DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 413

[HCFA–1905–FC]

RIN 0938–AI84

Medicare Program; Schedule of Per-Beneficiary Limitations on Home Health Agency Costs for Cost Reporting Periods Beginning on or After October 1, 1997

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period sets forth, in accordance with section 4602 of the Balanced Budget Act of 1997, a new schedule of limitations on home health agency costs that may be paid under the Medicare program for cost reporting periods beginning on or after October 1, 1997. These limitations are in addition to the per-visit limitations that were set forth in our January 2, 1998 notice with comment period.

DATES: *Effective Date:* This rule is effective October 1, 1997.

Applicability Date: The schedule of per-beneficiary limitations is applicable for cost reporting periods beginning on or after October 1, 1997.

Comment Date: Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on June 1, 1998.

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–1905–FC, P.O. Box 7517, Baltimore, Maryland 21207–0517.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, D.C. 20201, or

Room C5–09–26, Central Building, 7500 Security Boulevard, Baltimore, Maryland 21244–1850

Comments may also be submitted electronically to the following E-mail address: HCFA1905FC@hcfa.gov. E-mail comments must include the full name and address of the sender and must be submitted to the referenced address in order to be considered. All comments must be incorporated in the E-mail message because we may not be able to access attachments.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1905–FC.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW, Washington, D.C., on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (Phone: (202) 690–7890).

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FOR FURTHER INFORMATION CONTACT: Michael Bussacca, (410) 786–4602.

SUPPLEMENTARY INFORMATION:

I. Background

A. Program History

Section 1861(v)(1)(A) of the Social Security Act (the Act) authorizes the Secretary to establish limitations on allowable costs incurred by a provider of services that may be paid under the Medicare program, based on estimates of the costs necessary for the efficient delivery of needed health services. Under this authority, we have maintained limitations on home health agency (HHA) per-visit costs since 1979. Additional statutory provisions specifically governing the limitations applicable to HHAs are contained at section 1861(v)(1)(L) of the Act. These limits will be replaced by the establishment of a prospective payment system for home health services. However, section 1861(v)(1)(L)(v) of the Act, as added by section 4602(c) of the Balanced Budget Act of 1997 (BBA '97), Pub. L. 105–33, requires the Secretary to establish an interim system of payment limitations prior to implementation of the prospective payment system. Payments by Medicare under this interim system of payment limitations must be the lower of an HHA's actual reasonable allowable costs, per-visit limitations in the aggregate, or a per-beneficiary limitation in the aggregate as described in sections 1861(v)(1)(L)(v)(I) and (v)(1)(L)(vi)(I) of the Act.

Section 1861(v)(1)(L)(v)(I) requires the per-beneficiary annual limitation be a blend of: (1), an agency-specific per-beneficiary limitation based on 75 percent of 98 percent of the reasonable costs (including nonroutine medical supplies) for the agency's 12-month cost reporting period ending during Federal fiscal year (FY) 1994, and (2), a census region division per-beneficiary limitation based on 25 percent of 98 percent of the regional average of such costs for the agency's census division for cost reporting periods ending during FY 1994, standardized by the hospital wage index. The reasonable costs used in the per-beneficiary limitation calculations in 1 and 2 above will be updated by the home health market basket excluding any changes in the home health market basket with respect to cost reporting periods that began on or after July 1, 1994 and before July 1, 1996. This per-beneficiary limitation based on the blend of the agency-specific and census region division per-beneficiary limitations will then be multiplied by the agency's unduplicated census count of beneficiaries (entitled to benefits under Medicare) to calculate the HHA's aggregate per-beneficiary limitation for the cost reporting period subject to the limitation.

For new providers and providers without a 12-month cost reporting period ending in Federal fiscal year 1994, the per-beneficiary limitation will be equal to the median of these limitations applied to other HHAs as determined under section 1861(v)(1)(L)(v) of the Act.

B. Relevant Provisions of the Balanced Budget Act of 1997

The BBA '97 made several changes that affect the amount of costs to be paid under Medicare for services provided by HHAs. The provisions of BBA '97 that we are implementing in this final rule with comment period are as follows.

1. Additions to Cost Limitations

Section 1861(v)(1)(L)(v) was added to the Act by section 4602(c) of BBA '97 and requires the establishment of an interim system of limitations for services furnished by home health agencies.

Payment will not exceed the lesser of reasonable costs or the aggregate effect of the per-visit limitations published on January 2, 1998 (63 FR 89) or if lower, the aggregate per-beneficiary limitation as described in this final rule with comment.

A per-beneficiary limitation for agencies with a 12-month cost reporting period ending during Federal FY 1994 is determined as follows: (1), an agency-specific per-beneficiary limitation based on 75 percent of 98 percent of the reasonable costs (including nonroutine medical supplies) for the agency's 12-month cost reporting period ending during Federal fiscal year (FY) 1994, and (2), a census region division per-beneficiary limitation based on 25 percent of 98 percent of the regional average of such costs for the agency's census division for cost reporting periods ending during FY 1994, standardized by the hospital wage index. The reasonable costs used in the per-beneficiary limitation calculations in 1 and 2 above will be updated by the home health market basket excluding any changes in the home health market basket with respect to cost reporting periods that began on or after July 1, 1994 and before July 1, 1996. This per-beneficiary limitation based on the blend of the agency-specific and census region division per-beneficiary limitations will then be multiplied by the agency's unduplicated census count of beneficiaries (entitled to benefits under Medicare) to calculate the HHA's aggregate per-beneficiary limitation for the cost reporting period subject to the limitation.

How these per-beneficiary limitations are determined is explained further in section V of this document.

2. New Providers and Providers Without a 12-Month Cost Reporting Period Ending in FY 1994

Section 1861(v)(1)(L)(vi) was added to the Act by section 4602(c) of BBA '97 and requires the per-beneficiary limitation for new providers and those providers without a 12-month cost reporting period ending in FY 1994 be equal to the median of the section 1861(v)(1)(L)(v) per-beneficiary limitations applied to other HHAs.

Also, an HHA that had a 12-month cost reporting period ending during Federal FY 1994 and had altered its corporate structure or name will not be considered a new provider for purposes of determining the per-beneficiary limitation. Examples of an HHA that has altered its corporate structure but has kept its operational structure as a freestanding or provider-based HHA would be an agency that has gone from being a non-profit entity to a profit entity or an agency that has gone from being a subchapter S corporation to a proprietary individual. The most common occurrence of an agency changing its name would be a change in ownership whereby the new owners change the name of the agency but continue operating as a freestanding or provider-based HHA. The per-beneficiary limitation that applies to these types of changes will be determined under section 1861(v)(1)(L)(v).

3. Reduction in Market Basket Updates

Section 1861(v)(1)(L)(iv) was added to the Act by section 4601(a) of BBA '97 and requires the Secretary not to take into account any changes in the home health market basket with respect to cost reporting periods which began on or after July 1, 1994 and before July 1, 1996 in establishing the section 1861(v)(1)(L) limitations for cost reporting periods beginning after September 30, 1997. This, in effect, reduces the factors for increasing the costs in the data base used in calculating the per-beneficiary limitations. These factors are set forth in section IV. of this document.

