wilmington-Newark, DE–MD	1.0931	1.0284	1.1191
New Castle, DE			
Cecil, MD			
9200 Wilmington, NC	0.9507	0.8675	0.9402
New Hanover, NC			
Brunswick, NC			
9260 Yakima, WA	0.9038	0.8770	0.9907
Yakima, WA			
9270 Yolo, CA	1.0452	1.0260	1.0199
Yolo, CA			
9280 York, PA	1.0718	1.0923	0.9264
York, PA			
9320 Youngstown-Warren, OH	0.8731	0.8594	0.9543
Columbiana, OH			
Mahoning, OH			
Trumbull, OH			
9340 Yuba City, CA	1.0615	1.0246	1.0706
Sutter, CA			
Yuba, CA			
9360 Yuma, AZ	0.9209	0.9020	0.9529
Yuma, AZ			

TABLE 8.—WAGE INDEX FOR RURAL AREAS

Rural area	Wage index		
	SNF98	SNF99	HOSP
Col. A	Col. B	Col. C	Col. D
Alabama	0.7724	0.8020	0.7489
Alaska	1.4132	1.3582	1.2392
Arizona	1.0111	0.9175	0.8317
Arkansas	0.6972	0.7278	0.7445
California	0.9685	0.9712	0.9861
Colorado	0.8710	0.9147	0.8968
Connecticut	1.2870	1.0540	1.1715
Delaware	1.0854	0.9338	0.9074
Florida	0.8331	0.8921	0.8919
Georgia	0.7850	0.7985	0.8329
Guam	0.0000	0.0000	0.9611
Hawaii	1.1915	1.2995	1.1059
Idaho	0.8892	0.8320	0.8678
Illinois	0.8296	0.8274	0.8160
Indiana	0.8875	0.9008	0.8602
Iowa	0.7706	0.7834	0.8030
Kansas	0.7562	0.7941	0.7605
Kentucky	0.8237	0.7905	0.7931
Louisiana	0.6699	0.7014	0.7681
Maine	0.8766	0.8908	0.8766
Maryland	0.9015	0.8780	0.8651
Massachusetts	1.1740	1.2039	1.1204
Michigan	0.9505	0.9655	0.8987
Minnesota	1.1396	1.0221	0.8881
Mississippi	0.7412	0.7885	0.7491
Missouri	0.7904	0.7898	0.7698
Montana	0.8996	0.8606	0.8688
Nebraska	0.7977	0.8182	0.8109
Nevada	0.8621	0.9222	0.9232
New Hampshire	1.1065	1.1171	0.9845
New Jersey [1]	.....	.....	.....
New Mexico	0.6834	0.8052	0.8497
New York	1.0081	0.9981	0.8499
North Carolina	0.9255	0.9028	0.8445
North Dakota	0.7649	0.7779	0.7716
Ohio	0.8895	0.8948	0.8670
Oklahoma	0.7481	0.7275	0.7491
Oregon	0.8616	0.8455	1.0132
Pennsylvania	0.9870	0.9443	0.8578
Puerto Rico	0.3897	0.3866	0.4264
Rhode Island [1]	.....	.....	.....
South Carolina	0.7941	0.8367	0.8370
South Dakota	0.7946	0.8373	0.7570
Tennessee	0.8656	0.8415	0.7838
Texas	0.7512	0.7528	0.7502
Utah	0.9492	0.8196	0.9037
Vermont	0.9914	1.0299	0.9274
Virginia	0.8157	0.8601	0.8189
Virgin Islands	0.0000	0.0000	0.6306
Washington	0.9539	0.9475	1.0434
West Virginia	0.8260	0.8668	0.8231
Wisconsin	0.9516	0.9893	0.8880
Wyoming	0.9081	0.8314	0.8817

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

We have drawn the following conclusions from these tables and our analysis of the wage data:

A comparison of the wage index based on hospital data with one based on SNF-specific wage data has created many significant variances, not only between the SNF wage index and the hospital wage index, but also between the two SNF wage indexes illustrated in Tables 7 and 8. While we would expect some changes from year to year, and between a wage index based on SNF data and one based on hospital data, we believe that the large quantity of significant variations raises questions as to the reliability of the SNF-specific wage data.

The following illustrates the impact of using the various wage indexes contained in Tables 7 and 8:

- When comparing the FY 1998 SNF-specific wage index to the hospital wage index, we found the number of areas that:

Increased more than 20%—15 (the highest was 44.59%)
Increased between 10–20%—53

Increased between 5–10%—49
Increased between 0–5%—64
Decreased between 0–5%—69
Decreased between 5–10%—56
Decreased between 10–20%—51
Decreased greater than 20%—12 (the largest was 37.55%)

• When comparing the FY 1999 SNF-specific wage index to the hospital wage index, we found the number of areas that:

Increased more than 20%—12 (the largest was 53.86%)
Increased between 10–20%—47
Increased between 5–10%—67
Increased between 0–5%—70
Decreased between 0–5%—56
Decreased between 5–10%—60
Decreased between 10–20%—44
Decreased greater than 20%—13 (the largest was 33.06%)

• When comparing the FY 1998 SNF-specific wage index to the FY 1999 SNF-specific wage index, we found the number of areas that:

Increased more than 20%—9 (the largest was 51.86%)
Increased between 10–20%—25
Increased between 5–10%—52
Increased between 0–5%—102
Decreased between 0–5%—110
Decreased between 5–10%—44
Decreased between 10–20%—22
Decreased greater than 20%—5 (the largest was 33.73%)

The FY 1998 and FY 1999 SNF wage index had 6 areas with no values.

For FY 1998, from a total of 13,587 freestanding providers, we eliminated 2,674 providers because they had a zero value for wages or hours. For hospital-based SNFs, of the 2,185 providers, we eliminated 160 providers for the same reason. For FY 1999, of the 12,491 freestanding providers, we eliminated 2,461 providers because they had a zero value for wages or hours. For hospital-based SNFs, of the 2,034 providers, we eliminated 132 providers for the same reason. In addition, for FY 1998, we eliminated 231 providers that had average hourly wages either below $5.00, or above the 99th percentile ($24.15). For FY 1999, we eliminated 206 providers with average hourly wages either below $5.00, or above the 99th percentile ($24.79).

There are far fewer significant changes between MSAs in the annual hospital wage index. The latest comparison of the year-to-year differences in the hospital wage index (pre-classified, pre-floor) shows only 7 areas with increases of 10 percent or more and 4 with decreases greater than 10 percent. A comparison of the FY 1998 and 1999 SNF-specific wage indexes shows 34 areas that experienced an increase of 10 percent or more and 27 areas with decreases of 10 percent or more.

We believe that any changes to the wage index adjustment under the SNF PPS should support greater precision in Medicare payments; however, as a result of the variations in the SNF-specific wage data and the large number of SNFs that are unable to provide adequate wage and hourly data, we are concerned about the reliability of the data used in establishing a SNF wage index at this time.

We continue to believe that a wage index based on hospital wage data is the best and most appropriate to use in adjusting payments to SNFs, since both hospitals and SNFs compete in the same labor markets. We invite public comment on the SNF-specific wage data; however, for the reasons discussed above we currently plan to use the updated hospital wage data when we publish the final rule. In addition, in accordance with section 315(b) of BIPA 2000, since we currently do not have reliable SNF-specific wage data, we are not proposing at this time to develop or incorporate any type of geographic reclassification system for SNFs.

D. Updates to the Federal Rates

In accordance with section 1888(e)(4)(E) of the Act and section 311 of BIPA 2000, the proposed payment rates listed here reflect an update equal to the SNF market basket minus 0.5 percentage point, which equals 2.4 percent. For each succeeding FY, we will publish the rates in the **Federal Register** before August 1 of the year preceding the affected Federal FY.

E. 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 that beneficiaries who are correctly assigned to one of the upper 26 RUG–III groups in the initial 5-day, Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to that point.

Those beneficiaries assigned to any of the lower 18 groups are not automatically classified as either meeting or not meeting the definition, but instead receive an individual level of care determination using the existing administrative criteria. This presumption recognizes the strong likelihood that beneficiaries assigned to one of the upper 26 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.

We propose to continue the existing designation of the upper 26 RUG–III groups for purposes of this administrative presumption, consisting of the following RUG–III classifications: all groups within the Ultra High Rehabilitation category; all groups within the Very High Rehabilitation category; all groups within the High Rehabilitation category; all groups within the Medium Rehabilitation category; all groups within the Low Rehabilitation category; all groups within the Extensive Services category; all groups within the Special Care category; and, all groups within the Clinically Complex category.

F. Three-Year Transition Period

As noted previously, the rates that we now propose are for the fourth year of the SNF PPS. As a result, the PPS is no longer operating under the initial three-year transition period from facility-specific to Federal rates and, therefore, now equals 100 percent of the adjusted Federal per diem rate.

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

Using the XYZ SNF described in Table 9A, the following shows the adjustments made to the Federal per diem rate to compute the provider's actual per diem PPS payment. XYZ's 12-month cost reporting period begins October 1, 2001. Table 9B displays the 44 RUG–III categories and their respective add-ons, as provided in BBRA 1999 and BIPA 2000.

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

RUG group	Labor portion	Wage index	Adjusted labor	Nonlabor portion	Adjusted rate	Percent adjustment	Medicare days	Payment
RVC	$257.54	0.9038	$232.76	$84.14	$316.90	$350.81	50	$17,541
SSC	171.76	0.9038	155.24	56.12	211.36	[3] 262.09	25	6,552
IA2	113.56	0.9038	102.64	37.10	139.74	[4] 145.33	25	3,633
Total							100	27,726

[1] From Table 5.
[2] Reflects a 10.7 percent adjustment (the 4 percent adjustment from section 101(d) of BBRA 1999 and the 6.7 percent adjustment from section 314 of BIPA 2000).
[3] Reflects a 24 percent adjustment (the 4 percent and 20 percent adjustments from sections 101(a) and (d) of BBRA 1999).
[4] Reflects the 4 percent adjustment from section 101(d) of BBRA 1999.

TABLE 9.B.—BBRA 1999 & BIPA 2000 ADD-ONS, BY RUG–III CATEGORY

RUG–III category	4% [1]	10.7% [2]	24% [3]
RUC		X	
RUB		X	
RUA		X	
RVC		X	
RVB		X	
RVA		X	
RHC		X	
RHB		X	
RHA		X	
RMC		X	
RMB		X	
RMA		X	
RLB		X	
RLA		X	
SE3			X
SE2			X
SE1			X
SSC			X
SSB			X
SSA			X
CC2			X
CC1			X
CB2			X
CB1			X
CA2			X
CA1			X
IB2	X		
IB1	X		
IA2	X		
IA1	X		
BB2	X		
BB1	X		
BA2	X		
BA1	X		
PE2	X		
PE1	X		
PD2	X		
PD1	X		
PC2	X		
PC1	X		
PB2	X		
PB1	X		
PA2	X		
PA1	X		

[1] From BBRA 1999.
[2] Includes the 4% increase from BBRA 1999 and the 6.7% increase from BIPA 2000.
[3] Includes the 4% and 20% increases from BBRA 1999.

For rates addressed in this proposed rule, we are using wage index values that are based on hospital wage data from cost reporting periods beginning in FY 1996, the same wage data as used to compute the FY 2001 wage index values for the SNF PPS. We will incorporate updated wage data in the final rule for the FY 2002 SNF PPS update. XYZ's total PPS payment will equal $27,726.

III. The Skilled Nursing Facility Market Basket Index

A. Background

Section 1888(e)(5)(A) of the Act requires the Secretary to establish a market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in the SNF PPS. Effective for cost reporting periods beginning on or after July 1, 1998, we revised and rebased our 1977 routine costs input price index and adopted a total expenses SNF input price index using data from 1992 as the base year.

The term ''market basket'' technically describes the mix of goods and services needed to produce SNF care, and is also commonly used to denote the input price index that includes both weights (mix of goods and services) and price factors. The term ''market basket'' used in this proposed rule refers to the SNF input price index.

The 1992-based SNF market basket represents routine costs, costs of ancillary services and capital-related costs. The percentage change in the market basket reflects the average change in the price of a fixed set of goods and services purchased by SNFs to furnish all services. For further background information, see the May 12, 1998 **Federal Register** (63 FR 26289).

For purposes of SNF PPS, the SNF market basket is a fixed-weight (Laspeyres type) price index. (A Laspeyres type index compares the cost of purchasing a specified group of commodities at current prices to the cost of purchasing that same group in a selected base period.) The SNF market basket is constructed in three steps. First, a base period is selected and total base period expenditure shares are estimated for mutually exclusive and exhaustive spending categories. Total costs for routine services, ancillary services, and capital are used. These proportions are called ''cost'' or ''expenditure weights''. The second step is to match each expenditure category to a price/wage variable, called a price proxy. These price proxy variables are drawn from publicly available statistical series published on a consistent schedule, preferably at least quarterly. In the final step, the price level for each spending category is multiplied by the expenditure weight for that category. The sum of these products (that is, weights multiplied by proxy index levels) for all cost categories yields the composite index level in the market basket for a given quarter or year. Repeating the third step for other quarters and years produces a time series of market basket index levels, from which rates of growth can be calculated.

The market basket is described as a fixed-weight index because it answers the question of how much more or less it would cost, at a later time, to purchase the same mix of goods and services that was purchased in the base period. The effects on total expenditures resulting from changes in the quantity or mix of goods and services purchased subsequent or prior to the base period are, by design, not considered.

As discussed in the May 12, 1998 **Federal Register** (63 FR 26252), to implement section 1888(e)(5)(A) of the Act, we have revised and rebased the market basket so the cost weights and price proxies reflected the mix of goods and services that SNFs purchase for all costs (routine, ancillary, and capital-related) encompassed by SNF PPS in fiscal year 1992.

B. Rebasing and Revising the Skilled Nursing Facility Market Basket

The terms ''rebasing'' and ''revising'', while often used interchangeably, actually denote different activities. Rebasing means shifting the base year for the structure of costs of the input

price index (for example, for this proposed rule, we would shift the base year cost structure from fiscal year 1992 to fiscal year 1997). Revising means changing data sources, cost categories, and/or price proxies used in the input price index.

We are proposing to rebase and revise the SNF market basket to reflect 1997 total cost data (routine, ancillary, and capital-related). Fiscal year 1997 was selected as the new base year because 1997 is the most recent year for which relatively complete data are available. These data include settled 1997 Medicare Cost Reports as well as 1997 data from two U.S. Department of Commerce surveys: the Bureau of the Census' Business Expenditures Survey, and the Bureau of Economic Analysis' Annual Input-Output tables. Preliminary analysis of 1998 data from Medicare Cost Reports showed little change in cost shares from those in the 1997 Medicare Cost Reports.

In developing the proposed market basket, we reviewed SNF expenditure data from Medicare Cost Reports for FY 1997 for each freestanding SNF that had Medicare expenses. FY 1997 Cost Reports are those with cost reporting periods beginning after September 30, 1996 and before October 1, 1997. We maintained our policy of using data from freestanding SNFs because they reflect the actual cost structure faced by the SNF itself. By contrast, expense data for a hospital-based SNF is influenced by the allocation of overhead over the entire institution.

Data on SNF expenditures for six major expense categories (wages and salaries, employee benefits, contract labor, pharmaceuticals, capital-related, and a residual ''all other'') were edited and tabulated. Using these data, we then determined the proportion of total costs that each category represented. The six major categories for the revised and rebased cost categories and weights derived from SNF Medicare Cost Reports are summarized in Table 10.A.

TABLE 10.A.—1992 AND PROPOSED 1997 SKILLED NURSING FACILITY MAJOR COST CATEGORIES AND WEIGHTS FROM MEDICARE COST REPORTS

Cost categories	1992-based skilled nursing facility weights (percent)	Proposed 1997-based skilled nursing facility weights (percent)
Wages and Salaries	47.805	46.889
Employee Benefits	10.023	9.631
Contract Labor	12.852	6.478
Pharmaceuticals	2.531	3.006
Capital-related Costs	9.778	9.877
All Other Costs	17.012	24.119
Total Costs	100.000	100.000

We fully discuss the methodology for developing these weights in the Appendix. The main methodological difference between the 1992-based SNF market basket and the proposed 1997-based market basket is in the calculation of the contract labor weight. For the 1992-based market basket, we estimated this share using non-salary costs for therapy cost centers. For the proposed 1997-based index, we used the contract labor amounts for a subset of edited reports from Worksheet S–3 in the Medicare Cost Reports. We believe this new methodology provides a more accurate reflection of the share of total costs that are attributable to contract labor. The data from this worksheet were not available in the 1992 Medicare Cost Reports.