4. Application of the Wage Index Based on Site of Service Rendered

Section 1861(v)(1)(L)(iii) was amended by section 4604(b) of BBA '97 to require that the utilization of the area wage index applicable under section 1886(d)(3)(E) of the Act be determined using the survey of the most recent available wages and wage-related costs of hospitals located in the geographic area in which the home health services are furnished. In effect, the regional component of the per-beneficiary limitation that will apply for the beneficiary receiving services from the HHA will be the appropriate census region per-beneficiary limitation and adjusted by the appropriate wage index for the geographic area where the beneficiary received home health services. A Program Memorandum (Rev. AB–97–18), published in September 1997, outlined the billing changes that are needed to properly implement this provision.

5. Effective Date

Section 1861(v)(1)(L)(vii) of the Act was added by section 4602(c) of BBA '97.

Beginning in FY 1998, the Secretary is required to establish the per-beneficiary limitations by August 1 of each year. However, for cost reporting periods beginning on or after October 1, 1997, the Secretary need only establish those limitations by April 1, 1998. In accordance with section 1861(v)(1)(L)(vii)(I), we are establishing by April 1, 1998, the per-beneficiary limitations for cost reporting periods beginning on or after October 1, 1997.

II. Per-Beneficiary Limitations

The cost report data used to develop the schedule of per-beneficiary limitations set forth in this final rule are for cost reporting periods ending in Federal FY 1994, as required by section 4602(c) of BBA '97. We have updated the per-beneficiary limitations to reflect the expected cost increases occurring between the cost reporting periods for the data contained in the database and September 30, 1998 (excluding, as required by statute, any changes in the home health market basket for cost reporting periods beginning on or after July 1, 1994 and before July 1, 1996).

The interim payment sets limitations according to two different methodologies. For agencies with cost reporting periods ending during Federal FY 1994, the limitation is based on 75 percent of 98 percent of the agencies' own reasonable costs and 25 percent of 98 percent of the average census region division costs. At the end of the agency's cost reporting period subject to the per-beneficiary limitations, the labor component of the census region division per-beneficiary limitation is adjusted by a wage index based on where the home health services are rendered.

For new providers and providers without a cost reporting period ending during Federal FY 1994, the per-beneficiary limitation is based on the standardized national median of the blended agency-specific and census region division per-beneficiary limitations described above. This is done by simply arraying the agencies' per-beneficiary limitations and selecting the median case. This national per-beneficiary limitation is then standardized for the effect of the wage index. The wage index is applied to the

labor component of the national per-beneficiary limitation at the end of the cost reporting period beginning on or after October 1, 1997, and is based on where the home health services are rendered.

The detailed methodologies for calculating the per-beneficiary limitations and how they are applied to agencies' costs for cost reporting periods beginning on or after October 1, 1997 are described below.

A. Agency-Specific Rates

Section 1861(v)(1)(L)(v)(I) of the Act requires that 75 percent of the per-beneficiary limitation be based on 98 percent of the reasonable costs for the agency's 12-month cost reporting period that ended during FY 1994. Reasonable costs are the lesser of the actual Medicare costs of the discipline services or the aggregate discipline limitation, plus nonroutine medical supplies. This amount is multiplied by 98 percent and divided by the HHA's Federal FY 1994 unduplicated census count of beneficiaries to calculate the agency-specific per-beneficiary amount. An intricate and important part of the agency-specific per-beneficiary computation is the use of the Federal FY 1994 unduplicated census count of beneficiaries. After BBA '97 was enacted, many HHAs and their trade association representatives asserted that the unduplicated census counts of beneficiaries, as reported on the Federal FY 1994 Medicare cost report, was frequently an incorrect figure. Even though this number was a statistic required to be reported to Medicare, it was apparently not carefully monitored by HHAs because it did not impact Medicare payments at that time.

Through an analysis of our database to be used in establishing the regional per-beneficiary limitations, which includes the same cost reporting period used in establishing the agency-specific per-beneficiary limitation, we confirmed that the unduplicated census count was not reliable. Based upon this determination, we generated a more accurate unduplicated census count from HCFA's Standard Analytical File (SAF), which is generated from our National Claims History File. The unduplicated census count was created from the SAF by matching all claims to each agency's cost reporting period ending in Federal FY 1994 and identifying individual beneficiaries represented in the claims. Each beneficiary was counted only once for all the claim(s) identified for that cost reporting period for each agency. A list of HHAs and associated unduplicated census counts from the SAF has been disseminated to the intermediaries for calculating the agency-specific per-beneficiary limitations. If the intermediary has an HHA that has a 12-month cost reporting period that ended in Federal FY 1994 and that agency was not on the list for an unduplicated census count from SAF, the intermediary must contact HCFA so that an unduplicated census count can be generated from SAF.

B. Regional Rates by Census Division

Section 1861(v)(1)(L)(v)(I) of the Act requires that 25 percent of the per-beneficiary limitation be based on 98 percent of the standardized regional average of reasonable costs for the agency's census division for cost reporting periods ending during Federal FY 1994. To develop the schedule of per-beneficiary limitations by census region, we extracted the totals of the Medicare allowable costs, the aggregate cost per-visit limitation, and the Medicare nonroutine medical supply costs from settled Medicare cost reports of all HHAs for cost reporting periods ending in Federal FY 1994. How this data was used in calculating the regional rates by census division is explained further in section V.B..

Section 1861(v)(1)(L)(v)(I) requires that the costs used in calculating the per-beneficiary limitations be updated using the home health market basket index. However, section 1861(v)(1)(L)(iv) prohibits the Secretary from taking into account any changes in the home health market basket with respect to cost reporting periods which began on or after July 1, 1994 and before July 1, 1996. Therefore, we adjusted the database used in calculating the regional per-beneficiary limitations by the market basket index excluding any changes in the home health market basket with respect to cost reporting periods which began on or after July 1, 1994 and before July 1, 1996.

C. Wage Index

A wage index is used to adjust the labor-related portion of the standardized regional average per-beneficiary limitation to reflect differing wage levels among areas. In establishing the regional average per-beneficiary limitation, we used the FY 1998 hospital wage index, which is based on 1994 hospital wage data.

Each HHA's labor market area is determined based on the definitions of Metropolitan Statistical Areas (MSAs) issued by the Office of Management and Budget (OMB). Section 1861(v)(1)(L)(iii) of the Act requires us to use the current hospital wage index (that is, the FY 1998 hospital wage index, which was published in the **Federal Register** on August 29, 1997 (62 FR 46070)) without regard to whether such hospitals have been reclassified to a new geographic area, to establish the HHA cost limitations. Therefore, the schedule of standardized regional average per-beneficiary limitations reflects the MSA definitions that are currently in effect under the hospital prospective payment system.

We are continuing to incorporate exceptions to the MSA classification system for certain New England counties that were identified in the July 1, 1992 notice (57 FR 29410). These exceptions have been recognized in setting hospital cost limitations for cost reporting periods beginning on and after July 1, 1979 (45 FR 41218), and were authorized under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–11). Section 601(g) of Public Law 98–21 requires that any hospital in New England that was classified as being in an urban area under the classification system in effect in 1979 will be considered urban for purposes of the hospital prospective payment system. This provision is intended to ensure equitable treatment under the hospital prospective payment system. Under this authority, the following counties have been deemed to be urban areas for purposes of payment under the inpatient hospital prospective system:

- Litchfield County, CT in the Hartford, CT MSA.
- York County, ME and Sagadahoc County, ME in the Portland, ME MSA.
- Merrimack County, NH in the Boston-Brockton-Nashua, MA–NH MSA
- Newport County, RI in the Providence Fall-Warwick, RI MSA

We are continuing to grant these urban exceptions for the purpose of applying the Medicare hospital wage index to the HHA standardized regional average per-beneficiary limitations. These exceptions result in the same New England County Metropolitan Area definitions for hospitals, skilled nursing facilities, and HHAs. In New England, MSAs are defined on town boundaries rather than on county lines but exclude parts of the four counties cited above that would be considered urban under the MSA definition. Under this notice, these four counties are urban under either definition, New England County Metropolitan Area or MSA.

Section 1861(v)(1)(L)(iii), amended by section 4604(b) of BBA '97, requires the use of the area wage index applicable under section 1886(d)(3)(E) of the Act and determined using the survey of the most recent available wages and wage-related costs of hospitals located in the

geographic area in which the home health service is furnished without regard to whether such hospitals have been reclassified to a new geographic area pursuant to section 1886(d)(8)(B) of the Act. Effective with cost reporting periods beginning on or after October 1, 1997, the wage-index, as applied to the labor portion of the regional per-beneficiary limitation, must be based on the geographic location in which the home health service is actually furnished rather than the physical location of the HHA itself.

III. Determination of Old or New Home Health Agencies

The per-beneficiary limitation determined under section 1861(v)(1)(L)(v)(''clause v'' HHAs) will apply to all HHAs that have a 12-month cost reporting period ending during FY 1994. There are, however, HHAs that had a 52/53 week cost reporting cycle that ended in Federal FY 1994, or a 13-month cost reporting period that ended during Federal FY 1994 (as allowed in accordance with Medicare principles of reimbursement). For purposes of determining the per-beneficiary limitation, these HHAs will be deemed to be ''clause v'' HHAs. Also, an HHA that had a 12-month cost reporting period ending in Federal FY 1994 and altered its corporate structure or name is a ''clause v'' HHA for purposes of determining the per-beneficiary limitation.

Section 1861(v)(1)(L)(vi) of the Act states that for new HHAs and agencies without a 12-month cost reporting that ended in FY 1994 (''clause vi'' HHAs), the per-beneficiary limitation is the median of these limitations applied to other HHAs, as determined by the Secretary.

A. Less Than a Twelve-Month Cost Reporting Period During Federal FY 1994

Without exception, all HHAs that did not have a 12-month cost reporting period that ended in Federal FY 1994 will have the national per-beneficiary limitation applied to the agency's unduplicated census count of Medicare beneficiaries for the cost reporting period beginning on and after October 1, 1997. The national per-beneficiary limitation that applies to the unduplicated census count of Medicare beneficiaries for ''clause vi'' HHAs is in Table 3b.

B. HHAs Entering the Medicare Program After Federal FY 1994

New HHAs that entered the Medicare program after Federal FY 1994 will have the national per-beneficiary limitation applied to the unduplicated census count of Medicare beneficiaries for cost reporting periods beginning on or after October 1, 1997. A new HHA is one that did not have approval to participate in the Medicare program under present or previous ownership prior to October 1, 1993.

C. Other

There are cases in which there could be changes in a ''clause v'' type HHA's operational structure, after Federal FY 1994, that could have an impact on the determination of the per-beneficiary limitation that is applicable to the HHA for cost reporting periods beginning on or after October 1, 1997. Examples of such changes are mergers, consolidations, and changes in ownership resulting in a change in the operational structure. The policies that apply when there are changes in the operational structure of an HHA after its cost reporting ended after FY 1994 are as follows:

1. Mergers or Consolidations of Like HHAs (Two or More Freestanding or Two or More Provider-Based Agencies) With Cost Reporting Periods Ending in Federal Fiscal Year 1994

There could be cases in which the merger or consolidation of two or more like HHAs (freestanding or provider-based) would not alter the surviving HHA's corporate structure, but applying the surviving HHA's per-beneficiary limitation to the combined operational structure would not be appropriate. Therefore, if two or more like HHAs (two or more freestanding agencies or two or more provider-based agencies) that had cost reporting periods that ended in Federal FY 1994 merge or consolidate after Federal FY 1994, the per-beneficiary limitation will be recalculated based on an average of the agencies' Medicare costs weighted by their unduplicated census counts in Federal FY 1994. If the agencies have different cost reporting period year ends, the costs must be inflated to common year end dates. For example, HHA 1, with a cost reporting period that ended March 31, 1994, merged on December 1, 1996 with HHA 2, with a cost reporting period that ended November 30, 1993. HHA 2's corporate structure did not change, but the operational structure changed with the inclusion of HHA 1. The Medicare allowable reasonable costs, the aggregate per-visit limitation, and the nonroutine medical supply costs of HHA 1 will be updated to November 30, 1996. The Medicare allowable costs, the aggregate per-visit limitation, and the nonroutine medical supply costs of HHA 2 will be updated to November 30, 1996. The lesser of the combined updated Medicare allowable reasonable costs or the combined updated aggregate per-visit limitation, plus the combined updated nonroutine medical supply costs will be divided by the combined unduplicated patient census counts. The weighted average per-beneficiary amount will then be further updated to October 31, 1998 to derive the per-beneficiary limitation that applies to the HHA's cost reporting period which began November 1, 1997. The same procedures would apply if HHA 1 and HHA 2 were subunits in Federal FY 1994.

2. Mergers or Consolidations When Only One of the HHAs Had a Cost Report That Ended in Federal Fiscal 1994

There could be situations in which two or more HHAs merge or consolidate into one after Federal FY 1994 and only one of the HHAs had a cost reporting period ending in Federal FY 1994. The statute is specific as to what per-beneficiary limitation applies to agencies with cost reporting periods ending in Federal FY 1994 and what per-beneficiary limitation applies to agencies that do not have a cost reporting period ending in Federal FY 1994. The two methodologies do not interrelate sufficiently to allow the application of a methodology similar to the methodology described in section III. C.1. above. Because the two methodologies do not interrelate, we have taken a position that we believe is equitable within the constraints of the statute. If HHAs merge or consolidate after Federal FY 1994 and only one of the HHAs had a cost reporting period that ended in Federal FY 1994, the agency will be considered a ''clause vi'' agency with respect to applying the per-beneficiary limitation. That is, the per-beneficiary limitation will be the national per-beneficiary limitation that applies to new agencies.