Relative weights within the six major categories were derived using relative cost shares from the Bureau of the Census' 1997 Business Expenditures Survey (BES), 1997 Medicare Cost Reports, and the Bureau of Economic Analysis' (BEA) 1997 Annual Input-Output tables. They were used to disaggregate and allocate costs within the six major categories determined from the 1997 SNF Medicare Cost Reports. The BEA Input-Output database is benchmarked at 5-year intervals and updated annually between benchmarks. We are using the annual update for 1997. The BES is updated every five years.

The capital-related portion of the proposed rebased and revised SNF PPS market basket employs the same overall methodology used to develop the capital-related portion of the 1992-based SNF market basket, described in the May 12, 1998 **Federal Register** (63 FR 26289). It is also the same methodology used for the inpatient hospital PPS capital input price index described in the **Federal Register** May 31, 1996 (61 FR 27466) and August 30, 1996 (61 FR 46196). The strength of this methodology is that it reflects the vintage nature of capital, which represents the acquisition and use of capital over time.

Our work resulted in 21 separate categories for the proposed rebased and revised SNF market basket. The 1992-based total cost SNF market basket also had 21 separate cost categories. Detailed descriptions of each cost category and respective price proxy in the proposed 1997-based SNF market basket are provided in the Appendix to this proposed rule.

As in the 1992-based SNF market basket, the proposed 1997-based SNF market basket does not include a separate cost category for professional liability insurance. Our analysis of the BEA 1997 Annual Input-Output survey indicated that the general category for insurance carriers (which includes professional liability insurance as a subset) was, at just 0.2 percent, a small share of the total costs in 1997. It has been our policy in the past not to provide detailed breakouts of cost categories unless they represent a significant portion of the providers' costs. We also reviewed data available on professional liability insurance from Worksheet S–2 of the SNF Medicare Cost Reports, but found that nearly all SNFs did not report data for malpractice premiums, paid losses, or self-insurance in 1997.

Professional liability insurance is included with other insurance paid to carriers in the all other labor-intensive services cost category. We are soliciting comments on possible data sources for professional liability insurance costs for SNFs. Recent indications are that professional liability insurance costs for SNFs are rising quickly. We are looking both for information that would be

available for a cost weight as well as for a time-series of professional liability premiums for a constant level of coverage, similar to the data we currently collect for hospitals and physicians from a small sample of insurance carriers.

After the 21 cost weights for the proposed revised and rebased SNF market basket were developed, we selected the most appropriate wage and price proxies currently available to monitor the rate of change for each expenditure category. With three exceptions (all for the capital-related expenses cost category), the wage and price proxies are based on Bureau of Labor Statistics (BLS) data and are grouped into one of the following BLS categories:

• *Employment Cost Indexes.* Employment Cost Indexes (ECIs) measure the rate of change in employment wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. They are not affected by shifts in occupation or industry mix. ECIs are superior to Average Hourly Earnings (AHEs) as price proxies for input price indexes for two reasons: (1) They measure pure price change, and (2) they are available by both occupational group and by industry.

• *Producer Price Indexes.* Producer Price Indexes (PPIs) measure price changes for goods sold in other than retail markets. PPIs were used when the purchases of goods or services were made at the wholesale level.

• *Consumer Price Indexes.* Consumer Price Indexes (CPIs) measure change in the prices of final goods and services bought by consumers. CPIs were only used when the purchases were similar to those of retail consumers rather than purchases at the wholesale level, or if no appropriate PPI was available.

The contract labor weight of 6.478 was reallocated to (1) wages and salaries, and (2) employee benefits, so that the same price proxies that we propose to use for direct labor costs are applied to contract costs. While we understand that the level of unit labor costs for contract labor can differ from the unit labor costs of a SNF employee, we feel that the rate at which these labor costs change should be similar. That is, unit contract labor costs should not grow any more or less rapidly than SNF employee labor costs. The rebased and revised cost categories, weights, and price proxies for the proposed 1997-based SNF market basket are listed in Table 10.B.

TABLE 10.B.—PROPOSED 1997-BASED SNF MARKET BASKET COST CATEGORIES, WEIGHTS, AND PRICE PROXIES

Cost category	1997-based skilled nursing facility market basket weight	Price proxy
Operating Expenses	90.123	
Compensation	62.998	
Wages and Salaries	52.263	ECI for Wages and Salaries for Private Nursing Homes.
Employee benefits	10.734	ECI for Benefits for Private Nursing Homes.
Nonmedical professional fees	2.634	ECI for Compensation for Private Professional, Technical and Specialty workers.
Utilities	2.368	
Electricity	1.420	PPI for Commercial Electric Power.
Fuels, nonhighway	0.426	PPI for Commercial Natural Gas.
Water and sewerage	0.522	CPI–U for Water and Sewarge.
Other Expenses	22.123	
Other Products	13.522	
Pharmaceuticals	3.006	PPI for Prescription Drugs.
Food	4.136	
Food, wholesale purchase	3.198	PPI for Processed Foods.
Food, retail purchase	0.937	CPI–U for Food Away From Home.
Chemicals	0.891	PPI for Industrial Chemicals.
Rubber and plastics	1.611	PPI for Rubber and Plastic Products.
Paper products	1.289	PPI for Converted Paper and Paperboard.
Miscellaneous products	2.589	PPI for Finished Goods less Food and Energy.
Other Services	8.602	
Telephone Services	0.448	CPI–U for Telephone Services.
Labor-intensive Services	4.094	ECI for Compensation for Private Service Occupations.
Non labor-intensive services	4.059	CPI–U for All Items.
Capital-related Expenses	9.877	
Total Depreciation	5.266	
Building & Fixed Equipment	3.609	Boeckh Institutional Construction Index (vintage-weighted over 23 years).
Movable Equipment	1.657	PPI for Machinery & Equipment (vintage-weighted over 10 years).
Total Interest	3.852	
Government & Nonprofit SNFs	1.890	Average Yield Municipal Bonds (Bond Buyer Index-20 bonds) (vintage-weighted over 22 years).
For-Profit SNFs	1.962	Average Yield Moody's AAA Bonds (vintage-weighted over 22 years).
Other Capital-related Expenses	0.760	CPI–U for Residential Rent.
0Total	*100.000	

*Total may not equal 100 due to rounding

In the proposed 1997-based SNF market basket, the labor-related share for FY 1997 is 73.588 percent, while the non-labor-related share is 26.412 percent. The labor-related share reflects the proportion of the average SNF's costs that vary with local area wages. This share includes wages and salaries, employee benefits, professional fees, labor-intensive services, and a 39.1 percent share of capital-related expenses, as shown in Table 10.C. By comparison, the labor-related share of the 1992-based SNF market basket was 75.888 percent. The labor-related share of the market basket is the sum of the weights for those cost categories that are influenced by the local labor market. The labor-related share is calculated from the base year, which for the proposed SNF market basket is FY 1997.

The labor-related share for capital-related expenses was estimated using a statistical analysis of individual SNF Medicare Cost Reports for 1997, similar to the analysis done on the 1992 SNF Medicare Cost Reports and explained in the May 12, 1998 **Federal Register** (63 FR 26289). The statistical analysis was necessary because the proportion of capital-related expenses related to local area wage costs cannot be directly determined from the SNF capital-related portion of the market basket. We used regression analysis with total costs per day in SNFs as the dependent variable and relevant explanatory variables for size, complexity, efficiency, age of capital, and local wage variation. To account for these factors, we used number of beds, case-mix indexes, occupancy rate, ownership, age of assets, length of stay, FTEs per bed, and wage index values based on the hospital wage index (wages and employee benefits) as independent variables. Our regression analysis indicated that the coefficient on the area wage index was 73.588, which represents the proportion of total costs that vary with local labor markets, holding constant other factors. From the operating portion of the market basket, we can specifically identify cost categories that reflect local labor markets and include them in the labor-related share. These cost categories equal 69.727, and reflect approximately 77 percent of operating costs. Thus, the labor-related share for capital-related costs is 3.861 (73.588 minus 69.727), and reflects approximately 39 percent of capital-related costs.

Capital-related expenses are determined in some proportion by local area labor costs (such as construction worker wages and building materials costs) that are reflected in the price of the capital asset. However, many other inputs that determine capital costs are not related to local area wage costs, such as equipment prices and interest rates. Thus, it is appropriate that capital-related expenses would vary less with local wages than would operating expenses for SNFs. Therefore, we are proposing to use this analysis in determining the labor-related share for SNF PPS.

All price proxies for the proposed revised and rebased SNF market basket are listed in Table 10.B and summarized in the Appendix to this proposed rule. A comparison of the yearly historical percent changes from FY 1995 through FY 2000 for the current 1992-based market basket and the proposed 1997-based market basket is shown in Table 10.D.

TABLE 10.C.—1992 AND PROPOSED 1997-BASED LABOR-RELATED SHARE

Cost category	1992-based skilled nursing facility market basket weight	Proposed 1997-based skilled nursing facility market basket weight
Wages and Salaries	54.262	52.263
Employee Benefits	12.797	10.734
Nonmedical Professional Fees	1.916	2.634
Labor-intensive Services	3.686	4.094
Capital-related	3.227	3.861
Total	75.888	73.588

TABLE 10.D.—COMPARISON OF THE 1992-BASED SKILLED NURSING FACILITY MARKET BASKET AND THE PROPOSED 1997-BASED SKILLED NURSING FACILITY MARKET BASKET, PERCENT CHANGES, 1995–2000

Fiscal years beginning October 1	1992-based skilled nursing facitlity market basket	Proposed 1997-based skilled nursing facility market basket
Historical:		
October 1994, FY 1995	2.9	3.0
October 1995, FY 1996	2.7	2.7
October 1996, FY 1997	2.4	2.4
October 1997, FY 1998	2.8	2.8
October 1998, FY 1999	3.1	3.0
October 1999, FY 2000	4.1	4.0
Historical average 1995–2000:	3.0	3.0

Released by HCFA, OACT, National Health Statistics Group.

The historical average rate of growth for 1995 through 2000 for the proposed SNF 1997-based market basket is similar to that of the 1992-based market basket. The proposed 1997-based SNF market basket provides a more current measure of the annual price increases for total care than the 1992-based SNF market basket because the cost weights reflect the structure of costs for the most recent year for which there are relatively complete data. The forecasted rates of

growth for FY 2002 for the proposed 1997-based and current 1992-based SNF market basket are shown in Table 10.E.

TABLE 10.E.—COMPARISON OF FORECASTED CHANGE FOR THE 1992-BASED SKILLED NURSING FACILITY MARKET BASKET, AND THE PROPOSED 1997-BASED SKILLED NURSING FACILITY MARKET BASKET PERCENT CHANGE FOR FY 2002

Fiscal Year beginning October 1	1992-based skilled nursing facility market basket	1997-based skilled nursing facility market basket
October 2001, FY 2002	3.0	2.9

Source: Standard & Poor's DRI HCC, 1st QTR, 2001; @ USMARCRO/MODTREND@CISSIM/TRENDLONG0201. Released by HCFA, OACT, National Health Statistics Group.

IV. Update Framework

A. The Need for an Update Framework

Medicare payments to SNFs are based on a predetermined national payment amount per day. Annual updates to these payments are required by section 1888(e) of the Act. These updates are usually based on the increase in the SNF market basket. For FY 2002, the update is set at market basket minus 0.5 percent. Our goal is to develop a method for analyzing and comparing expected trends in the underlying cost per day to use in establishing these updates.

The SNF market basket, or input price index, developed by HCFA's Office of the Actuary (OACT) is just one component in the SNF cost per day amount. It captures only the pure price change of inputs (labor, materials, and capital) used by the SNF to produce a constant quantity and quality of care. Other factors also contribute to the change in costs per day, which include changes in case-mix, intensity, and productivity.

Under the inpatient hospital PPS, HCFA and MedPAC use an update framework to account for these other factors and to make annual recommendations to the Congress concerning the magnitude of the update. We are currently examining these factors and exploring ways that they could be incorporated into an update framework for the SNF PPS. We are also examining some additional conceptual and data issues that must be considered when the framework is constructed and applied.

We are not proposing to apply an update framework in a recommendation to the Congress at this time. We are actively pursing development efforts aimed at producing an analytical framework which, by informing policy makers concerning the magnitude of annual updates, would support the continued appropriateness and relevance of the payment rates for services provided to beneficiaries in SNFs. To this end, we are requesting comments concerning the conceptual approach we have outlined in this proposed rule, including the utility and feasibility of this approach for SNFs. We are specifically interested in comments concerning whether certain factors should be accounted for in the framework, and suggestions concerning potential data sources and analysis to support the model. As with the existing methodology, the features of a SNF-specific update framework would need to be based on a sound policy and methodology.

B. Factors Inherent in SNF Payments per Day

In order to understand the factors that determine SNF costs per day, it is first necessary to understand the factors that determine SNF payments per day. Payments per day under SNF PPS are based on the cost and an implicit normal profit margin to the SNF in providing an efficient level of care. We have developed a methodology to identify a mutually exclusive and exhaustive set of factors included in SNF payments per day. The discussion here details a set of equations to identify these factors.

In its simplest form, the average payment per day to a SNF can be separated into a cost term and a profit term as shown in equation (1):

$$(1) \qquad \frac{\text{Payments}}{\text{Days}} = \frac{\text{Costs}}{\text{Days}} + \frac{\text{Profits}}{\text{Days}}$$

This equation can be made multiplicative by converting profit per day into a profit rate as shown in equation (2):

$$(2) \qquad \frac{\text{Payments}}{\text{Days}} = \frac{\text{Costs}}{\text{Days}} * \frac{\text{Payments}}{\text{Costs}}$$

An output price term can be introduced into the equation by multiplying and dividing through by input prices and productivity. As shown in equation (3), the term inside the brackets represents the output price, since an output price reflects the input price and profit margin adjusted for productivity:

$$(3) \qquad \frac{\text{Payments}}{\text{Days}} = \frac{\text{Costs}}{\text{Days}} * \left(\frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Prices}}{\text{Productivity}} \right) * \frac{\text{Productivity}}{\text{Input Prices}}$$

The cost per day term can be further separated by accounting for real case-mix. Under SNF PPS, Resource Utilization Groups (RUGs) are used to classify patients. Based on accurate RUG classification data, average real case-mix per day can be incorporated, as shown in equation (4):

$$(4) \qquad \frac{\text{Payments}}{\text{Days}} = \frac{\text{Costs/Days}}{\text{Real Case Mix/Days}} * \frac{\text{Real Case Mix}}{\text{Days}} * \left(\frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Prices}}{\text{Productivity}} \right) * \frac{\text{Productivity}}{\text{Input Prices}}$$

The term ''real'' is imperative here because only true case-mix should be measured, not case-mix caused by improper coding behavior. By rearranging the terms in equation (4), a set of mutually exclusive and exhaustive factors such as those shown in equation (5) can be identified:

$$(5)\qquad \frac{\text{Payments}}{\text{Days}} = \left(\frac{\frac{\text{Costs}}{\text{Days}}}{\text{Input Prices} * \frac{\text{Real Case Mix}}{\text{Days}}} * \text{Productivity} \right) * \frac{\text{Real Case Mix}}{\text{Days}} * \frac{1}{\text{Productivity}} * \text{Input Prices} * \frac{\text{Payments}}{\text{Costs}}$$

The term of the equation in brackets can be analyzed in two steps. First, excluding the productivity term from the equation results in case-mix adjusted real cost per day, which is input intensity per day. Second, multiplying input intensity by productivity results in case-mix adjusted real payment per day, or output intensity per day. The rationale behind this step is explained in detail in the next section.

The result of this exercise is that SNF payment per day can be determined from the following factors:

$$(6)\qquad \text{Payment Per Day} = \frac{\left(\begin{array}{c}\text{Case-Mix-Constant} \\ \text{Real Output Intensity} \\ \text{Per Day}\end{array} \right) * \left(\begin{array}{c}\text{Real Case Mix} \\ \text{Per Day}\end{array} \right) * (\text{Input Prices}) * (\text{Profit Margins})}{\text{Productivity}}$$

Thus, it holds that the change in SNF payment per day is a function of the change in these factors. In order to determine an annual update that most accurately reflects the underlying cost to the SNF of efficiently providing care, the four factors related to cost must be accounted for when an update framework is developed. A brief discussion of each factor, including specific conceptual and data issues, is provided in the next section.

C. Defining Each Factor Inherent in SNF Costs per Day

Each cost factor from equation (6) above is discussed here in detail. Because this is a basic conceptual discussion, it is likely that more detailed issues may be relevant that are not explored here.

1. Input Prices

Input prices are the pure prices of inputs used by the SNF in providing services. When we refer to inputs we are referring to costs, which have both a price and a quantity component. The price is an input price, and the quantity component reflects real inputs, or real costs. Similarly, when we refer to outputs, we are referring to payments, which also have both a price and a quantity component. The price component is the transaction output price, and the quantity component is the real output, or real payment. The real inputs include labor, capital, and materials, such as drugs. By definition, an input price reflects prices that SNFs encounter in purchasing these inputs, whereas an output price reflects the prices that buyers encounter in purchasing SNF services. We currently can measure input prices using the SNF market basket.

2. Productivity

Productivity measures the efficiency of the SNF in producing outputs. It is the amount of real outputs, or real payments, that can be produced from a given amount of real inputs, or real costs. For SNFs, these inputs are in the form of both labor and capital; thus, they represent multi-factor productivity, as not just labor productivity is reflected. The following set of equations shows how multi-factor productivity can be measured in terms of available data, such as payments, costs, and input prices:

$$\begin{aligned}\text{Productivity} &= \frac{\text{Real Payments}}{\text{Real Costs}} \\ &= \frac{(\text{Payments/Output Price})}{(\text{Costs/Input Price})} \\ &= \frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Price}}{\text{Output Price}}\end{aligned}$$

Rearranging the terms, this multi-factor productivity equation was used as the basis for incorporating an output price term in equation (3) above. This equation is the basis for understanding the relationship between input prices, output prices, profit margins, and productivity.

Equation (6) shows that productivity is divided through the equation, offsetting other factors. The theory behind this offset is that if an efficient SNF in a competitive market can produce more output with the same amount of inputs, the full increase in input costs does not have to be passed on by the provider to maintain a normal profit margin.

3. Real Case-Mix per Day

Real case-mix per day is the average overall mix of care provided by the SNF, as measured using the RUG classification system. Over time, a measure of real case-mix will change as care is given in more or less complex RUGs. Changes in the level of care within a RUG classification group would not be reflected in a case-mix measure based on RUGs, but instead should be captured in the intensity factor of equation (6).

The important distinction here is the difference between real and nominal case-mix. SNFs submit claims using the RUG classification system. The case-mix reflected by the claims is considered ''nominal''. However, the reported classification can reflect the true level of care provided or improper coding behavior. An example of improper coding behavior would be the upcoding, or case-mix ''creep,'' that took place when the hospital PPS was implemented. Any change in case-mix that is not associated with the actual level of care or a true change in the level of care provided must be excluded in order to determine real case-mix. Section 1888(e)(4)(F) of the Act provides us with the statutory authority to make adjustments to the unadjusted Federal per diem rates for changes caused by case-mix creep.

4. Case-Mix-Constant Real Output Intensity per Day

Intensity is the true underlying nature of the product or service and can take the form of output and/or input intensity. In the case of SNFs, output intensity per day is associated with real payment per day, while input intensity per day is associated with real cost per day. For example, input intensity would be associated with a therapist's hours when providing treatment, whereas output intensity would be associated with the amount of treatments a therapist provides. The underlying nature of SNF services is determined by such factors as technological capabilities, increased utilization of inputs (such as labor or drugs), site of care, and practice patterns. Because these factors can be difficult to measure, intensity per day is usually calculated as a residual after the other factors from equation (6) have been accounted for.

Accounting for output intensity associated with an efficient SNF can be more accurately analyzed using a SNF's costs rather than its payments. This analysis would also provide an alternative to developing or using a transaction output price index, which has been difficult for the Bureau of Labor Statistics (BLS) to measure for SNFs. The following series of equations shows how to use the definition of an output price as defined earlier to convert the equation for output intensity per day to reflect costs instead of payments, as used in equation (6):

$$\text{Case-Mix-Constant Real Output Intensity Per Day} = \frac{[\text{Payments/Days}]}{\text{Output Prices} * \text{Real Case Mix/Days}}$$

$$= \frac{[\text{Payments/Days}]}{\left(\frac{\text{Payments}}{\text{Costs}} * \frac{\text{Input Prices}}{\text{Productivity}}\right) * \text{Real Case Mix/Days}}$$

$$= \frac{\text{Payments/Days} * \text{Costs}}{\text{Payments} * \frac{\text{Input Prices}}{\text{Productivity}} * \text{Real Case Mix/Days}}$$

$$= \frac{\text{Payments} * [\text{Costs/Days}]}{\text{Payments} * \frac{\text{Input Prices}}{\text{Productivity}} * \text{Real Case Mix/Days}}$$

$$= \frac{[\text{Costs/Days}]}{\frac{\text{Input Prices}}{\text{Productivity}} * \text{Real Case Mix/Days}}$$

$$= \frac{[\text{Costs/Days}]}{\text{Input Prices} * \text{Real Case Mix/Days}} * \text{Productivity}$$

The last equation is identical to the term in brackets in equation (5), case-mix-constant real input intensity per day multiplied by productivity. Thus, output intensity per day can be defined in such a way that cost data from the SNF are utilized. This equation can be broken down even further to account for different types of input intensity per day. We discuss this matter more fully in the next section.

D. Applying the Factors That Affect SNF Costs per Day in an Update Framework

As discussed earlier, payments per day under SNF PPS must be updated each year. Currently, the updates are specified by legislation as the percent change in the SNF market basket for FY 2001, the percent change in the SNF market basket minus 0.5 percentage points for FY 2002 and FY 2003, and the percent change in the SNF market basket thereafter. However, it is important to understand the underlying trends in SNF costs per day for an efficient provider, especially should the change in these costs deviate from the legislated updates. The development of an update framework with a sound conceptual basis will provide this capability.

Earlier, factors inherent in SNF costs per day were identified. Changes in these factors determine the change in SNF costs per day. Fitting these factors into a framework would allow us to recommend updates each year that appropriately reflect changes in underlying costs for efficient SNFs. Accounting for each of these factors from equation (6) under SNF PPS is discussed below:

- Change in case-mix constant real output intensity per day would be accounted for in the update framework, reflecting the factors that affect not only case-mix constant real input intensity per day, but also productivity, which is determined separately. Factors that can cause changes in case-mix constant real input intensity per day include, but are not limited to, changes in site of service, changes in within-RUG case-mix, changes in practice patterns, changes in the use of inputs, and changes in technology available.
- As discussed earlier, changes in nominal case-mix are automatically included in the payment to the SNF. However, the law gives us the authority to make adjustments for case-mix change due to improper coding behavior. Therefore, the update framework should include an adjustment to convert changes in nominal case-mix per day to changes in real case-mix per day.
- Change in multi-factor productivity would be accounted for in the update framework. The availability of historical data on input prices, payments, and costs are useful in the analysis of this factor. MedPAC sets this factor as a target under hospital PPS.
- Changes in input prices for labor, material, and capital would be accounted for in the update framework. Our Office of the Actuary currently has an input price index, or market basket, for SNF services. This is the market basket referred to in the legislated updates. In an update framework, a

forecast error adjustment has typically been included, to reflect that the updates are set prospectively and some degree of forecast error is inevitable. In the case of the inpatient hospital PPS, this adjustment is made on a two-year lag and only if the error exceeds a defined threshold (0.25 percentage points).

E. Current HCFA Inpatient Hospital PPS and Illustrative SNF PPS Payment Update Frameworks

Table 11 shows the payment update framework for the current inpatient hospital PPS and an illustrative update framework for the SNF PPS. Some of the factors in the inpatient hospital PPS framework are computed using the Medicare Cost Report data, while others are determined based on policy considerations. The details of calculating each factor for the inpatient hospital PPS framework can be found in the August 1, 2000 **Federal Register** (65 FR 47054) final rule that set forth updates to the payment rates used under the inpatient PPS. This design for a SNF update framework is for illustrative purposes only, as much more work needs to be done to determine the appropriate level of detail for each factor and the manner in which the factors would be developed through policy. The numbers provided for the hospital update are only intended to serve as examples of prior updates recommended for the hospital PPS.

MedPAC supports the use of this type of framework for updating payments and applies a similar framework when it proposes updates to hospital payments in its annual recommendation to Congress. The appropriateness of this framework for updating inpatient hospital payments was discussed in the Health Care Financing Review, Winter 1992, in an article entitled, ''Are PPS Payments Adequate? Issues for Updating and Assessing Rates.'' A similar framework would be useful for analyzing updates to SNF payments.

TABLE 11.—CURRENT HCFA HOSPITAL PPS AND ILLUSTRATIVE SNF PPS PAYMENT UPDATE FRAMEWORKS

HCFA hospital PPS update	FY 2001 calculated hospital update percent change	Illustrative SNF PPS update
Percent Change in:		
HCFA PPS Hospital Market Basket	3.4	HCFA SNF Market Basket.
Forecast Error	0.0	Forecast Error.
Productivity	−0.5 to −0.4	Productivity.
Output Intensity	0.0 to −0.6	Output Intensity:
Science and Technology		Science and Technology
Practice Patterns.		
Real within-DRG Change		Real within-RUG Change.
Site of Service		Utilization of Inputs.
		Site of Service.
Case-mix Adjustment Factors:		Case-mix Adjustment Factors:
Projected Case-mix	−0.5	Nominal across-RUG Case-mix.
Real across-DRG Change	0.5	Real across-RUG Change.
Total Cost per Admission	−0.5 to −1.0	Total per Diem Cost.
Other Policy Factors:		Other Policy Factors:
Reclassification and Recalibration	0.0	None.
Total Calculated Update	2.4 to 2.9	Total Calculated Update.

Table data derived from the August 1, 2000 **Federal Register**, Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2001 Rates; Final Rule.

F. Additional Conceptual and Data Issues

Three conceptual issues specific to the SNF PPS are the relevance of a site-of-service substitution adjustment, the necessity of an adjustment for RUG reclassification, and the handling of one-time factors.

Under the inpatient hospital PPS, a site-of-service substitution factor (captured as part of intensity) was necessary because of the incentive to shift care from hospital inpatient to such other settings as hospital outpatient, SNFs, or home health agencies (HHAs). For SNF PPS, it must be determined whether incentives to shift care to these other settings will continue or whether the SNF PPS will reduce these incentives and/or create alternative incentives to shift care out of SNFs. It is not clear without additional research in this area whether changes in behavior created by the different Medicare payment systems should be reflected in a SNF update framework.

A reclassification and recalibration adjustment under the inpatient hospital PPS is necessary to account for additional changes in the case-mix factor resulting from reclassifying and recalibrating the DRG classification software. This factor is applied to the current fiscal year update, but reflects the effect of revisions in the fiscal year two years prior. MedPAC does not account for this adjustment in its update framework. Whether a RUG reclassification adjustment would be necessary in the update framework would depend on the data availability and the likelihood of revisions to RUG classifications on a periodic basis.

There is also a question about how to handle one-time factors, such as the increased costs of converting computer systems to Year 2000 (Y2K) compliance. An update framework is the appropriate mechanism to account for these items, but because of uncertainty surrounding their impact on costs, determining an appropriate adjustment amount may be difficult. MedPAC has discussed this issue in prior sessions, but was unable to agree on the exact methodology for these types of factors.

The purpose of this conceptual discussion is not to determine how the identified factors of the update framework would be measured. We do recognize, however, that it would be important to use the Medicare Cost Report (MCR) and other relevant data from SNFs to analyze the factors that would account for growth in costs per day. As was the case for the inpatient hospital PPS, we will be required to make optimal use of the MCR data as we proceed in the development of an update framework methodology.

The lack of historical case-mix data is another important issue. These data are

currently being collected under contract but will not be available for most historical years. This factor may prove difficult to account for in a historical analysis. In addition, there is no information currently available to make the distinction between real and nominal case-mix change. There are also concerns about the BLS output price measures for SNFs, especially during the first years of publication in 1996 and 1997. Output prices are relevant for measuring productivity in a historical context. Most of these concerns were also encountered and addressed in the inpatient hospital PPS update framework.

The discussion here provides the conceptual basis for developing an update framework for SNF PPS that reflects changes in the underlying costs of efficiently providing SNF services. It is important to note that the framework does not handle distribution issues such as geographic wage variations.

Due to some variations in technical methodologies for measuring the factors of an update framework, and because of some of the data concerns mentioned earlier, implementing an update framework for SNF PPS would involve making significant policy decisions on issues similar to those for the inpatient hospital PPS update framework. We invite comments on the type of data sources to use, what other factors (if any) we should consider in an update framework, and any additional comments concerning the issues discussed in this proposed rule.

V. Consolidated Billing

The consolidated billing requirement established by section 4432(b) of BBA 1997 places the Medicare billing responsibility with the SNF for virtually all of the services that the SNF's residents receive, except for a small number of services that the law specifically identifies as being excluded from this provision. For services that are subject to this provision, the original legislation made no distinction as to whether the services were furnished during the course of a covered Part A SNF stay.

We have implemented consolidated billing only for services that are furnished during the course of a covered Part A SNF stay. We have not implemented consolidated billing for those services furnished to SNF residents who are not in a covered Part A stay (for example, residents who have exhausted their available days of coverage under the Part A SNF benefit, or who do not meet that benefit's post-hospital or level of care requirements). As explained in the final rule of July 30, 1999 (64 FR 41671), implementing the Part B aspect of the provision would entail making significant systems modifications, which have been delayed by systems constraints that arose in connection with achieving Y2K compliance.

In addition, recently enacted provisions in BIPA 2000 have also affected this aspect of consolidated billing. For services furnished on or after January 1, 2001, section 313(a) of BIPA 2000 amends section 1862(a)(18) of the Act by eliminating consolidated billing for most services furnished to SNF residents during noncovered stays. This amendment limits the application of consolidated billing to those services that are furnished during the course of a covered Part A stay, with one exception: for SNF residents in noncovered stays, the only services for which the SNF retains the Medicare billing responsibility are physical, occupational, and speech-language therapy. (The related requirements for fee schedule payment and appropriate HCFA Common Procedure Coding System (HCPCS) coding for Part B SNF services have not been repealed, and remain the law.) We propose to revise the regulations at § 411.15(p) to reflect this change.

We regard the provision of therapy services as an inherent and integral function of this type of facility, and we believe that the statutory requirement for SNFs to retain the Part B billing responsibility for these particular services reflects a number of policy considerations. First, these are services for which the SNF already has the billing responsibility under the separate Part B therapy cap provision enacted by section 4541 of BBA 1997. In addition, unlike some types of services (such as ambulance and laboratory) with which SNFs historically have had only limited billing experience, most SNFs are familiar with the procedures involved in furnishing and billing for therapy and other skilled rehabilitation services. In fact, section 1819(a)(1) of the Act describes such a facility in terms of being primarily engaged in furnishing skilled nursing or rehabilitation services to its residents. The SNF level of care definition in section 1814(a)(2)(B) of the Act defines a beneficiary's access to SNF coverage under Part A as involving the need for and receipt of ''skilled nursing care * * * or other skilled rehabilitation services * * *''.