3. Complete Changes in the Operational Structure of the HHA

There are situations when the costs of operations of the HHA could change either through a change of ownership or an internal reconfiguration of the operational structure within the same HHA after Federal FY 1994. Examples of this would be a freestanding agency becoming a provider-based agency or vice-versa. Even though this could be construed as an agency which has merely altered its corporate structure, the costs of operations are significantly different between a freestanding agency and a provider-based agency. We do not

believe the statute was intended to advantage or disadvantage different classes of agencies whose means of determining overhead costs are completely different. Generally, a freestanding agency has control over the overhead costs it incurs while a provider-based agency has little, if any, control over the overhead costs it incurs. Therefore, if ''clause v'' freestanding HHAs become provider-based, and vice versa, through a change in ownership or other means, after Federal FY 1994, these agencies will be considered ''clause vi'' agencies with respect to applying the per-beneficiary limitation. We also noted that branches within HHAs generally do not have direct overhead costs specifically identified to them on the Medicare cost report. HHAs that have branches report costs on the Medicare cost report as a single agency. As such, the branch does not exist as an independent agency certified by Medicare. The branch is encompassed in the parent agency's certification. Therefore, when branches within HHAs that have a cost reporting period ending in Federal FY 1994 become subunits after Federal fiscal 1994, whereby they are certified under Medicare to operate as a freestanding HHA, these new subunits will be considered ''clause vi'' agencies with respect to applying the per-beneficiary limitation.

IV. Market Basket

The 1993-based cost categories and weights are listed in Table 1 below.

TABLE 1.—1993-BASED COST CATEGORIES, BASKET WEIGHTS, AND PRICE PROXIES

Cost category	1993-based market basket weight	Price proxy
Compensation, including allocated Contract Services' Labor	77.668	
Wages and Salaries, Including allocated Contract Services' Labor.	64.226	HHA Occupational Wage Index.
Employee benefits, including allocated Contract Services' Labor.	13.442	HHA Occupational Benefits Index.
Operations & Maintenance	0.832	CPI–U Fuel & Other Utilities.
Administrative & General, including allocated Contract Services' Non-Labor	9.569	
Telephone	0.725	CPI–U Telephone.
Paper & Printing	0.529	CPI–U Household Paper, Paper Products & Stationery Supplies.
Postage	0.724	CPI–U Postage.
Other Administrative & General, including Allocated Contract Services Non-Labor.	7.591	CPI–Services.
Transportation	3.405	CPI–U Private Transportation.
Capital-Related	3.204	
Insurance	0.560	CPI–U Household Insurance.
Fixed Capital	1.764	CPI–U Household Insurance.
Movable Capital	0.880	PPI Machinery & Equipment.
Other Expenses, including allocated Contract Services' Non-Labor..	5.322	CPI–U All Items Less Food & Energy.
Total	100.000	

V. Methodology for Determining Per-Beneficiary Limitation

A. Agency-Specific Per-Beneficiary Limitation

Section 1861(v)(1)(L)(v) of the Act, in part, requires that 75 percent of the per-beneficiary limitation be based on 98 percent of the reasonable costs for the agency's 12-month cost reporting period during Federal FY 1994. Reasonable costs are defined as the lesser of the actual Medicare aggregate costs of discipline services or the aggregate discipline per-visit limitation. The Medicare allowable costs of nonroutine supplies is added to this amount and multiplied by 98 percent. The result of this computation is then divided by the HHA's Federal FY 1994 unduplicated census count of Medicare beneficiaries to derive the agency-specific limitation which will be 75 percent of the per-beneficiary limitation.

The computation of the agency-specific per-beneficiary limitation is performed by the HHA's intermediary. For provider-based HHAs, the reasonable costs are the lesser of line 7, columns 8 and 9, or line 14 columns 8 and 9, plus line 15, columns 8 and 9, as reported on Supplemental Worksheet H–5 (Form HCFA–2552–92-H (4/93)), of the Medicare cost report for the cost reporting period ending in Federal fiscal 1994, multiplied by 98 percent. The results are divided by the unduplicated census count of Medicare beneficiaries, as provided by HCFA. For freestanding HHAs, the reasonable costs are the lesser of line 7, column 9, or line 14, column 9, plus line 17, columns 7 and 8, as reported on Worksheet C (Form HCFA–1728–86 (6/76)) of the Medicare cost report for the cost reporting period ending during Federal FY 1994, multiplied by 98 percent. The results are divided by the unduplicated census count for Medicare beneficiaries, as provided by HCFA.

The agency-specific per-beneficiary limitation must also be adjusted using the latest available market basket factors to reflect expected cost increases occurring between the cost reporting period ending during Federal FY 1994 and the cost reporting period ending during FY 1998. The factors for inflating the agency-specific per-beneficiary limitation are provided on Tables 2 and 5 or determined using Table 6.

In establishing the agency-specific per-beneficiary limitation, it is important that the amount determined is an accurate reflection of the home health services provided to Medicare beneficiaries in Federal FY 1994. Because the per-beneficiary limitation required by section 1861(v)(1)(L)(v)(I) of the Act is established, in part, using agency-specific cost report data during Federal FY 1994, and the unduplicated census count of Medicare beneficiaries

as may have been reported on the cost report is not being used in the computation, we are allowing HHAs to request a review of the calculation of the agency-specific limitation which includes the number of unduplicated counts of Medicare beneficiaries used in the computation. HHAs will have 180 days from the notification date of the agency-specific per-beneficiary limitation to request a review from its intermediary that the number of unduplicated census counts of Medicare beneficiaries as provided by HCFA is incorrect or other data from the Federal FY 1994 cost report used in the calculation of the agency-specific amount is/are incorrect. The HHA would bear the burden of proof to document its proffer of the appropriate number of unduplicated census counts of Medicare beneficiaries or the other appropriate data used in the calculation. An unduplicated census count of Medicare beneficiaries is a count of one for each Medicare patient receiving home health services from an HHA during its cost reporting period, regardless of the number of services or the number of different plans of care that the patient may have been under during the HHA's cost reporting period. If the agency can demonstrate to the satisfaction of the intermediary that a change should be made, the intermediary would appropriately recalculate the agency-specific per-beneficiary limitation. The intermediary must provide to the HHA its determination, in writing, whether or not an adjustment is provided.

B. Census Division Standardized Regional Average Per-Beneficiary Limitations

Section 1861(v)(1)(L)(v)(I) of the Act requires, in part, that 25 percent of the per-beneficiary limitation be based on 98 percent of the standardized regional average of such costs for the agency's census division for cost reporting periods ending during Federal FY 1994 and such costs updated by the home health market basket index.

The standardized regional average per-beneficiary limitations by census region were determined by extracting settled actual data from Medicare cost reports ending in Federal FY 1994 for freestanding and provider-based HHAs. The unduplicated census counts in the data file were replaced with the unduplicated census counts of Medicare beneficiaries generated using the SAF. Section 1861(v)(1)(L)(iii) of the Act, as amended by section 4604 of BBA '97, requires that we base the payments for home health services on the location where the services are provided. The file created from the SAF accumulated the number of beneficiaries in each MSA/non-MSA area serviced by each HHA. This file was created by matching all claims to each agency's cost reporting period to determine the unduplicated census counts by MSA/non-MSA area. This file was merged with the cost report file and replaced the unduplicated census counts reported by the HHAs on the Medicare cost report. HHAs were grouped within their appropriate census region based on the HHAs' State and county code. Agencies not located in a census region, e.g. Puerto Rico, were grouped separately rather than arbitrarily assigned to a census region.

In order to account for the statutory requirement that the wage index used in calculating the limitations be based on the location where the home health service was furnished rather than the location of the HHA, it was necessary to develop a wage-index weighted by the number of beneficiaries in each MSA/non-MSA in each census region. The unduplicated census counts of Medicare beneficiaries for each MSA/non-MSA serviced by the HHA were multiplied by the appropriate wage index that applied to that MSA/non-MSA. The product of these computations were totaled for each HHA to yield a wage index adjusted unduplicated census count of Medicare beneficiaries. The lesser of the Medicare reasonable costs or aggregate per-visit limitation plus nonroutine medical supplies for each HHA were totaled for each census region. The total costs in each census region was divided by the total wage index adjusted unduplicated census counts of Medicare beneficiaries in each region to arrive at a standardized average cost per-beneficiary for the labor component. This approximates the same effect as though each HHA in the census region had its average costs per-beneficiary adjusted by its average wage-index for the beneficiaries serviced in its service areas. We then adjusted the average per-beneficiary limitations using the latest available market basket factors to reflect expected cost increases occurring between the cost reporting periods that ended in Federal FY 1994 and September 30, 1998 excluding any changes in the home health market basket with respect to cost reporting periods which began on or after, July 1, 1994 and before July 1, 1996 as shown in Table 2 below.

The statute is silent with respect to the regional per-beneficiary limitation that would apply to Puerto Rico and Guam. Neither of these areas fall within the census divisions referred in the statute. We do not believe it was the intent of Congress to have HHAs in Puerto Rico and Guam subject to a blend of 75 percent agency-specific per beneficiary limitation and 25 percent of zero since they do not fall within the census divisions. Therefore, based on the HHAs in our data base that are located in Puerto Rico and Guam, we have developed regional per-beneficiary limitations specific to Puerto Rico and Guam using the same methodology as we used for the census divisions. These per-beneficiary limitations for which 25 percent of the per-beneficiary limitation will be based can be found on Table 3c.

C. National Per-Beneficiary Limitation

Section 1861(v)(1)(L)(vi)(I) of the Act, as added by section 4602(c) of BBA '97, requires that for new HHAs and HHAs without a 12-month cost reporting period ending in Federal FY 1994, the per-beneficiary limitation will be the median of these limitations applied to other HHAs. This means that we must establish a national per-beneficiary limitation based on ''the median of these limits (or the Secretary's best estimates thereof) applied to other HHAs as determined by the Secretary'', referring back to the per-beneficiary limitations that apply to HHAs that have a cost reporting period ending in Federal FY 1994. This required us to calculate the per-beneficiary limitation for each HHA in our data base, blending the 75 percent agency-specific per-beneficiary component with the 25 percent census region per-beneficiary component. Because the wage index will be applied to the labor component of the census region per-beneficiary limitation for ''clause v'' HHAs in determining the aggregate per-beneficiary limitation, we adjusted the census region per-beneficiary limitations for the varying effects of the wage indexes. This adjustment methodology used a beneficiary-weighted wage adjustment factor based on the geographic location of beneficiaries in our data base as described in B. above. We blended the agency-specific per-beneficiary component with the standardized census region per-beneficiary component, arrayed the results, and established the median per-beneficiary amount. This is the ''unadjusted median per-beneficiary limitation''. In order to apply a wage index adjustment factor to the national per-beneficiary limitation, the median per-beneficiary limitation had to be adjusted to standardize the agency-specific per-beneficiary component in the same fashion as the census region per-beneficiary limitation component so that the final labor component to which the new agencies

would apply their appropriate wage indexes would be uniformly standardized in both its agency-specific per-beneficiary limitation component and its census region per-beneficiary component. To standardize the agency-specific per-beneficiary component of the median per-beneficiary limitation, we calculated an adjustment factor to apply to the median per-beneficiary limitations. The adjustment factor was determined by calculating the ratio of the fully standardized per-beneficiary median (standardized for both the agency specific and the census region amounts) and the unadjusted blended median of the ''clause v'' agencies. It is the labor component of this adjusted median of the per-beneficiary limitations for the agencies in our data base, standardized in both the 75 percent agency-specific per beneficiary limitation and the 25 percent census region per-beneficiary limitation components to which new agencies will apply their appropriate wage indexes.

In summary, we calculated a national per-beneficiary limitation based on the median of the per-beneficiary limitations that apply to HHAs that have a cost reporting period ending during Federal FY 1994. To establish this national per-beneficiary limitation, we blended 75 percent agency-specific per-beneficiary component with the 25 percent census region division per-beneficiary component for each agency in our data base, arrayed the results and determined the median. The application of this median per-beneficiary limitation requires that we apply a wage index to the labor component of the national per-beneficiary limitation. In calculating the median to be used as the national per-beneficiary limitation for new agencies and agencies without a 12-month cost reporting period ending during Federal FY 1994, we recognized that the agency-specific component was not standardized for the effects of area wage differences. In order to apply a wage index, we determined an appropriate adjustment factor to apply to the national per-beneficiary limitation that effectively took out any differences in area wages for the agency-specific component of the median per-beneficiary limitation. The result is a fully standardized national per-beneficiary limitation.

D. Update of Data Base

The data used to develop the per-beneficiary limitations and the national per-beneficiary limitation was adjusted using the latest available market basket factors to reflect expected cost increases occurring between the cost reporting periods contained in our database and September 30, 1998, excluding any changes in the home health market basket with respect to cost reporting periods which began on or after July 1, 1994 and before July 1, 1996. The following inflation factors were used in calculating the Census region and national per-beneficiary limitations:

TABLE 2.—FACTORS FOR INFLATING DATABASE DOLLARS TO SEPTEMBER 30, 1998

[Inflation adjustment factors [1]]

Fiscal Year End	1993	1994
October 31	1.08619	.....
November 30	1.08349	.....
December 31	1.08080	.....
January 31	.....	1.07813
February 28	.....	1.07550
March 31	.....	1.0729
April 30	.....	1.07046
May 31	.....	1.06800
June 30	.....	1.06565
July 31	.....	1.06354
August 31	.....	1.06165
September 30	.....	1.05993

[1] Source: The Home Health Agency Price Index, produced by HCFA. The forecasts are from Standard and Poor's DRI 3rd QTR 1997; @USSIM/TREND25YR0897@CISSIM/Control973 forecast exercise which has historical data through 1997:2.

Multiplying nominal dollars for a given FY end by their respective inflation adjustment factor will express those dollars in the dollar levels for the FY ending September 30, 1998.