Finally, since the inception of the Medicare program, section 1861(h)(3) of the Act has provided for coverage of physical, occupational, and speech-language therapy services under the Part A extended care benefit when furnished either directly by the facility, or by others under arrangements with the facility. Thus, physical, occupational, and speech-language therapy are unique among SNF services because the law has always explicitly provided for Part A coverage of them when furnished under an arrangement with an outside supplier in which the SNF performs the Medicare billing for the services.

Section 313 of BIPA 2000 also contains a number of technical and conforming changes to reflect the amendment of section 1862(a)(18) of the Act, as discussed above. Section 313(b)(1) amends section 1842(b)(6)(E) of the Act (which provides that only the SNF can receive Part B payments for services furnished to those of its residents in noncovered stays), by limiting payment to SNFs to only those situations in which the SNF elects to furnish such Part B services—either directly with its own resources, or under an arrangement with an outside supplier in which the SNF assumes the billing responsibility. We are revising the regulations at § 410.150 to reflect this change. This section of the legislation also removes the existing language in section 1842(b)(6)(E) of the Act that refers to services furnished to a resident of ''* * * a part of a facility that includes a skilled nursing facility (as determined under regulations)''. As explained in the May 12, 1998, SNF PPS interim final rule (63 FR 26297), BBA 1997 originally introduced this language in order to apply the consolidated billing requirement not only to the portion of a nursing home that is actually certified as a Medicare SNF, but also to any noncertified remainder:

> This avoids creating a perverse incentive for SNFs to set aside a nonparticipating section in which they could otherwise circumvent the Consolidated Billing requirement for those residents who are not in a covered Part A stay.

However, since the consolidated billing requirement has now been limited to those residents in Part A covered stays, and physical, occupational, and speech-language therapy in noncovered stays, the language that extended its applicability to the noncertified portion of a nursing home is no longer relevant. This is reflected in our proposed change to the regulation at § 411.15.

Section 313(b)(2) of BIPA 2000 amends section 1842(t) of the Act by deleting a similar reference to the noncertified portion of a nursing home. Section 1842(t) of the Act requires that Part B claims for physician services furnished to SNF residents (which are excluded from consolidated billing)

must include the SNF Medicare provider number. Section 313(b)(2) of BIPA 2000 also expands this requirement to apply to Part B claims for all types of services furnished to SNF residents. For a SNF resident in a covered Part A stay, this expanded requirement would apply to claims for any type of service that is excluded from consolidated billing (and, thus, is separately billable to Part B by an outside source). For residents in a noncovered stay, it would encompass claims for all Part B services that the resident receives. We are proposing to revise the regulations at § 424.32 to reflect this change.

Section 313(b)(3) of BIPA 2000 amends the existing language in section 1866(a)(1)(H)(i)(I) of the Act by requiring compliance with section 1862(a)(18), as amended, under the terms of a SNF's Medicare provider agreement. We are proposing to revise the regulations at § 489.20 to reflect this change. Finally, section 313(d) of BIPA 2000 directs the Office of Inspector General to monitor payments for services furnished to SNF residents during noncovered stays, in order to help prevent duplicate payment or the excessive provision of services.

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

A. Current System for Payment of Swing-bed Facility Services Under Part A of the Medicare Program

Section 1883 of the Act permits certain small, rural hospitals to enter into a swing-bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed. Currently, Part A pays for SNF services furnished in Medicare swing-bed hospitals on a cost-related basis, with both calculated rate and retrospective, reasonable cost-based components. Under Medicare payment principles set forth in section 1883(a)(2)(B) of the Act and regulations at § 413.114, swing-bed facilities receive payment for two major categories of costs: routine and ancillary.

Routine costs are the costs of those services included by the provider in a daily service charge. Routine service costs include regular room, dietary, and nursing services, minor medical supplies, medical social services, psychiatric social services, and the use of certain facilities and equipment for which a separate charge is not made. Ancillary costs are costs for specialized services, such as therapy, drugs, and laboratory services, that are directly identifiable to individual patients. Capital-related costs, such as the cost of land, building, equipment, and the interest incurred in financing the acquisition of such items, are not reimbursed separately. Instead, they are incorporated into the routine and ancillary cost components of the rate.

Under Medicare rules, the reasonable cost of ancillary services is paid in full. For routine operating costs, swing-bed providers are paid a predetermined rate equal to the average reasonable routine cost of all freestanding SNFs in the census region. This pre-determined rate is based on annual cost report data, is adjusted for inflation, and is calculated on a calendar year basis. For swing-bed payment purposes, there are nine regions.

B. Requirement of the Balanced Budget Act of 1997 for Swing-Bed Facility Services To Be Paid Under the Prospective Payment System for Skilled Nursing Facilities

Section 1888(e)(7) of the Act and section 203 of BIPA 2000 confers authority on the Secretary to specify when swing-bed hospitals become subject to the SNF PPS, subject to the limitation that swing-bed hospitals cannot be paid under the SNF PPS for cost reporting periods prior to July 1, 1999, and must be paid under the SNF PPS by the end of the transition period described in section 1888(e)(2)(E) of the Act. The SNF PPS transition period ends June 30, 2002, the day immediately following the last day that any SNF could be eligible for the blended rate provisions established for the three-year transition period.

We are proposing to revise the regulations at § 413.114 to provide that swing-bed payments be made under the SNF PPS to swing-bed hospitals for cost reporting periods beginning on and after October 1, 2001, to ensure that the conversion is made within the statutory time frames. By selecting October 1, 2001 as the effective date, we can integrate the swing-bed hospitals into the SNF PPS program using the same time lines that are statutorily required for the annual SNF PPS updates.

Under BBA 1997, this conversion to the SNF PPS was intended to apply to payments to swing-bed facilities in critical access hospitals (CAHs) as well as to those facilities in rural hospitals. However, section 203 of BIPA 2000 exempted CAHs with swing-beds from the SNF PPS. Therefore, only rural hospitals with swing-beds will be subject to the SNF PPS.

Since the application of the SNF PPS to non-CAH swing-bed providers will not occur until the final portion of the SNF PPS phase-in period, those swing-bed providers are not eligible for a blended rate. Upon their PPS effective dates, all rural hospital swing-bed providers will be paid at the per diem Federal payment rate in effect for rural providers when services were delivered.

Section 4407 of BBA 1997 redefined the movement of patients from hospitals from PPS hospitals to SNFs as transfers rather then discharges. This provision applies to hospital discharges for 10 specific DRGs (014, 113, 209, 210, 211, 236, 263, 264, 429, and 483), and mandates that payment for these post-acute transfers cannot exceed the sum of 50 percent of the regular transfer payment and 50 percent of the regular DRG payment. This provision applies to all transfers from a DRG hospital to a SNF that is currently reimbursed under the SNF PPS.

Swing-bed discharges from acute to SNF-level care were specifically exempted from this provision, and swing-bed hospitals would retain their exempt status when they become subject to the SNF PPS. However, in connection with the possible reevaluation of the existing swing-bed conditions of participation discussed in the following section, and the potential for changes associated with a change in payment methodology, we plan to monitor swing-bed activity to determine whether any additional changes may be necessary. We are also mindful of the unique relationship between acute care and SNF-level services in a swing-bed facility. For this reason, we are soliciting comments on this issue, with particular emphasis on both the need for a swing-bed transfer provision and the expected impact it would have on swing-bed hospital operations. For a more detailed explanation of the policy regarding PPS hospital discharges to post-acute care providers, please see Program Memorandum A–98–26 (July, 1998).

C. Requirements of BBRA 1999 Affecting Swing-Bed Payment and Eligibility

Section 408 of BBRA 1999 modified the swing-bed provisions in section 1883(b) of the Act as follows:

- Hospitals with more than 49 and fewer than 100 beds will no longer be required to discharge beneficiaries from swing-beds within 5 days of a community SNF bed becoming available.
- Hospitals will no longer have a cap on the number of days of swing-bed services they can provide. The requirement that swing-bed days be no more than 15 percent of the total bed days was removed.

• Hospitals will no longer be required to obtain state Certificate of Need approval for swing-beds.

By removing the per discharge restrictions on length of stay and the aggregate caps on the facility's ratio of swing-bed to acute days, these BBRA 1999 provisions give swing-bed hospitals more flexibility in determining how to use their swing-beds. Under BBRA 1999, the implementation date of these amendments is to coincide with the timeframe for the swing-bed transition to the SNF PPS schedule. We propose to revise the regulations at § 413.114 to implement this change.

Since swing-bed services are provided within an acute care facility and have historically represented short stay services, swing-bed providers have not been subject to the full set of participation requirements that apply to SNFs. Instead, they have been subject to the hospital conditions of participation, plus an abbreviated set of SNF participation requirements specified in § 482.66. It is not our intent to change the swing-bed conditions of participation at this time; however, we are aware that the BBRA 1999 amendments may encourage swing-bed facilities to make greater use of their facilities to serve beneficiaries with longer term needs, who otherwise would have been transferred to a SNF. We plan to monitor swing-bed utilization and practice patterns to determine whether changes are occurring that warrant a review of swing-bed conditions of participation. We welcome comments on the need for and nature of changes, if any, that would be most helpful in ensuring continued high quality services in swing-bed facilities.

D. Implications of Swing-Bed Facility Conversion to the SNF PPS

The SNF PPS is an outgrowth of substantial research efforts beginning in the 1970s. It is based on the recognition that differences in patient characteristics result in different levels of resource utilization. Unlike some older payment methodologies that paid a flat per diem amount, a case-mix system measures the intensity of care and services required for each patient and then translates that into a payment level.

Under the SNF PPS, payment rates are based on mean SNF costs in a base year, updated for inflation. Swing-bed routine cost reimbursement is similarly based on a precalculated average cost. However, under the current methodology, swing-beds are paid at a rate consisting of the average of the freestanding nursing facility costs within the region. In contrast, under the SNF PPS, costs are calculated using both freestanding and hospital-based SNF data.

The ability to identify differences in patient service needs is crucial to the development of a case-mix system. For the SNF PPS, we needed a sophisticated patient classification system that specifically captured resource use of individuals receiving SNF-level care. The Resource Utilization Group, version 3 (RUG–III) is a 44-group patient classification system that was designed specifically to measure SNF-level services. RUG–III establishes a hierarchy of major patient types, organized into seven major categories. Each of these categories is further differentiated by patient characteristics and service needs to yield the 44 specific patient groups used for payment. Differences in service use are shown by assigning a weight or case mix index to each RUG–III group. This weight represents the amount of nursing and rehabilitation staff time, weighted by salary level, and is standardized to reflect the relative value of each group within the 44-group system.

Detailed descriptions of the RUG–III classification methodology are included in the May 12, 1998 SNF PPS final rule (63 FR 25252). Additional information on the RUG–III system is available in the annual SNF PPS updates (64 FR 41645, July 30, 1999, and 65 FR 46770, July 31, 2000). Like the DRG system used in the inpatient hospital PPS, the RUG–III system has been automated. Program specifications, record layouts and RUG–III coding logic may be found on HCFA's web site at *www.hcfa.gov/medicaid/mds2.0/default.htm.*

All data needed to classify a Medicare beneficiary into one of the RUG–III groups is contained in the MDS 2.0. The MDS 2.0 is a resident assessment instrument used by SNFs for care planning, quality monitoring, and SNF PPS payment. As described in Section G below, we plan to use the MDS 2.0 to calculate SNF PPS payments for swing-bed services.

All providers currently subject to the SNF PPS perform periodic MDS 2.0 assessments for Medicare beneficiaries in Part A stays. Facilities then generate electronic MDS 2.0 records, and transmit each beneficiary's assessment to a designated state agency. These electronic MDS 2.0 records are then transmitted by the state agency to HCFA's data repository. For more information on MDS encoding and transmission, see HCFA's final rule mandating the transmission of MDS records (62 FR 67174, December 23, 1997) and the HCFA web site at *www.hcfa.gov/medicaid/mds2.0/default.htm.*

Under SNF PPS, providers must transmit their MDS 2.0 assessments to the appropriate state agency and receive confirmation that the MDS 2.0 record has been accepted into the state's MDS 2.0 data base before submitting a bill to the Part A FI. Billing instructions have been developed for SNFs subject to the SNF PPS. Three Program Memorandums were issued shortly after the introduction of the SNF PPS, and provide a basic understanding of the current billing requirements (Program Memorandums A–98–16 (May 1998), A–98–20 (June 1998), and A–98–26 (July 1998)). In addition, each Part A FI has developed its own SNF PPS training materials and billing instructions. HCFA staff will be working with the FIs to review these billing requirements and to identify any changes or additions needed to accommodate swing bed providers. We are soliciting comments on concerns related to billing or claims processing in swing-bed facilities.

Finally, swing-bed claims are already subject to medical review to ensure that the services provided to Medicare beneficiaries are reasonable and necessary, and meet Medicare's SNF level of care criteria. Under the SNF PPS, these reviews will be modified to verify the accuracy of the clinical data used to determine the RUG–III group billed. We will work with the appropriate contractors to finalize procedures for these swing-bed reviews, and we plan to publish specific instructions and guidelines later this year.

E. SNF PPS Rate Components

The SNF PPS methodology is discussed in detail in the regulations at 42 CFR Part 413, subpart J. As this methodology is only now being applied to swing-bed hospitals, the major components of the PPS Federal rate are summarized below.

• The nursing component includes direct nursing care and the cost of non-therapy ancillary services required by Medicare beneficiaries. This portion of the rate is case-mix adjusted using the RUG–III classification system described in detail in the May 12, 1998 SNF PPS interim final rule (63 FR 26252). Swing-bed facilities will be reimbursed under the rural facility rates as shown in Table 6.

• The therapy component includes physical, occupational, and speech-language therapy services provided to beneficiaries in a Part A stay and, like the nursing component, is case-mix adjusted. Payment varies based on the actual therapy resource minutes

received by the beneficiary and reported on the MDS assessment instrument.

• The non-case-mix therapy component is a standard amount to cover the cost of therapy assessments of beneficiaries who were determined not to need continued therapy services. This payment is added to the rate for all RUG–III groups except those in the Rehabilitation category.

• The non-case-mix component is also a standard amount added to the rate for each RUG–III group to cover administrative and capital-related costs. The specific costs included in this rate component are described in the May 12, 1998 SNF PPS interim final rule (63 FR 26252).

The RUG–III system utilizes data from the MDS to determine the appropriate payment level for nursing and therapy services. Upon transition to PPS, swing-bed providers will be required to complete MDS assessments according to the same Medicare payment assessment schedule designated for SNFs: on the 5th, 14th, 30th, 60th, and 90th days of post-hospital extended care (Part A SNF) services.

In addition, the portion of the Federal rate attributable to wage-related costs is adjusted by a wage index. For swing-bed facilities, we will use the wage index applicable to the county in which the facility is located or, in the absence of a county wage index, the rural rate for the state in which the facility is located.

F. Implementation of the SNF PPS for Swing-Bed Facilities

Under section 1888(e)(7) of the Act, swing-bed providers (other than CAHs) would be subject to the SNF PPS by the end of the SNF PPS transition period described in section 1888(e)(2)(E) of the Act. However, swing-bed services are not subject to the consolidated billing requirement for services furnished to SNF residents under section 1862(a)(18) of the Act, but instead are subject to the similar bundling requirement for services furnished to hospital inpatients under section 1862(a)(14) of the Act (see section VI.J below).

G. Use of the Resident Assessment Instrument—Minimum Data Set (MDS 2.0)

Swing-bed facilities are not currently subject to the clinical MDS requirements, but will be required under the PPS to perform the Medicare-required MDS assessments.

The MDS required for payment purposes includes the MDS face sheet, Sections AA–R, and Section T. In addition, swing-bed providers, like other nursing facilities, must complete the discharge and reentry tracking forms as appropriate to track the beneficiary's movement into and out of the post-acute care facility. Swing-bed facilities that also participate in the Medicaid program may also be required, at State option, to complete Section S.

When completing the MDS, swing-bed facility staff should use the instructions in the Long Term Care RAI User's Manual. A copy of this manual is available on the HCFA web site at *www.hcfa.gov/medicaid/mds20/man-form.htm* and is also available for purchase.

The types of assessments used to support SNF PPS billing are described below.