The procedure followed to develop these tables, based on requirements from BBA '97, was to hold the June 1994 level for input price index constant through June 1996. From July 1996 forward, we trended the revised index forward using the percentage gain each month from the HCFA Home Health Agency Input Price Index.

Thus, the monthly trend of the revised index is the same as that of the HCFA market basket for the period from July 1996 forward.

E. Short Period Adjustment Factors for Cost Reporting Periods Consisting of Fewer Than 12 Months

HHAs with cost reporting periods beginning on or after October 1, 1997 may have cost reporting periods that are less than 12 months in length. This may happen, for example, when a new provider enters the Medicare program after its selected FY has already begun, or when a provider experiences a change of ownership before the end of the cost reporting period. As explained in section V. of this preamble, the data used in calculating the census region and the national per-beneficiary limitations were updated to September 30, 1998. Therefore, the cost limitations published in this document are for a 12-month cost reporting period beginning October 1, 1997 and ending September 30, 1998. For 12-month cost reporting periods beginning after October 1, 1997 and before October 1, 1998, cost reporting period adjustment factors are provided in Table 5. However, when a cost reporting period consists of fewer than 12 months, adjustments must be made to the data that have been developed for use with 12-month cost reporting periods. To promote the efficient dissemination of cost limitations to agencies with cost reporting periods of fewer than 12 months, we are publishing an example and tables to enable intermediaries to calculate the applicable adjustment factors.

Cost reporting periods of fewer than 12 months may not necessarily begin on the first of the month or end on the last day of the month. In order to simplify the process in calculating ''short

period'' adjustment factors, if the short cost reporting period begins before the sixteenth of the month, we will consider the period to have begun on the first of that month. If the start period begins on or after the sixteenth of the month, it will be considered to have begun at the beginning of the next month. Also, if the short period ends before the sixteenth of the month, we will consider the period to have ended at the end of the preceding month; if the short period ends on or after the sixteenth of the month, it will be considered to have ended at the end of that month.

Example

1. After approval by its intermediary, a ''clause v'' HHA changed its FY end from June 30 to December 31. Therefore, the HHA had a short cost reporting period beginning on July 1, 1998 and ending on December 31, 1998. The cost reporting period ending during Federal FY 1994 would have been the cost reporting period ending on June 30, 1994. The per visit limitation that applies to this short period must be adjusted as follows:

Step 1—From Table 6, sum the index levels for the months of July 1998 through December 1998: 6.63687

Step 2—Divide the results from Step 1 by the number of months in short period: 6.6387 ÷ =1.106145

Step 3—From Table 6, sum the index levels for the months in the common period of October 1997 through September 1998: 13:06926

Step 4—Divide the results in Step 3 by the number of months in the common period: 13.06926 ÷ 12 = 1.089105

Step 5—Divide the results from Step 2 by the results from Step 4. This is the adjustment factor to be applied to the published per-beneficiary limitations: 1.106145 ÷ 1.1089106 = 1.015646

Step 6—Apply the results from Step 5 to the published per-beneficiary limitations in the same manner as shown in the example in VIII.C.

VI. Exceptions or Adjustments to Per-beneficiary Limitation

The Medicare regulations at 42 CFR 413.30 contain the general rules under which HCFA may establish limitations on provider costs, including provisions under which a provider may request a reclassification, exception, or exemption from the cost limitations under that section.

We do not believe that the Congress intended these general rules to apply to the establishment of the per-beneficiary limitations. First, we note that unlike other provisions of the statute that provide specific language for exceptions or exemptions to the limitations on costs, the statute is silent with respect to providing exceptions or exemptions to the per-beneficiary limitations. Section 1861(v)(1)(L)(ii) of the Act, which addresses the application of the per-visit limitations, is very specific that the Secretary may provide exemptions or exceptions to the per-visit limitations that are applied on a discipline basis. There is no similar language under sections 1861(v)(1)(L)(v) and 1861(v)(1)(L)(vi) of the Act, which provides for the establishment of the per-beneficiary limitations. Moreover, it seems unlikely that Congress intended for exceptions or exemptions to apply to the per-beneficiary limitations since in establishing the mid-session budget, there were no monies earmarked from the projected Medicare savings to pay for exemptions or exceptions to the per-beneficiary limitation.

Therefore, we are not allowing agencies to file for exceptions or exemptions to the per-beneficiary limitations.

We are revising section 413.30(a) to recognize the addition of the per-beneficiary cost limitation as a limitation on costs. Also, we are revising section 413.30(c) to state that HHAs may not request a reclassification, an exception, or an exemption from the per-beneficiary cost limitation.

VII. Review of the Agency-Specific Per-Beneficiary Limitation

For HHAs with a cost reporting period ending during Federal FY 1994, 75 percent of the per-beneficiary limitation is based on the Medicare data contained in that cost report.

We recognize that for most HHAs, that cost report has been settled and unless the HHA has an appeal with respect to the cost settlement pending for that FY, the data contained within the agency-specific per-beneficiary calculation has been settled. HHAs that have pending appeals (for example, an outstanding cost limitation exception to the per-visit limitation or appeals of adjustments resulting from Medicare principles of reimbursement) that may impact the cost reporting data used in calculation of the agency-specific portion of the per-beneficiary limitation, will have the agency-specific per-beneficiary limitation recalculated when the appeal is favorably resolved on behalf of the HHA.

There are, however, certain data used from the cost report in calculating the per-beneficiary limitations that do not impact the settlement of the cost report, that is, the use of the number of unduplicated census counts of Medicare beneficiaries whereby a reopening request of the cost report would not be warranted. This is particularly of concern since the unduplicated census counts on the Medicare cost reports have been alleged to be incorrect and HCFA will be providing the unduplicated census counts to be used by the intermediaries in calculating the agency-specific per-beneficiary limitation.

Given the importance of the calculation of the agency-specific per-beneficiary limitation, we are allowing HHAs 180 days after the date of the notice by the intermediary of the HHA's agency-specific per-beneficiary limitation to request a review of the agency-specific per-beneficiary calculation. The request may address the specific data used in calculating the agency-specific per-beneficiary limitation as shown on the Medicare cost report (that is, the lesser of Medicare reasonable costs or the aggregate per-visit limitation), the costs of nonroutine medical supplies, the unduplicated census count provided by HCFA, or the appropriate market basket increases, as provided in this document. This request for review may also address the calculation such as addition, subtraction, multiplication, or division. This request for review is not applicable to those cost report settlement appeals, which may have an impact on the data used in calculating the agency-specific per-beneficiary limitation and are pending under another authority under the Medicare regulations or statute. The agency's request must include sufficient documentation for the intermediary to determine that a recalculation of the agency-specific per-beneficiary limitation is warranted.

After receipt of all the necessary documentation needed to make a sound determination on the agency's request, the intermediary must respond to the request within 90 days of receiving the fully documented request.

VIII. Computing the Per-Beneficiary Limitation

A. Agency-Specific Per-Beneficiary Limitation

To arrive at the agency-specific limitation, which will represent 75 percent of the total per-beneficiary limitation that is to apply to the unduplicated census count of the Medicare beneficiaries for cost reporting periods beginning on or after October 1, 1997, the intermediary will calculate as follows from data on the Medicare cost report for the cost reporting period ending during Federal FY 1994:

For provider-based HHAs, the lesser of line 7, columns 8 and 9, or line 14, columns 8 and 9 plus line 15 columns 8 and 9, as reported on Supplemental Worksheet H–5 (Form HCFA–2552–92–H(4/93) OMB approval number 0938–0050, expiration date 08/31/2000), multiplied by 98 percent and the product divided by the unduplicated census count of Medicare beneficiaries,

as provided by HCFA, times the appropriate market basket increases from Tables 2 and 5; determined using Table 6.

For freestanding HHAs, the lesser of line 7, column 9, or line 14, column 9, plus line 17, columns 7 and 8, as reported on Worksheet C (Form HCFA–1728–86 (6/76)), multiplied by 98 percent and the product divided by the unduplicated census count of Medicare beneficiaries, as provided by HCFA, times the appropriate market basket increases from Tables 2 and 5 or determined using Table 6.

The product of the calculation of the agency-specific limitation is multiplied by 75 percent to arrive at the agency-specific portion of the per-beneficiary limitation.

To arrive at the regional census division per-beneficiary limitation, which will represent 25 percent of the overall per-beneficiary limitation, the HHA's intermediary first determines the adjusted labor-related component by multiplying the labor-related component of the appropriate regional census division per-beneficiary limitation where the beneficiary(s) received HHA services by the appropriate wage index based on where the beneficiary(s) received HHA services. The nonlabor component of the appropriate regional census division per-beneficiary limitation is added to the adjusted labor component and multiplied by 98 percent. The results are then multiplied by 25 percent. The 75 percent agency-specific portion is added to the 25 percent adjusted regional census division portion to arrive at the adjusted per-beneficiary limitation, which will be multiplied by the total unduplicated patient census count of patients for whom services were furnished in that area.

A separate per-beneficiary limitation has to be calculated for each MSA and/or nonMSA serviced by the HHA.

The aggregate limitation for all MSA and/or non-MSA areas for each HHA will be compared to the lower of the Medicare reasonable costs or the aggregate per-visit limitation and the lowest amount after this comparison is the allowable Medicare reasonable costs for payment purposes. The following is an example of how the per-beneficiary limitations are calculated for ''clause v'' type agencies which provide services to Medicare beneficiaries in more than one MSA area. The aggregate per-beneficiary limitation calculation example is given at section IX.

Example: Calculation of Per-Beneficiary Limitations for an HHA Furnishing Services to Patients Both in Dallas, Texas and Patients in Rural Texas

Blended Per-Beneficiary Limitation for Services in Dallas MSA

Agency-Specific Component

1. Agency-Specific Per-beneficiary Limitation $6,000. (As calculated by the intermediary)
2. Adjusted Agency-Specific Per-beneficiary Limitation (Line 1 × .75)=$4,500.

Census Region Division Component

3. Labor Portion of West South Central Region Per-beneficiary Limitation $4,456.47. (From Table 3a)
4. Dallas, TX Wage Index .9703. (From Table 4a)
5. Adjusted Labor Portion (Line 3 Times Line 4)= $4,324.11.
6. Nonlabor Portion of West South Central Region Per-beneficiary Limitation $1,281.37. (From Table 3a)
7. Adjusted West South Central Region Per-beneficiary Limitation (((Line 5 Plus Line 6)X .98) X .25)= $1,373.34.

Agency-Specific/Census Region Division Blended Per-Beneficiary Limitation

8. Blended Per-beneficiary Limitation for HHA services furnished to Medicare beneficiaries in Dallas, Texas(Line 2 Plus Line 7) = $5,873.34.

Per-Beneficiary Limitation for Services in Rural Texas/Census Region Division Component

9. Labor Portion of West South Central Region Per-beneficiary = $4,456.47. (From Table 3a)
10. Rural Texas Wage Index = .7404. (From Table 4b)
11. Adjusted Labor Portion (Line 9 X Line 10) = $3,299.57.
12. Nonlabor portion of West South Central Region Per-beneficiary Limitation = $1,281.37. (From Table 3a)
13. Adjusted Per-beneficiary Limitation (((Line 11 Plus Line 12)X .98) X.25) = $1,122.33.

Agency-Specific/Census Region Division Blended Per-Beneficiary Limitation

14. Blended Rural Per-beneficiary Limitation for HHA services furnished to Medicare beneficiaries in rural Texas (Line 2 Plus Line 13) = $5,622.33.

The process shown in the above examples would have to be repeated for each MSA and/or non-MSA where the HHA has an unduplicated census count of Medicare beneficiaries which received HHA services.

B. National Per-Beneficiary Limitation

New HHAs, HHAs without a 12-month cost reporting period ending during Federal FY 1994, and certain other HHAs described in section III.C. will be subject to a national per-beneficiary limitation.

As with the census region division per-beneficiary limitations, the national per-beneficiary limitation has a labor-related component and a nonlabor component. To arrive at the adjusted national per-beneficiary limitation, which is to apply to each unduplicated census count of Medicare beneficiary based on where the HHA services were furnished, the intermediary first determines the adjusted labor-related component by multiplying the labor-related component of the national per-beneficiary limitation by the appropriate wage index based on where the beneficiary received the HHA services.

The sum of the adjusted labor-related component and nonlabor component is the adjusted national per-beneficiary limitation applicable to the unduplicated census count of Medicare beneficiaries in the area for which the wage index was used. The following is an example of the calculation of the per-beneficiary limitations for a new HHA providing services to Medicare beneficiaries in more than one MSA area.

Example: Calculation of Adjusted National Per-Beneficiary Limitations for a Provider-Based HHA Providing HHA Services to an Unduplicated Census Count of Medicare Beneficiaries of in Dallas, Texas, and an Unduplicated Census Count of Medicare Beneficiaries in Rural Texas

National Per-Beneficiary Limitation for Dallas, Texas

1. Labor component of national per-beneficiary limitation = $2,607.07. (From Table 3b)
2. Wage-index applicable to Dallas, Texas = .9703 (From Table 4a)
3. Adjusted labor component (Line 1 X Line 2) = $2,529.64.
4. Nonlabor component of national per-beneficiary limitation $749.62. (From Table 4b)
5. Adjusted national per-beneficiary limitation (Line 3 Plus Line 4) X .98 = $3,213.67.

National Per-Beneficiary Limitation for Rural Texas

6. Labor component of national per-beneficiary limitation = $2,607.07. (From Table 4b)
7. Wage index applicable to rural Texas = .7404. (From Table 4b)
8. Adjusted labor component of national per-beneficiary (Line 6 X Line 7) = $1,930.27.
9. Nonlabor component of national per-beneficiary limitation = $749.62. (From Table 3b)
10. Adjusted national per-beneficiary limitation ((Line 8 Plus Line 9) X .98) = $2,626.29.