1. Regularly Scheduled Medicare Assessments

MDS assessments must be performed in accordance with a predetermined schedule based upon the start of a Medicare Part A covered stay. The assessments are due on days 5, 14, 30, 60, and 90 of the SNF Part A covered stay.

2. Readmission/Return Assessments (MDS Item A8b=5)

This MDS reason for assessment is used when a beneficiary who is receiving Part A SNF care in a swing-bed is hospitalized and then returns to the swing-bed. The assessment reference date of the Readmission/Return Assessment must be set within 5 days of the readmission, as with a regular Medicare 5-day assessment. Like the 5-day assessment, there are 3 grace days available.

3. Other Medicare-Required Assessments (OMRA)

Other Medicare-Required Assessments (OMRAs) must be performed when a beneficiary in a covered Part A stay stops receiving therapy, but continues to receive other skilled services, thus remaining eligible for Part A services. This assessment must be performed between 8 and 10 days after the cessation of all rehabilitation therapy services. It may not be used to indicate changes in the amount or frequency of service or to show reductions in the number of therapy disciplines provided. For example, an OMRA is not required to show that a beneficiary's speech-language therapy has been discontinued when the beneficiary is still receiving physical therapy. This assessment is not required if the beneficiary's Part A stay is discontinued when the therapy is stopped.

Since swing-bed facilities do not perform significant change or significant correction assessments, we have no method of recognizing changes in the beneficiary's clinical status that occur outside the regular SNF PPS assessment schedule. For this reason, we are proposing to modify the MDS 2.0 by adding a new reason for an OMRA assessment specific to swing-bed facilities. Swing-bed providers would then use this additional reason for assessment code when preparing off-cycle assessments reflecting changes in patient status that change the RUG-III group and payment rate.

H. Required Schedule for Completing the MDS

Swing-bed providers would follow the same MDS completion schedule for Medicare PPS assessments as other providers reimbursed under the SNF PPS. When performing an MDS assessment, the registered nurse coordinating the assessment would first establish the period of time that would be used to observe and assess the beneficiary. The last day of the observation period is defined as the Assessment Reference Date (ARD). The ARD is the date used to determine the timeliness of the Medicare-required MDS assessments. The assessment schedule is shown in Table 12.

The Medicare Assessment Window refers to the days on which the MDS ARD may be set in order for the assessment to be considered timely. For example, the ARD for the 5-day assessment should be set between days 1 and 5 of the beneficiary's admission to the swing-bed. Since we realize that there will be exceptional circumstances in which additional time will be needed, we have provided for grace days. MDS assessments with ARDs on a grace day would also be considered timely. The timeliness of the MDS assessments may be monitored to identify providers that routinely perform assessments during the grace period.

In addition, Medicare PPS assessments are required to be completed within 14 days of the ARD. An MDS is considered completed on the date the Assessment Coordinator indicates on the MDS in Section R(2)(b). Swing-bed providers that fail to perform assessments or that perform late assessments (ARD outside of the specified assessment window) are paid at the default rate. This default rate is equal to the rate paid for the lowest acuity level in the RUG-III system, PA1.

TABLE 12.—ASSESSMENT SCHEDULE

Type of assessment	Assessment window days	Grace days	Payment period days
5 day	1–5	6–8	14
14 day	11–14	15–19	14
30 day	21–29	30–34	30
60 day	50–59	60–64	30
90 day	80–89	90–94	10

Each assessment would then be used to calculate a RUG–III group for payment. As shown in Table 12, the RUG–III group is used to bill Medicare for Medicare-covered days of SNF care. The days shown in the payment period column are the maximum number of covered days that can be billed using the 5, 14, 30, 60, and 90 day assessments. Swing-bed care, like care in SNFs, is covered by Medicare when the beneficiary meets the Medicare level of care and medical necessity criteria.

I. RUG–III ''Grouper'' Methodology and Software

RUG–III is a patient classification system that classifies beneficiaries receiving SNF care based on the amount of nursing and therapy resources needed to provide that level of care. RUG–III establishes a seven level hierarchy based on resource use. The seven levels are rehabilitative services, extensive care, special care, clinically complex, cognitive impairment, behavior, and reduced physical function. The classification system is then subdivided into 44 groups using activities of daily living (ADL) deficits, depression, and the provision of restorative nursing services as classification criteria. All data necessary to classify a patient into one of the RUG–III categories is contained on the MDS 2.0.

Swing-bed bills would be paid in the same manner as for all other providers subject to the SNF PPS. Swing-bed facilities would encode and transmit their MDS data to the appropriate State agency. The RUG–III group on the MDS would be validated by the State upon acceptance of the facility's MDS data file. The provider would bill Medicare using the validated RUG–III code. Detailed information on the RUG–III system can be found in the July 30, 1999 SNF PPS final rule published in the **Federal Register** (64 FR 41684), and on HCFA's PPS web site at *www.hcfa.gov/medicare/snfpps.htm.*

Detailed information on the RUG–III software can be found at *www.hcfa.gov/medicaid/mds20/default.htm.* These software groupers are available from many software vendors, however, we have developed the standard software grouper product, RAVEN, which is available to all providers at no cost. We also provide ongoing support for the RAVEN software, and have a Help Desk to assist providers with data transmission and other technical problems. The RAVEN software may be downloaded by accessing HCFA's web site at *www.hcfa.gov/medicaid/mds20/raven.htm.*

J. Applicability of Consolidated Billing to SNF Services Furnished in Swing-Bed Facilities

As enacted by section 4432(b) of BBA 1997, the SNF consolidated billing requirement (which places the Medicare billing responsibility for almost the entire range of Medicare-covered services with the SNF) is based on services that are furnished to SNF residents. However, a swing-bed agreement allows for the provision of SNF services to inpatients of certain small, rural hospitals. These swing-bed services are not subject to the SNF consolidated billing requirement at section 1862(a)(18) of the Act, since that provision applies to services that are furnished to residents of SNFs. Rather, these swing-bed services are subject to the hospital bundling requirement at section 1862(a)(14) of the Act, which applies to services that are furnished to inpatients of hospitals.

The hospital bundling requirement is a longstanding provision that has applied uniformly to all hospitals (including those with swing-bed agreements) and does not represent a new requirement or a change in existing procedures for these facilities. The hospital bundling provision is conceptually similar to the SNF consolidated billing requirement (since it places with the hospital the Medicare billing responsibility for virtually all services that the patient receives), and actually served as the model for the SNF consolidated billing legislation. Like SNF consolidated billing, hospital bundling specifically excludes the services of several types of practitioners (services furnished by physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, clinical psychologists, and certified registered nurse anesthetists). However, unlike SNF consolidated billing, the hospital bundling provision does not provide for the additional exclusion of certain other types of services, such as dialysis or erythropoietin (EPO).

When the SNF PPS was implemented in July 1998, we received several questions concerning the relationship between SNF consolidated billing and Medicare's preadmission payment window provision, which requires that certain services furnished during the period immediately preceding an inpatient hospital admission be included in the payment for the hospital admission. The most common question is related to situations in which a SNF resident in a covered Part A SNF stay receives outpatient services from a hospital, and is subsequently admitted to that same hospital as an inpatient within three days. Both hospital and SNF providers were unsure whether the hospital outpatient services should be included on the hospital inpatient bill or were included in the SNF PPS payment. Since this issue is relevant to swing-bed patients who may require a readmission to an acute care hospital (either within the same facility or to another hospital), we are reiterating our previous clarification on this point.

Section 1886(a)(4) of the Act includes a preadmission payment window provision for hospitals. Under this provision, certain Part B services furnished by a hospital (or by an entity wholly owned or operated by the hospital) within three days before an inpatient admission to that hospital are included in the Medicare Part A payment for the hospital admission. However, we clarified the application of the payment window provisions in a final regulation published in the **Federal Register** on February 11, 1998 (63 FR 6865–66), to explain that this provision does not apply to Part A services furnished during the preadmission period by home health agencies, SNFs, and hospices. The preadmission payment window applies

only to services that are ''otherwise payable under Medicare Part B.'' Therefore, those preadmission services that are covered under the Part A SNF benefit would not be within the scope of the preadmission payment window provision.

However, services furnished on the day that a SNF resident is admitted to a hospital as an inpatient are not included in the SNF PPS payment rate. Thus, the outpatient hospital services furnished on that day would be subject to the preadmission payment window provision. In addition, services excluded from the SNF PPS under consolidated billing are considered Part B services and, when provided within three days of admission as a hospital inpatient, are subject to the preadmission payment window. Among these SNF PPS-excluded services are certain exceptionally intensive services furnished in the hospital setting: cardiac catheterization, computerized axial tomography (CT) scans, magnetic resonance imaging (MRIs), ambulatory surgery involving the use of an operating room, emergency services, radiation therapy, angiography, and certain lymphatic and venous procedures.

For a complete list of services that are reimbursed separately from the SNF PPS rate, please refer to Program Memorandums A–98–37 (November 1998, reissued as A–00–01, January 2000) and AB–00–18 (March 2000).

K. Costs Associated With Automating the MDS: Preliminary Estimates

In accordance with section 1888(e)(7) of the Act, we propose to apply the SNF PPS to swing-bed providers (other than CAHs) effective with cost reporting periods beginning on or after October 1, 2001, consistent with the statutory mandate to implement this provision by the end of the SNF PPS transition period described in section 1888(e)(2)(E) of the Act. Reimbursement under the SNF PPS is contingent upon the periodic completion of an MDS assessment, which is used to assign each beneficiary to an acuity level. Payment is then based on that acuity level. Therefore, all swing-bed providers must automate the MDS data collection and transmission process and be capable of transmitting MDS data no later than the effective date of the conversion to PPS. We anticipate that swing-bed providers will incur some incremental costs associated with automating and transmitting the MDS. Most start up costs associated with automating the MDS will be related to hardware, software, and staff training. These costs will vary with the size of each swing-bed facility, the facility's current level of computer technology, and the familiarity of staff with the MDS assessment instrument.

At the current time, a number of swing-bed hospitals also operate distinct part SNFs, and have systems in place to prepare, store, and transmit MDS assessments. We estimate that approximately 30 percent of the nation's 1,240 Medicare swing-bed providers presently have the hardware and software capability for automated MDS data collection and transmission. Other facilities may be using computers for other applications and may need to upgrade their systems to provide access to clinical and/or data entry staff within the swing-bed unit. For swing-bed hospitals that do not currently operate distinct part SNFs, we expect that a significant percentage will have either very limited capacity or no computer system at all.

Based on our experience with SNFs, we have developed this preliminary estimate of the costs a swing-bed provider can expect to incur. Costs are separated into two categories, start-up and maintenance.

- *Hardware*: We estimate total hardware costs associated with automating the MDS to be approximately $2,000 to $2,500 for a typical swing-bed provider. This amount includes the cost of a computer, communications components capable of running MDS software and transmitting MDS assessments, and a laser printer. This estimate is based on the most recent cost data available for a system that meets the specifications required by the State system. As noted earlier in this proposed rule, we expect that many swing-bed hospitals already have some computer capability and will not need to buy an entirely new system. Based on information currently available, we have no way to quantify the number of providers requiring upgrades to their existing computer systems in order to operate the MDS software. However, the cost of upgrading existing systems should be substantially less than the hardware cost estimates provided here. It is also possible that some providers may elect more sophisticated and expensive multi-user systems. However, since these systems are not generally appropriate for small facilities, are not required for SNF PPS payment purposes, we have considered this type of multi-user system to be an optional expense, and did not include it in the cost estimates. For this analysis, we assumed that all providers would purchase new hardware, and that assumption may overstate the cost estimates.

This cost estimate is based on a computer system suitable for a small business, and assumes that the facility will add applications and data files over time to support ongoing operations. We anticipate that many swing-bed hospitals will choose to purchase this type of system even though it will initially provide excess capacity, and believe that the selection is appropriate. Facilities may, of course, choose a more basic configuration at lower cost. A comparison between a small business industry standard configuration and the minimum system capable of running the necessary MDS software is shown in Table 13.A. Ongoing hardware maintenance costs for nursing homes are expected to average about $100 annually. Service contracts are also available for new PC purchases.

TABLE 13.A.—PPS COMPUTER REQUIREMENTS

Component	Small business standard	Basic MDS processing
Processor	Pentium III 933/133MH	Pentium III.
Memory	128MB sdram	32 MB.
Keyboard	Standard with PC	Standard with PC.
Monitor	17″ color monitor	14″ color monitor.
Hard Drive	20GB	100MB.
Floppy Drive	1.44MB 3.5″	1.44MB 3.5″.
Operating System	Win2000	Windows 98, NT.
Data Backup	Iomega 250MB Zip drive	Optional.
Mouse	Standard with PC	Standard with PC.
Modem	v.90 56K voice/data/fax	28.8k voice/data/fax.
Media Options	20/48X CD–Rom	Optional.
Communications software	Netscape or comparable device	Netscape or comparable device.

TABLE 13.A.—PPS COMPUTER REQUIREMENTS—Continued

Component	Small business standard	Basic MDS processing
Applications Software	Microsoft Small Business Norton AntiVirus	Optional Anti-virus software, recommended.
Printer	Laser Printer	Laser Printer.

• *Software:* Swing-bed providers desiring only to meet the MDS data submission requirements may use RAVEN, the MDS software developed by HCFA, which is available free of charge. RAVEN allows facilities to perform the basic encoding and formatting functions, and allows users to store and retrieve MDS documents. We already provide ongoing support for the RAVEN software, and the RAVEN Help Desk will be available to swing-bed providers to resolve software or transmission problems. We expect that RAVEN will meet the needs of many small swing-bed providers.

Some facilities will choose more sophisticated software programs that can be used to meet other clinical or operational needs, such as care planning, order entry, quality assurance, or billing. There are currently over 100 vendors marketing MDS software products, and the cost of MDS software packages varies widely. Depending on the number of work stations, the level of customer support, and the scope of reporting subsystems, an MDS processing system can cost anywhere from approximately $500 to $5,000 or more per year. Generally, the higher-priced software is designed for large SNFs or multi-facility chains and would be inappropriate for a small swing-bed facility. We would expect that swing-bed facilities that choose not to use RAVEN could purchase proprietary MDS software and support services at a cost ranging from $500 to $1,200 per year. While we have considered the possibility, absent a survey of swing-bed providers, we have no way to quantify how many will elect to purchase more elaborate proprietary MDS processing systems. The extra functionality associated with these systems is not required for payment under the SNF PPS, and should be considered optional costs. However, we have included a cost range in these estimates since we do not want to discourage providers from using MDS systems for other functions, such as quality assurance.

All swing-bed providers will need a common data communications software package to transmit MDS assessments to the State. This communications package must meet our specifications related to transmission of MDS data, which represent current technology. The cost of the communications software, the anti-virus software and the most common small business suite of word processing and spread sheet computer applications is included in the cost estimate for a small business standard configuration PC system.

• *Supplies:* Supplies necessary for collection and transmission of data including diskettes, computer paper, and toner, will vary according to the size of the facility in terms of residents served and assessments required. For the average facility, supply costs should average approximately $200 per year.

• *Maintenance:* There are costs associated with normal maintenance of computer equipment, such as the replacement of disk drives or memory chips. Typically, such maintenance is provided via extended warranty agreements with the original equipment manufacturer, system reseller, or a general computer support firm. These maintenance costs are estimated to average no more than $100 per year.

L. Provider Training

We recognize our responsibility to provide initial training, as well as ongoing technical support. We are currently evaluating training options and solicit comments on training methods, vehicles, and timeframes.

VII. Provisions of the Proposed Rule

The provisions of this proposed rule are as follows:

• In § 410.150, we propose to revise paragraph (b)(14) to reflect that Part B makes payment to the SNF for its resident's services only in those situations where the SNF itself furnishes the services, either directly or under an arrangement with an outside source.

• In § 411.15, we propose to revise paragraph (p)(1) to indicate that except for physical, occupational, and speech-language therapy, consolidated billing applies only to those services that a SNF resident receives during the course of a covered Part A stay. We would also make conforming revisions in §§ 489.20(s) and 489.21(h), in the context of the requirements of the SNF provider agreement. We propose to revise paragraph (p)(2) to indicate that, for Part B services furnished to a SNF resident, the requirement to enter the SNF's Medicare provider number on the Part B claim (which previously applied only to claims for physician services) would apply to all types of Part B claims. We would also make conforming revisions in the requirements regarding claims for payment, at §§ 424.32(a)(2) and (a)(5). We would revise the wording of the existing requirement in § 424.32(a)(5) for a SNF to include appropriate HCPCS coding and its Medicare provider number on the claims that it files for its residents' services, by adding that these requirements also apply to these claims when they are filed by an outside entity. In addition, we would revise § 411.15(p)(3) to exclude from the definition of a SNF resident, for consolidated billing purposes, those individuals who reside in the noncertified portion of an institution that also contains a participating distinct part SNF.

• In accordance with section 1888(e)(2)(E) of the Act, we propose to revise § 413.114 to reimburse swing-bed services of rural hospitals (other than CAHs, which would be paid on a reasonable cost basis) under the SNF PPS described in regulations at subpart J of that part. This conversion to the SNF PPS would be effective for services furnished during cost reporting periods beginning on or after October 1, 2001. We also propose to revise paragraph (d)(1) of this section to reflect the BBRA 1999 modifications to the special requirements for swing-bed facilities with more than 49 but fewer than 100 beds (as discussed in section VI.C of this preamble), and to make a conforming revision in § 424.20(a)(2).

VIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 60-day notice in the **Federal Register** and solicit public comment when a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comments on the following issues:

• Whether the information collection is necessary and useful to carry out the proper functions of the agency;

• The accuracy of the agency's estimate of the information collection burden;

• The quality, utility, and clarity of the information to be collected; and

• Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the information collection requirements discussed below.

§ 413.114(a)(2)—Implementing the requirement in section 1888(e)(7) of the Act for the SNF PPS to encompass swing-bed services furnished in rural hospitals will require these providers to complete MDS assessments, in accordance with the schedule prescribed in regulations at 42 CFR 413.343(b). Accordingly, we are including in this proposed rule the following discussion of the anticipated burden for rural hospitals as a result of implementing this requirement.

On December 23, 1997, we issued in the **Federal Register** a final regulation requiring Medicare-certified SNFs and Medicaid-certified nursing facilities (NFs) to encode and transmit MDS data to HCFA in electronic format (42 FR 67174). In that rule, we provided cost estimates for training staff and conducting ongoing functions related to the preparation, data entry and transmission of MDS data. The estimates presented here are based on the analysis presented in the MDS automation rule, but are updated to reflect current wage data and unique aspects of swing-bed providers. We also used 1999 claims data to calculate the number of swing-bed stays and the average length of stay. These data were used to estimate ongoing MDS-related costs.

Using the best available 1999 claims data, we identified 97,576 swing bed stays. There are currently 1,250 swing-bed facilities. The average annual number of admissions is 78 per swing-bed hospital. Using the same 1999 claims data, the average length of stay is 8.79 days. Accordingly, on average, a typical swing-bed facility would need to complete only one MDS per admission, since the PPS 5-day assessment governs payment for the first 14 days of the stay.

• *Data Entry:* Based upon our experience with SNFs, we estimate that swing-bed facilities will need to train at least one staff person to handle the data entry and MDS processing system. State agencies currently train SNF staff on these functions, and the training is generally completed in a single half-day session. Additional training materials and updates to program requirements are generally posted on the MDS web sites, and are available to staff at no cost. By distributing information electronically, and providing Help Desks for software and transmission problems, we minimize the need for staff travel, and reduce the ongoing costs associated with encoding and transmitting MDS data.

Facilities may choose among a variety of approaches to encode the MDS data in electronic format. In many SNFs, the nurses conducting the assessments input their responses directly into the computer, and the data entry time is incorporated into the MDS preparation time. In others, a data entry operator is used to input the MDS data and maintain the MDS processing system. For SNFs, the data entry function averages 15 minutes per assessment. We also expect that staff will require approximately 2 hours per month to perform system-related functions such as processing corrections, retrieving assessment information, printing copies, verifying the accuracy of the data entered into the system, and reviewing program updates and training materials.

The hourly rate for data entry was estimated at $15, and reflects the salary differentials between the two types of staff typically performing this function: RNs and data operators.

• *Electronic Transmission:* Swing-bed staff will also need training on data transmission procedures. Again, state agencies have already developed training programs in this area, and this training will be available to swing-bed personnel. Generally, a facility would send one person to a half-day training program. This individual would be responsible for handling data transmission functions, and would be expected to train other facility staff on a time-available basis. We will make the MDS transmission system available to swing-bed providers prior to the effective date of the transition to the SNF PPS, and allow staff to practice transmission procedures. We would expect that each swing-bed provider would have successfully transmitted at least one MDS data file prior to the updated SNF PPS effective date. Once the designated individual has been trained, we estimate that the MDS transmission will take approximately one hour per month.

The hourly rate of data transmission was estimated at $15, and reflects the salary differentials between the two types of staff typically performing this function: RNs and data operators.

• *MDS Coding:* Training time will vary depending on the familiarity of swing-bed staff with MDS coding procedures and the presence of a hospital-based SNF that is already subject to the SNF PPS requirements. Many swing-bed hospital employees may have prior experience in a SNF where they were trained in MDS coding procedures. In addition, in 1999, approximately 25 percent of swing-bed hospitals also had hospital-based SNF facilities, and have a pool of trained staff who can assist swing-bed employees with MDS coding procedures. Regardless of the amount of inhouse support available, we believe it is advisable for each swing-bed hospital to designate an RN to assume lead responsibility, and to ensure that this RN is fully trained. We estimate that the initial training in MDS clinical coding and SNF PPS assessment scheduling will require two days.

Based upon the experience SNFs have had in completing the MDS, we estimate that it generally takes 45 minutes to complete a comprehensive assessment. We considered reducing this estimate for swing-bed providers for two reasons. First, the requirements for comprehensive assessments which are mandated under the Omnibus Budget Reconciliation Act of 1987, Pub.L. 100–203 (OBRA 1987) are somewhat higher than those applicable to the SNF PPS assessments. Second, SNF staff generally have limited knowledge concerning the care the patient received prior to the SNF admission, and limited access to the records from the prior hospital stay. As a result, the RN in the SNF conducting a 5-day PPS assessment has to build a completely new knowledge base about the patient's condition and care needs. By contrast, in a swing-bed hospital, the staff caring for the patient have the advantages of observing the patient during the acute portion of the stay, and should have more information already available when completing the SNF PPS 5-day assessment. However, rather than reducing the time estimate, we are using the higher number to reflect the expected learning curve over the first year as staff become more familiar with and proficient in completing the MDS.

As stated above, swing-bed providers averaged 78 stays per year with an average swing-bed length of stay of slightly under 9 days. Therefore, swing-bed providers would generally complete just one SNF PPS assessment for most patients; i.e., the 5-day assessment that governs payment for the first 14 days of a stay.

Although our projections are based on the most recent available data, and indicate that swing-bed providers will generally complete only one MDS per beneficiary during the course of a swing-bed stay, we are aware that this

utilization pattern could change. We note that the restrictions on beneficiary length of stay and the caps on the percentage of bed days that could be used for swing-bed service were eliminated by section 408 of BBRA 1999, effective with cost reporting periods beginning on and after October 1, 2002. With this added flexibility, swing-bed providers may decide to adjust their admission practices, and may serve more patients requiring longer lengths of stay. If this change occurs, swing-bed staff may be required to perform additional MDS assessments. Therefore, we plan to monitor swing-bed utilization patterns to identify any changes in provider practices and evaluate the impact of these changes on swing-bed performance under the SNF PPS. However, for the current analysis, we have used the best available historical data to project future experience.

To calculate the costs of preparing the MDS, we used 1998 Bureau of Labor Statistics nursing wage data including fringe benefits, updated to FY 2002 levels using the SNF market basket factor. The average hourly rate of $24.70 is used in the calculations shown in Table 13.B. The Aggregate Cost-Basic Option column estimates are based on October, 2000 data showing 1,250 certified swing-bed providers. The aggregate calculations assume that all providers chose either the basic or small business option. Absent a survey of all providers, we have no way to quantify the number of providers requiring upgrades to existing computer systems in order to operate the MDS software. We have assumed purchase of a new system for all providers, which may result in an overstatement of actual anticipated costs. The Basic Option-Cost/Facility Hardware estimate includes a laser printer, operating software, basic applications software, including Word 2000 and Excel 2000, and a one year service agreement and anti-virus software. The Small Business Option-Cost/Facility Hardware estimate includes a laser printer, operating software, Microsoft Office Suite applications software, anti-virus software, and a one year service agreement. The Communications Software estimate reflects the cost of Netscape or other communications software. It is assumed that swing-bed providers will use the free RAVEN software for MDS processing. This software was developed and tested by HCFA, and has been widely used by both hospital-based and freestanding SNFs during the past three years. We cannot quantify the number of providers who will choose to purchase proprietary systems, and therefore have included a cost range. We believe that the free RAVEN software, along with the associated Help Desk Services will meet the needs of most providers. The use of proprietary systems should be considered an optional cost.

TABLE 13.B.—SWING-BED RURAL HOSPITAL COST OF COMPLETING MDS

Category	Basic option-cost/facility	Small business option—cost/facility	Aggregate cost—basic option	Aggregate cost—small business option
Hardware	$1,400.00	$2,100.00	$1,750,000.00	$2,625,000.00
Comm. Software	100.00	100.00	125,000.00	125,000.00
MDS Software	0–1,200.00	0–1,200.00	0–1,500,000.00	0–1,500,000.00
Staff Training—MDS Coding	494.00	494.00	617,500.00	617,500.00
Staff Training—Entry and Transmission	240.00	240.00	300,000.00	300,000.00
Start Up Costs	2,234.00	2,934.00	2,792,500.00	3,667,500.00
MDS Preparation	1,445.00	1,445.00	216,750.00	216,750.00
MDS Entry	292.50	292.50	365,625.00	365,625.00
MDS Transmission	180.00	180.00	225,000.00	225,000.00
Supplies	200.00	200.00	250,000.00	250,000.00
Maintenance	100.00	100.00	125,000.00	125,000.00
Operating Cost	2,217.50	2,217.50	1,182,375.00	1,182,375.00
Estimated First Year Costs	4,451.50–5,651.50	5,151.50–6,351.50	3,974,875.00–5,474,875.00	4,849,875.00–6,349,875.00

§ 424.32(a)(5)—We propose to revise section 424.32(a)(5) to reflect the new statutory requirement that all Part B claims for services furnished to SNF residents must include the SNF's Medicare provider number. Because the burden associated with this additional requirement is incidental to the completion of a claim, we are unable to estimate the burden associated with this new requirement, and explicitly solicit comment. As a result of this new requirement, we will be revising the OMB clearance package for the HCFA–1500 (Common Claim Form), OMB number 0938–0008, which is currently being reviewed by OMB for re-approval.

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements in §§ 413.411(a)(2) and 424.32(a)(5). These requirements are not effective until they have been approved by OMB.

If you have any comments on any of these information collection and record keeping requirements, please mail one original and three copies within 60 days of the publication date directly to the following:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn: John Burke, HCFA–1163–P.

And: Office of Information and Regulatory Affairs, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt, HCFA Desk Officer.

IX. Regulatory Impact Analysis

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

Executive Order 12866 directs agencies to assess costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). This proposed rule is a major

rule as defined in Title 5, United States Code, section 804(2), because we estimate its impact will be to increase the payments to SNFs by approximately $300 million in FY 2002. The update set forth in this proposed rule applies to payments in FY 2002. Accordingly, the analysis that follows describes the impact of this one year only. In accordance with the requirements of the Act, we will publish a notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis.

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

Executive Order 13132 (effective November 2, 1999) establishes certain requirements that an agency must meet when it promulgates regulations that impose substantial direct compliance costs on State and local governments, preempt State law, or otherwise have Federalism implications. As stated above, this rule will have no consequential effect on State and local governments.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and governmental agencies. Most SNFs and most other providers and suppliers are small entities, either by virtue of their nonprofit status or by having revenues of $10 million or less annually. For purposes of the RFA, all States and tribal governments are not considered to be small entities, nor are intermediaries or carriers. Individuals and States are not included in the definition of a small entity.

The policies contained in this proposed rule would update the SNF PPS rates by increasing the payment rates published in the July 31, 2000 notice (65 FR 46770). While we do not believe that this will have a significant effect upon small entities overall, some individual providers may experience significant increases in payments, while others (those that are concluding their final year under the transition from facility-specific to full Federal rates) may experience significant decreases, as discussed later in this section.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds. We have examined the impact on the 1,250 swing-bed facilities that would start receiving payment under the SNF PPS effective with cost reporting periods beginning on or after October 1, 2001, and find that the payments to these facilities will increase overall. Some swing-bed facilities may receive significant increases in Medicare related payments, as described later in this section. Accordingly, the following analysis includes a specific examination of the projected impact of these provisions on small rural hospitals.

A. Background

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

This proposed rule sets forth updates of the SNF PPS rates contained in the July 31, 2000 final rule (65 FR 46770). Table 14 presents the projected effects of the policy changes in the SNF PPS from FY 2001 to FY 2002, as well as statutory changes effective for FY 2001 and FY 2002. In so doing, we estimate the effects of each policy change by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as days or case-mix.

This analysis incorporates the latest estimates of growth in service use and payments under the Medicare SNF benefit based on the latest available Medicare claims data and MDS 2.0 assessment data from 1999. We plan to update this data in the final rule. We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, very susceptible to forecasting errors due to other changes in the forecasted impact time period. Some examples of such possible events are newly legislated general Medicare program funding changes by the Congress, or changes specifically related to SNFs. In addition, changes to the Medicare program may continue to be made as a result of BBA 1997, BBRA 1999, BIPA 2000 or new statutory provisions. Although these changes may not be specific to SNF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon SNFs.

B. Impact of the Proposed Rule

The purpose of this proposed rule is not to initiate significant policy changes with regard to the SNF PPS; rather, it is to provide an update to the rates for FY 2002. We believe that the revisions and clarifications mentioned elsewhere in the preamble (for example, the update to the wage index used for adjusting the Federal rates) will have, at most, only a negligible overall effect upon the regulatory impact estimate specified in the rule. As such, these revisions will not represent an additional burden to the industry.

The aggregate increase in payments associated with this proposed rule is estimated to be $300 million. The effect of the 20 percent add-on from BBRA 1999 is $1.0 billion; however, since this add-on became effective in FY 2001, it has already been reflected in the impact analysis for last year's final rule (65 FR 46770) and, thus, does not represent a new, additional impact for the FY 2002 payment rates. There are three areas of change that produce this increase for facilities:

1. The effect of facilities being paid the full Federal rate.

2. The implementation of provisions in BIPA 2000, such as the 16.6 percent increase in the nursing component of each RUG and the elimination of the one percent reduction in the SNF market basket for FY 2001.

3. The total change in payments from FY 2001 levels to FY 2002 levels. This includes all of the previously noted changes in addition to the effect of the update to the rates.

As seen in Table 14, some of these areas are expected to result in increased aggregate payments and others are expected to tend to lower them. The breakdown of the various categories of data in the table is as follows:

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

The second column in the table shows the number of facilities in the impact database. The third column shows the effect of the expiration of the transition and movement to the full Federal rates for all SNFs. This change has an overall effect of lowering payments by an estimated 8.5 percent, affecting hospital-based facilities more than freestanding facilities. The main reason for such a large decrease is the BBRA 1999 provision that allowed facilities to choose the full Federal rate. When given the option to do so, an estimated 43 percent of the facilities elected to go to the full Federal rate. This meant that the only facilities left to transition to the full Federal rate are ones for which the expiration of the transition will cause a decrease in reimbursement. In contrast, those facilities receiving the full Federal rate will experience an 11.6 percent increase in payments. The overall effect, therefore, reduced reimbursement, but the effects across regions are quite variable.

The fourth column shows the projected effect of the 16.66 percent add-on to the nursing portion of the Federal rate mandated by BIPA 2000. As expected, this results in an increase in payments for all facilities; however, as seen in the table, the varying effect of the SNF PPS transition results in a distributional impact. In addition, since this increase only applies to the nursing portion of the payment rate, the effect on total expenditures is less than 16.66 percent.

The fifth column of the table shows the effect of the change in the add-on for the rehabilitation RUGs. The total impact of this change is zero percent; however, there are distributional effects of this change, as seen in the table.

The sixth column of the table shows the effect of all of the changes on the FY 2002 payments. This includes all of the previous changes, including the update to this year's payment rates by the market basket. Rebasing of the market basket index from 1992 to 1997 had little impact on the overall changes displayed in this column. It is projected that payments will increase by 2.1 percent in total, assuming facilities do not change their care delivery and billing practices in response. As can be seen from this table, the combined effects of all the changes vary widely by specific types of providers and by location. For example, freestanding facilities experience payment increases, while the effects of the transition cause decreases in payments for hospital-based providers.

TABLE 14.—PROJECTED IMPACT OF FY 2002 UPDATE TO THE SNF PPS

	Number of facilities	Transition to federal rates (percent)	Add-on to nursing rates (percent)	Add-on to rehab RUGs (percent)	Total FY 2002 change (percent)
Total	9037	−8.5	7.9	0.0	2.1
Urban	6300	−9.0	8.0	0.1	1.7
Rural	2737	−6.7	7.5	−0.5	3.2
Hospital based urban	683	−14.7	8.5	−0.8	−5.1
Freestanding urban	5617	−8.1	7.9	0.3	2.8
Hospital based rural	533	−9.7	8.2	−2.0	−1.0
Freestanding rural	2204	−6.2	7.4	−0.3	3.9
Urban by region.					
New England	630	−3.9	8.1	0.2	7.6
Middle Atlantic	877	−2.9	8.4	−1.7	7.0
South Atlantic	959	−10.5	7.7	0.8	0.5
East North Central	1232	−7.6	7.8	0.9	3.9
East South Central	212	−8.8	7.8	0.4	2.1
West North Central	469	−10.6	7.9	0.1	−0.2
West South Central	519	−19.5	8.1	0.1	−9.9
Mountain	303	−17.3	7.5	1.5	−6.7
Pacific	1070	−13.9	8.0	0.5	−3.4
Rural by region.					
New England	88	−0.9	7.5	−0.4	9.7
Middle Atlantic	144	−4.4	7.7	−1.5	4.9
South Atlantic	373	−5.3	7.5	0.1	5.4
East North Central	561	−5.1	7.4	0.0	5.4
East South Central	255	−5.1	7.9	−2.6	3.1
West North Central	581	−8.2	7.7	−1.4	0.8
West South Central	354	−14.9	7.5	0.2	−5.2
Mountain	204	−11.6	7.2	−0.1	−2.1
Pacific	151	−7.4	7.2	0.6	3.3

In accordance with section 1888(e)(7) of the Act, we propose to pay rural hospitals for SNF-level swing-bed services under the SNF PPS effective with cost report periods beginning on and after October 1, 2001. In making this proposal, we have examined the anticipated impact of this payment change on swing-bed facilities.

We analyzed data from swing-bed claims for calendar years 1996 through 1998 to determine Medicare payments made under the current swing-bed payment system. The claims data reflect the predetermined routine cost payments and the interim payment for ancillary services. While the interim payment rate for ancillary services is subject to final cost settlement, it represents a reasonable proxy for actual swing-bed payments.

We then adjusted the historical data on swing-bed payments to 2002 levels. For calendar years 1999 through 2001, we projected the average payment per day, using the 6.5 percent growth rate calculated from the most recent

available data from calendar years 1997 and 1998. For 2002, we used a blended growth rate that reflects a projected increase in payment for routine services equal to the market basket of 2.4 percent, but retains the historical growth factor of 6.5 percent for ancillary payments. In 1998, the average payment per day was $205.41. The estimated swing-bed payment per day for 2002 under the existing method of reimbursement is $258.41.

We then estimated the amount that would have been paid for the same services under the SNF PPS. This estimate reflected both adjustments for geographic variation and case-mix. For the geographic adjustment, we used the average rural wage index for FY 2001 (that is, 0.8700). For case-mix, although Medicare swing-bed claims do not include all of the data elements necessary to classify patients in exactly the same way as the patients would be classified in the RUG–III system, there is enough information to assign Medicare swing-bed patients to RUG–III categories at a general level. To generate this classification, we used the MEDPAR case-mix analog described in detail in the SNF PPS interim final rule published on May 12, 1998 (63 FR 26252). As a result, we were able to estimate how the national swing-bed population would classify into RUG–III categories. We found that 69 percent of the covered days would be assigned to just two RUG–III categories (or six groups): medium rehabilitation and extensive services.

We also noted that 9 percent of the covered days were assigned to categories that are not typically associated with a Medicare level of care (impaired cognition and lower groups). We have not assumed that these claims were paid in error. Rather, we are assuming that these patients had skilled care needs other than ones that could be captured using the MEDPAR case-mix analog, and we have included these stays in our analysis.

TABLE 15.—RUG–III FREQUENCY DISTRIBUTION USING CALENDAR YEAR 1999 CLAIMS

RUG–III category level	Number of days paid	Percent of total days
Ultra High Rehab	30,618	3
Very High Rehab	33,687	4
High Rehab	76,596	9
Medium Rehab	264,614	30
Low Rehab	58,016	7
Extensive Services	288,131	33
Special Care	11,540	1
Clinically Complex	35,304	4
Impaired Cognition	4,737	1
Other	72,293	8
Totals	875,536	100

Our next step was to project the SNF PPS payments for these swing-bed services. For the purposes of this analysis, we used the calendar year frequency distribution and number of covered swing-bed days shown in Table 15. Unique nursing case-mix weights have already been developed for each level of the MEDPAR case-mix analog. These weights were used to adjust the proposed FY 2002 rural SNF PPS rates set forth in this proposed rule to determine the SNF PPS rates used in this estimate. We adjusted these rates for all BBRA and BIPA add-ons applicable for FY 2002.

Based on our analysis, the FY 2002 SNF PPS payment amount exceeds the projected payments under the current swing-bed payment system for that year in 5 of the 10 case-mix analog categories that included 79 percent of the swing bed days. In fact, for the two most common RUG-III categories, medium rehabilitation and extensive services, the projected increases are substantial: 14 percent for medium rehabilitation and 16 percent for extensive services. In addition, records in two of the categories where the projected SNF PPS rate is lower than the projected swing-bed payment amount under the present system (impaired cognition and other) group into much higher categories when using the full RUG–III algorithm.

In terms of aggregate Medicare expenditures, we estimate that the transition to SNF PPS will increase payments for SNF-level swing-bed services by 9 percent, or approximately $20 million, while the aggregate costs will be approximately $20 million in benefits and 6.32 million for completion of the MDS assessments.

Based on these estimates, we believe the financial impact on swing-bed providers will be positive, with the anticipated 9 percent payment increase serving to offset the estimated start-up costs associated with MDS completion and transmission (described in section VI.K of this proposed rule).

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

X. Federalism

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

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 413

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

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare.

42 CFR Part 482

Grant programs-health, Hospitals, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

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

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for part 410 continues to read as follows:

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

* * * * *

Subpart I—Payment of SMI Benefits

2. In § 410.150, the introductory text of paragraph (b) is republished, and paragraph (b)(14) is revised to read as follows:

§ 410.150 To whom payment is made.

* * * * *

(b) *Specific rules.* Subject to the conditions set forth in paragraph (a) of this section, Medicare Part B pays as follows:

* * * * *

(14) To an SNF for services (other than those described in § 411.15(p)(2) of this chapter) that it furnishes to a

resident (as defined in § 411.15(p)(3) of this chapter) of the SNF who is not in a covered Part A stay.

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

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

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

Subpart A—General Exclusions and Exclusion of Particular Services

4. In § 411.15, paragraph (p)(1) is revised, and paragraph (p)(2) introductory text, paragraph (p)(2)(i), and paragraph (p)(3) introductory text are revised to read as follows:

§ 411.15 Particular services excluded from coverage.

* * * * *

(p) *Services furnished to SNF residents.* (1) *Basic rule.* Except as provided in paragraph (p)(2) of this section, any service furnished to a resident of an SNF during a covered Part A stay by an entity other than the SNF, unless the SNF has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to the SNF's residents. Services subject to exclusion under this paragraph include, but are not limited to—

(i) Any physical, occupational, or speech-language therapy services, regardless of whether the services are furnished by (or under the supervision of) a physician or other health care professional, and regardless of whether the resident who receives the services is in a covered Part A stay; and

(ii) Services furnished as an incident to the professional services of a physician or other health care professional specified in paragraph (p)(2) of this section.

(2) *Exceptions.* The following services are not excluded from coverage, provided that the claim for payment includes the SNF's Medicare provider number in accordance with § 424.32(a)(5) of this chapter:

(i) Physicians' services that meet the criteria of § 415.102(a) of this chapter for payment on a fee schedule basis.

* * * * *

(3) *SNF resident defined.* For purposes of this paragraph, a beneficiary who is admitted to a Medicare-participating SNF is considered to be a resident of the SNF. Whenever the beneficiary leaves the facility, the beneficiary's status as an SNF resident for purposes of this paragraph (along with the SNF's responsibility to furnish or make arrangements for the services described in paragraph (p)(1) of this section) ends when one of the following events occurs—

* * * * *

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

5. The authority citation for part 413 is amended to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, 1886, and 1888 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395(f)b, 1395g, 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, 1395ww, and 1395yy).

Subpart F—Specific Categories of Costs

6. In § 413.114:

a. Paragraph (a) is revised.

b. In paragraph (c), the heading is revised.

c. Paragraph (d)(1) introductory text is revised.

§ 413.114 Payment for posthospital SNF care furnished by a swing-bed hospital.

(a) *Purpose and basis.* This section implements section 1883 of the Act, which provides for payment for posthospital SNF care furnished by rural hospitals and CAHs having a swing-bed approval.

(1) *Services furnished in cost reporting periods beginning prior to October 1, 2001.* Posthospital SNF care furnished in general routine inpatient beds in rural hospitals and CAHs is paid in accordance with the special rules in paragraph (c) of this section for determining the reasonable cost of this care. When furnished by rural and CAH swing-bed hospitals approved after March 31, 1988 with more than 49 beds (but fewer than 100), these services must also meet the additional payment requirements set forth in paragraph (d) of this section.

(2) *Services furnished in cost reporting periods beginning on and after October 1, 2001.* Posthospital SNF care furnished in general routine inpatient beds in rural hospitals (other than CAHs) is paid in accordance with the provisions of the prospective payment system for SNFs described in subpart J of this part. Posthospital SNF care furnished in general routine inpatient beds in CAHs is paid based on reasonable cost, in accordance with the provisions of subparts A through G of this part (other than paragraphs (c) and (d) of this section).

* * * * *

(c) *Special rules for determining the reasonable cost of posthospital SNF care furnished in cost reporting periods beginning prior to October 1, 2001.*

(d) *Additional requirements*—(1) *General rule.* For services furnished in cost reporting periods beginning prior to October 1, 2001, in order for Medicare payment to be made to a swing-bed hospital with more than 49 beds (but fewer than 100), the following payment requirements must be met:

* * * * *

7. In § 413.337, paragraph (e) is added to read as follows:

§ 413.337 Methodology for calculating the prospective payment rates.

* * * * *

(e) Pursuant to section 101 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) and revised by section 314 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), using the best available data, the Secretary will issue a new regulation with a newly refined case-mix classification system to better account for medically complex patients. Upon issuance of the new regulation, the temporary increases in payment for certain high cost patients will no longer be applicable.

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

8. The authority citation for part 424 continues to read as follows:

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

9. In § 424.20(a)(2), the heading is revised to read as follows:

§ 424.20 Requirements for posthospital SNF care.

(a) * * *

(2) *Special requirement for certifications performed prior to October 1, 2001: A swing-bed hospital with more than 49 beds (but fewer than 100) that does not transfer a swing-bed patient to a SNF within 5 days of the availability date.* * * *

* * * * *

Subpart C—Claims for Payment

10. In § 424.32, the introductory text of paragraph (a) is republished, and paragraphs (a)(2) and (a)(5) are revised.

§ 424.32 Basic requirements for all claims.

(a) A claim must meet the following requirements:

* * * * *

(2) A claim for physician services, clinical psychologist services, or clinical social worker services must include appropriate diagnostic coding for those services using ICD–9–CM.

* * * * *

(5) All Part B claims for services furnished to SNF residents (whether filed by the SNF or by another entity) must include the SNF's Medicare provider number and appropriate HCPCS coding.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

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

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

Subpart B—Essentials of Provider Agreements

12. In § 489.20, the introductory text is republished, and the introductory text of paragraph (s) is revised.

§ 489.20 Basic commitments.

The provider agrees to the following:

* * * * *

(s) In the case of an SNF, either to furnish directly or make arrangements (as defined in § 409.3 of this chapter) for any physical, occupational, or speech-language therapy services furnished to a resident of the SNF under § 411.15(p) of this chapter (regardless of whether the resident is in a covered Part A stay), and also either to furnish directly or make arrangements for all other Medicare-covered services furnished to a resident during a covered Part A stay, except the following:

* * * * *

13. In § 489.21, the introductory text is republished, and paragraph (h) is revised to read as follows:

§ 489.21 Specific limitations on charges.

Except as specified in subpart C of this part, the provider agrees not to charge a beneficiary for any of the following:

* * * * *

(h) Items and services (other than those described in § 489.20(s)(1) through (15)) required to be furnished under § 489.20(s) to a resident of an SNF (defined in § 411.15(p) of this chapter), for which Medicare payment would be made if furnished by the SNF or by other providers or suppliers under arrangements made with them by the SNF. For this purpose, a charge by another provider or supplier for such an item or service is treated as a charge by the SNF for the item or service, and is also prohibited.

Note: This appendix will not appear in the Code of Federal Regulations.

Appendix—Technical Features of the Proposed 1997 Skilled Nursing Facility Market Basket Index

As discussed in the preamble of this proposed rule, we propose to revise and rebase the SNF market basket. This appendix describes the technical aspects of the 1997-based index that we are proposing in this rule. We present this description of the market basket in three steps:

- A synopsis of the structural differences between the 1992-and the 1997-based market baskets.
- A description of the methodology used to develop the cost category weights in the proposed 1997-based market basket.
- A description of the data sources used to measure price change for each component of the proposed 1997-based market basket, making note of the differences, if any, from the price proxies used in the 1992-based market basket.

I. Synopsis of Structural Changes Adopted in the Proposed Revised and Rebased 1997 Skilled Nursing Facility Market Basket

We are proposing just one major structural change between the current 1992-based and the proposed 1997-based SNF market baskets, which is that more recent SNF cost data would be used in the proposed revised and rebased SNF market basket.

The proposed 1997-based market basket contains cost shares for six major cost categories that were derived from an edited set of FY 1997 Medicare Cost Reports for freestanding SNFs that had Medicare expenses. FY 1997 cost reports have cost reporting periods beginning after September 30, 1996 and before October 1, 1997. The 1992-based market basket used data from the PPS–9 Medicare Cost Reports for freestanding SNFs with Medicare expenses greater than 1 percent of total expenses. PPS–9 cost reports have cost reporting periods beginning after September 30, 1991 and before October 1, 1992. Cost allocations for the proposed 1997-based SNF market basket within the six major cost categories use Medicare Cost Reports and two Department of Commerce data sources: the 1997 Business Expenditures Survey, Bureau of the Census, Economics and Statistics Administration, and the 1997 Bureau of Economic Analysis' Annual Input-Output tables.

II. Methodology for Developing the Cost Category Weights

Cost category weights for the proposed 1997-based market basket were developed in two stages. First, base weights for six main categories (wages and salaries, employee benefits, contract labor, pharmaceuticals, capital-related expenses, and a residual ''all other'') were derived from the SNF Medicare Cost Reports described above. The residual ''all other'' cost category was divided into subcategories, using U.S. Department of Commerce data sources for the nursing home industry. Relationships from the 1997 Business Expenditures Survey and data from the 1997 Annual Input-Output tables were used to allocate the all other cost category.

Below we describe the source of the main category weights and their subcategories in the proposed 1997-based market basket.

- *Wages and Salaries:* The wages and salaries cost category is derived using 1997 SNF Medicare Cost Reports. The share was determined using wages and salaries from Worksheet S–3, part II and total expenses from Worksheet B. This share represents the wage and salary share of costs for employees of the nursing home, and does not include the wages and salaries from contract labor, which is allocated to wages and salaries at a later step.
- *Employee Benefits:* The weight for employee benefits was determined using 1997 Medicare Cost Reports. The share was derived using wage-related costs from Worksheet S–3, part II.
- *Contract Labor:* The weight for the contract labor cost category was derived using 1997 Medicare Cost Reports. For the proposed 1997-based SNF market basket, we used an edited group of cost reports with data filled in for contract labor on Worksheet S–3, part II. This methodology differed from that of the 1992 SNF market basket (where we estimated contract labor costs using data from Worksheet A) since Worksheet S–3, part II, was not available in the 1992 Cost Reports. This methodology produces results that are similar to the contract labor share in the 1997 Business Expenditures Survey. Contract labor was not available in the 1992 Asset and Expenditure Survey. As explained in the preamble, contract labor costs were distributed between the wages and salaries and employee benefits cost categories, under the assumption that contract costs should move at the same rate as direct labor costs even though unit labor cost levels may be different.
- *Pharmaceuticals:* The pharmaceuticals cost weight was derived from 1997 SNF Medicare Cost Reports. This share was calculated using non-salary costs from the pharmacy and drugs charged to patients' cost centers from Worksheet A.
- *Capital-Related:* The weight for the overall capital-related expenses cost category was derived using 1997 SNF Medicare Cost Report data from Worksheet B. The subcategory and vintage weights within the overall capital-related expenses were derived using additional data sources. The methodology for deriving these weights is described below.

In determining the subcategory weights for capital, we used a combination of information from the 1997 SNF Medicare Cost Reports and the 1997 Census Business Expenditures Survey. We estimated the depreciation expense share of capital-related expenses from the SNF Medicare Cost Reports using data from edited cost reports with data completed on Worksheet G. For the 1992-based SNF market basket, we had used depreciation expenses from the 1992 Asset

and Expenditure Survey. When we calculated the ratio of depreciation to wages from the 1997 SNF Medicare Cost Reports, the result was consistent with the ratio from the 1997 Business Expenditures Survey. The distribution between building and fixed equipment and movable equipment was determined from the 1997 Business Expenditures Survey. From these calculations, depreciation expenses (not including depreciation expenses implicit from leases) were estimated to be 33.2 percent of total capital-related expenditures in 1997.

The interest expense share of capital-related expenses was also derived from the same edited 1997 SNF Medicare Cost Reports. Interest expenses are not identifiable in the 1997 Business Expenditures Survey. We determined the split of interest expense between for-profit and not-for-profit facilities based on the distribution of long-term debt outstanding by type of SNF (for-profit or not-for-profit) from the 1997 SNF Medicare Cost Reports. Interest expense (not including interest expenses implicit from leases) was estimated to be 24.3 percent of total capital-related expenditures in 1997.

We used the 1997 Business Expenditures Survey to estimate the proportion of capital-related expenses attributable to leasing building and fixed and movable equipment. This share was estimated to be 34.9 percent of capital-related expenses in 1997. The split between fixed and movable lease expenses was directly available from the 1997 Business Expenditures Survey. We used this split, and the distribution of depreciation and interest calculated above to distribute leases among these cost categories. The remaining residual is considered to be other capital-related expenses (insurance, taxes, other). Other capital-related expenses were estimated to be 7.7 percent of total capital-related expenditures in 1997.

Table A–1 shows the capital-related expense distribution (including expenses from leases) in the proposed 1997 SNF PPS market basket and the 1992 SNF market basket.

TABLE A–1.—CAPITAL-RELATED EXPENSE DISTRIBUTION

	1992-based SNF capital-related expenses*	Proposed 1997-based SNF capital-related expenses*
Total	100.0	100.0
Depreciation	60.5	53.3
Building and Fixed Equipment	42.1	36.5
Movable equipment	18.4	16.8
Interest	32.6	39.0
Other capital-related expense	6.9	7.7

*As a percent of Total Capital-Related Expenses.

As explained in section III.B of the preamble, our methodology for determining the price change of capital-related expenses accounts for the vintage nature of capital, which is the acquisition and use of capital over time. In order to capture this vintage nature, the price proxies must be vintage-weighted. The determination of these vintage weights occurs in two steps. First, we must determine the expected useful life of capital and debt instruments in SNFs. Second, we must identify the proportion of expenditures within a cost category that are attributable to each individual year over the useful life of the relevant capital assets, or the vintage weights.

The derivation of useful life of capital is explained in detail in the May 12, 1998 interim final rule (63 FR 26252). The useful lives for the proposed 1997-based SNF market basket are the same as the 1992-based SNF market basket. The data source that was previously used to develop the useful lives of capital is no longer available and a suitable replacement has not been identified. We welcome comments on any data sources that would provide the necessary information for determining useful lives of capital and debt instruments.

Given the expected useful life of capital and debt instruments, we must determine the proportion of capital expenditures attributable to each year of the expected useful life by cost category. These proportions represent the vintage weights. We were not able to find an historical time series of capital expenditures by SNFs. Therefore, we approximated the capital expenditure patterns of SNFs over time using alternative SNF data sources. For building and fixed equipment, we used the stock of beds in nursing homes from the HCFA National Health Accounts for 1962 through 1997. We then used the change in the stock of beds each year to approximate building and fixed equipment purchases for that year. This procedure assumes that bed growth reflects the growth in capital-related costs in SNFs for building and fixed equipment. We believe this assumption is reasonable since the number of beds reflects the size of the SNF, and as the SNF adds beds, it also adds fixed capital.

For movable equipment, we used available SNF data to capture the changes in intensity of SNF services that would cause SNFs to purchase movable equipment. We estimated the change in intensity as the trend in the ratio of non-therapy ancillary costs to routine costs from the 1989 through 1997 SNF Medicare Cost Reports. We estimated this ratio for 1962 through 1988 using regression analysis. The time series of the ratio of non-therapy ancillary costs to routine costs for SNFs measures changes in intensity in SNF services, which are assumed to be associated with movable equipment purchase patterns. The assumption here is that as non-therapy ancillary costs increase compared with routine costs, the SNF caseload becomes more complex and would require more movable equipment. Again, the lack of direct movable equipment purchase data for SNFs over time required us to use alternative SNF data sources. The resulting two time series, determined from beds and the ratio of non-therapy ancillary to routine costs, reflect real capital purchases of building and fixed equipment and movable equipment over time, respectively.

To obtain nominal purchases, which are used to determine the vintage weights for interest, we converted the two real capital purchase series from 1963 through 1997 determined above to nominal capital purchase series using their respective price proxies (Boeckh institutional construction index and PPI for machinery and equipment). We then combined the two nominal series into one nominal capital purchase series for 1963 through 1997. Nominal capital purchases are needed for interest vintage weights to capture the value of the debt instrument.

Once these capital purchase time series were created for 1963 through 1997, we averaged different periods to obtain an average capital purchase pattern over time. For building and fixed equipment we averaged thirteen 23-year periods, for movable equipment we averaged twenty-six 10-year periods, and for interest we averaged fourteen 22-year periods. The vintage weight for a given year is calculated by dividing the capital purchase amount in any given year by the total amount of purchases during the expected useful life of the equipment or debt instrument. This methodology was described in full in the May 12, 1998 **Federal Register** (63 FR 26252). The resulting vintage weights for each of these cost categories are shown in Table A–2.

APPENDIX TABLE A–2.—VINTAGE WEIGHTS FOR PROPOSED 1997-BASED SNF PPS CAPITAL-RELATED PRICE PROXIES

Year	Building and fixed equipment	Movable equipment	Interest
1	0.082	0.083	0.025
2	0.086	0.088	0.028
3	0.085	0.089	0.031
4	0.083	0.090	0.034
5	0.077	0.091	0.038
6	0.069	0.097	0.042
7	0.063	0.106	0.046
8	0.060	0.111	0.049
9	0.050	0.116	0.051
10	0.040	0.128	0.051
11	0.040	.....	0.052
12	0.036	.....	0.053
13	0.030	.....	0.051
14	0.020	.....	0.050
15	0.016	.....	0.049
16	0.014	.....	0.048
17	0.012	.....	0.049
18	0.017	.....	0.050
19	0.018	.....	0.051
20	0.023	.....	0.051
21	0.025	.....	0.049
22	0.027	.....	0.051
23	0.029	.....	.....
Total	1.000	1.000	1.000

Sources: 1997 SNF Medicare Cost Reports; HCFA, National Health Accounts.

Note: Totals may not sum to 1.000 due to rounding.

• *All Other:* Subcategory weights for the All Other category were derived using information from two U.S. Department of Commerce data sources. Weights for the three utilities cost categories, as well as that for telephone services, were derived from the 1997 Business Expenditure Survey. Weights for other cost categories were derived from the 1997 Annual Input-Output tables.

III. Price Proxies Used To Measure Cost Category Growth

A. Wages and Salaries

For measuring price growth in the wages and salaries cost component of the 1997-based SNF market basket, we propose using the percentage change in the ECI for wages and salaries for private nursing homes. The ECI for wages and salaries for private nursing homes is a fixed-weight index that measures the rate of change in employee wage rates per hour worked. It measures pure price change and is not affected by shifts among occupations. Average Hourly Earnings (AHE) confounds changes in the proportion of different occupations with changes in earnings levels for a given occupation and, thus, is an inferior price proxy for our purpose. Even so, using the AHE for nursing homes has little effect on the percentage change in the overall proposed 1997 SNF market basket. If we used the AHE instead of the ECI, the average annual growth rate between 1995 and 2000 would have been higher by 0.1 percentage points per year. This difference reflects skill mix shifts that would be reflected in other factors of an update framework as conceptualized in section IV of the preamble. In addition, while the ECI is for all nursing homes, not just SNFs, 77 percent of employment in the nursing home industry in 1998 and 1999 was in SNFs. While this wage measure includes other nursing homes in addition to skilled nursing facilities, we believe it adequately reflects the wage changes occurring in SNFs. It is also the only acceptable statistical source for nursing home wages that met our criteria of reliability, timeliness, accessibility, and relevance.

B. Employee Benefits

For measuring price growth in the proposed 1997-based market basket, the percentage change in the ECI for benefits for private nursing homes is used. The ECI for benefits for private nursing homes is also a fixed-weight index that measures pure price change and is not affected by shifts in occupation. Again, we believe that the ECI for nursing homes is the most acceptable and appropriate benefit series available from reliable, timely, accessible, and relevant statistical sources.

C. All Other Expenses

• *Nonmedical professional fees:* The ECI for compensation for Private Industry Professional, Technical, and Specialty Workers is used to measure price changes in nonmedical professional fees.

• *Electricity:* For measuring price change in the electricity cost category, the PPI for Commercial Electric Power is used.

• *Fuels, nonhighway:* For measuring price change in the Fuels, Nonhighway cost category, the PPI for Commercial Natural Gas is used.

• *Water and Sewerage:* For measuring price change in the Water and Sewerage cost category, the CPI–U (Consumer Price Index for All Urban Consumers) for Water and Sewerage is used.

• *Food-wholesale purchases:* For measuring price change in the Food-wholesale purchases cost category, the PPI for Processed Foods is used.

• *Food-retail purchases:* For measuring price change in the Food-retail purchases cost category, the CPI–U for Food Away From Home is used. This reflects the use of contract food service by some SNFs.

• *Pharmaceuticals:* For measuring price change in the Pharmaceuticals cost category, the PPI for Prescription Drugs is used.

• *Chemicals:* For measuring price change in the Chemicals cost category, the PPI for Industrial Chemicals is used.

• *Rubber and Plastics:* For measuring price change in the Rubber and Plastics cost category, the PPI for Rubber and Plastic Products is used.

• *Paper Products:* For measuring price change in the Paper Products cost category, the PPI for Converted Paper and Paperboard is used.

• *Miscellaneous Products:* For measuring price change in the Miscellaneous Products cost category, the PPI for Finished Goods less Food and Energy is used. This represents a change from the 1992 SNF market basket, in which the PPI for Finished Goods is used. Both food and energy are already adequately represented in separate cost categories and should not also be reflected in this cost category.

• *Telephone Services:* The percentage change in the price of Telephone Services as measured by the CPI–U is applied to this component.

• *Labor-Intensive Services:* For measuring price change in the Labor-Intensive Services cost category, the ECI for Compensation for Private Service Occupations is used.

• *Non Labor-Intensive Services:* For measuring price change in the Non Labor-Intensive Services cost category, the CPI–U for All Items is used.

D. Capital-Related

All capital-related expense categories have the same price proxies as those used in the 1992-based SNF PPS market basket described in the May 12, 1998 **Federal Register** (63 FR 26252). The price proxies for the SNF capital-related expenses are described below:

• *Depreciation—Building and Fixed Equipment:* The Boeckh Institutional Construction Index for unit prices of fixed assets.

• *Depreciation—Movable Equipment:* The PPI for Machinery and Equipment.

• *Interest—Government and Nonprofit SNFs:* The Average Yield for Municipal Bonds from the Bond Buyer Index of 20 bonds. HCFA input price indexes, including this rebased SNF index, appropriately reflect the rate of change in the price proxy and not the level of the price proxy. While SNFs may face different interest rate levels than those included in the Bond Buyer Index, the rate of change between the two is not significantly different.

• *Interest—For-profit SNFs:* The Average Yield for Moody's AAA Corporate Bonds. Again, the proposed rebased SNF index focuses on the rate of change in this interest rate and not the level of the interest rate.

• *Other Capital-related Expenses:* The CPI–U for Residential Rent.

APPENDIX TABLE A–3.—A COMPARISON OF PRICE PROXIES USED IN THE 1992-BASED AND PROPOSED 1997-BASED SKILLED NURSING FACILITY MARKET BASKETS

Cost category	1992-based price proxy	1997-based price proxy
Wages and Salaries	ECI for Wages and Salaries for Private Nursing Homes	Same.
Employee Benefits	ECI for Benefits for Private Nursing Homes	Same.

APPENDIX TABLE A–3.—A COMPARISON OF PRICE PROXIES USED IN THE 1992-BASED AND PROPOSED 1997-BASED SKILLED NURSING FACILITY MARKET BASKETS—Continued

Cost category	1992-based price proxy	1997-based price proxy
Nonmedical professional fees	ECI for Compensation for Private Professional and Technical Workers.	Same.
Electricity	PPI for Commercial Electric Power	Same.
Fuels	PPI for Commercial Natural Gas	Same.
Water and sewerage	CPI–U for Water and Sewerage	Same.
Food—Wholesale purchases	PPI—Processed Foods	Same.
Food—Retail purchases	CPI–U—Food Away From Home	Same.
Pharmaceuticals	PPI for Prescription Drugs	Same.
Chemicals	PPI for Industrial Chemicals	Same.
Rubber and plastics	PPI for Rubber and Plastic Products	Same.
Paper products	PPI for Converted Paper and Paperboard	Same.
Miscellaneous products	PPI for Finished Goods	PPI for Finished Goods less Food and Energy.
Telephone services	CPI–U for Telephone Services	Same.
Labor-intensive services	ECI for Compensation for private service occupations	Same.
Non labor-intensive services	CPI–U for All Items	Same.
Depreciation: Building and Fixed Equipment	Boeckh Institutional Construction Index	Same.
Depreciation: Movable Equipment	PPI for Machinery and Equipment	Same.
Interest: Government and Nonprofit SNFs	Average Yield Municipal Bonds (Bond Buyer Index-20 bonds)	Same.
Interest: For-profit SNFs	Average Yield Moody's AAA Bonds	Same.
Other Capital-related Expenses	CPI–U for Residential Rent	Same.

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

Dated: March 8, 2001.

Michael McMullan,

Acting Deputy Administrator, Health Care Financing Administration.

Dated: April 23, 2001.

Tommy G. Thompson,

Secretary.

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