C. Adjustment Factor for Reporting Year Beginning After October 1, 1997 and Before October 1, 1998

If an HHA has a 12-month cost reporting period beginning on or after November 1, 1997, the adjusted census region division per-beneficiary

limitation or the adjusted national per-beneficiary limitation is again revised by an adjustment factor from Table 5 that corresponds to the month and year in which the cost reporting period begins. Each factor represents the compounded rate of monthly increase derived from the projected annual increase in the market basket index, and is used to account for inflation in costs that will occur after the date on which the per-beneficiary limitations become effective.

In adjusting the agency-specific per-beneficiary limitation for the market basket increases since the end of the cost reporting period ending during Federal year 1994, the intermediary should increase the agency-specific per-beneficiary limitation to September 30, 1998. Thus, when the per-beneficiary limitation needs to be further adjusted for the cost reporting period, the adjusted blended per-beneficiary limitation can be adjusted by the same factor. For example, if the HHAs in the examples above had a cost reporting period beginning January 1, 1998, its per-beneficiary limitations would be further adjusted as follows:

Computation of Revised Per-Beneficiary Limitations Blended per-beneficiary limitation for Dallas MSA = $5,873.34.

Adjustment factor from Table 5. 1.00781

Adjusted blended per-beneficiary limitation for Dallas MSA $5,919.21

National per-beneficiary limitation for Dallas, Texas = 3,213.67

Adjustment factor from Table 5. 1.00781

Adjusted national per-beneficiary limitation = $3,238.77

IX. Schedule of Per-Beneficiary Limitations

The schedule of per-beneficiary limitations set forth below applies to cost reporting periods beginning on or after October 1, 1997. The intermediaries will compute the adjusted per-beneficiary limitations using the wage index(s) published in Tables 4a and 4b of section X. for each MSA and/or non MSA for which the HHA provides services to Medicare beneficiaries. The intermediary will notify each HHA it services of its applicable per-beneficiary limitation(s) for the area(s) where the HHA furnishes HHA services to Medicare beneficiaries. Each HHA's aggregate per-beneficiary limitation cannot be determined prospectively, but depends on each HHA's unduplicated census count of Medicare beneficiaries by location of the HHA services furnished for the cost reporting periods subject to this document.

Section 1861(v)(1)(L)(vi)(II) of the Act as added by section 4602(c) of BBA ''97, requires the per-beneficiary limitations to be prorated among HHAs for Medicare beneficiaries who use services furnished by more than one HHA. The per-beneficiary limitation will be prorated based on a ratio of the number of visits furnished to the individual beneficiary by the HHA during its cost reporting period to the total number of visits furnished by all HHAs to that individual beneficiary during the same period.

The proration of the per-beneficiary limitation will be done based on the fraction of services the beneficiary received from the HHA. For example, if an HHA furnished 100 visits to an individual beneficiary during its cost reporting period ending September 30, 1998, and that same individual received a total of 400 visits during that same period, the HHA would count the beneficiary as a .25 unduplicated census count of Medicare patient for the cost reporting period ending September 30, 1998.

The HHA costs that are subject to the per-beneficiary limitations include the costs of nonroutine medical supplies furnished in conjunction with patient care. Durable medical equipment and drugs directly identifiable as services to an individual patient are excluded from the per-beneficiary limitations and are paid without regard to this schedule of per-beneficiary limitations.

The intermediary will determine the aggregate per-beneficiary limitation for each HHA by multiplying the unduplicated census count of Medicare beneficiaries according to the location where the services are furnished by the HHA, by the respective per-beneficiary limitation. The sum of these amounts is compared to the lesser of the HHA's total allowable costs or the aggregate per-visit limitation plus the allowable Medicare costs of nonroutine medical supplies. An example of how the aggregate per-beneficiary limitation is computed for an HHA providing HHA services to Medicare beneficiaries in both Dallas, Texas and rural Texas is as follows:

Example: HHA X, a HHA located in Dallas, TX, has unduplicated census count of 400 Medicare beneficiaries in the Dallas MSA and an unduplicated census count of 200 Medicare beneficiaries in rural Texas during its 12-month cost reporting period ending September 30, 1998. For simplicity, we are using the same blended per-beneficiary limitation that is used in the example under VIII. A above. The aggregate per-beneficiary limitation is calculated as follows:

DETERMINING THE AGGREGATE PER-BENEFICIARY LIMITATION

MSA/non-MSA area	Per beneficiary limitation (1)	Unduplicated census count of Medicare beneficiaries	Total limitation
Dallas, TX	$5,873.34	400	$2,349,336
Rural, TX	5,622.33	200	1,124,466
Aggregate Limitation			3,473,802

1 Blended per-beneficiary limitation adjusted by the appropriate wage index.

TABLE 3A.—STANDARDIZED PER-BENEFICIARY LIMITATION BY CENSUS REGION DIVISION, LABOR/NONLABOR

Census region division	Labor component	Nonlabor component
New England (CT, ME, MA, NH, RI, VT)	$2,670.73	$ 767.92
Middle Atlantic (NJ, NY, PA)	1,979.21	569.08
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	2,985.69	858.48
East North Central (IL, IN, MI, OH, WI)	2,421.00	696.11

TABLE 3A.—STANDARDIZED PER-BENEFICIARY LIMITATION BY CENSUS REGION DIVISION, LABOR/NONLABOR—Continued

Census region division	Labor component	Nonlabor component
East South Central (AL, KY, MS, TN)	4,590.61	1,319.94
West North Central (IA, KS, MN, MO, NE, ND, SD)	2,325.36	668.62
West South Central (AR, LA, OK, TX)	4,456.47	1,281.37
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	2,936.88	844.44
Pacific (AK, CA, HI, OR, WA)	2,275.12	654.17

TABLE 3B.—STANDARDIZED PER-BENEFICIARY LIMITATION FOR NEW AGENCIES AND AGENCIES WITHOUT A 12-MONTH COST REPORT ENDING DURING FEDERAL FY 1994

	Labor component	Nonlabor component
National	$2,607.07	$ 749.62

TABLE 3C.—STANDARDIZED PER-BENEFICIARY LIMITATIONS FOR PUERTO RICO AND GUAM

	Labor component	Nonlabor component
Puerto Rico	$1,940.26	$ 557.88
Guam	$1,873.76	$ 538.76

X. Wage Indexes

TABLE 4A.—WAGE INDEX FOR URBAN AREAS

	Urban area (constituent counties or county equivalents)	Wage index
0040	Abilene, TX; Taylor, TX	0.8287
0060	Aguadilla, PR; Aguada, PR; Aguadilla, PR; Moca, PR	0.4188
0080	Akron, OH; Portage, OH; Summit, OH	0.9772
0120	Albany, GA; Dougherty, GA; Lee, GA	0.7914
0160	Albany-Schenectady-Troy, NY; Albany, NY; Montgomery, NY; Rensselaer, NY; Saratoga, NY; Schenectady, NY; Schoharie, NY.	0.8480
0200	Albuquerque, NM; Bernalillo, NM; Sandoval, NM; Valencia, NM	0.9309
0220	Alexandria, LA; Rapides, LA	0.8162
0240	Allentown-Bethlehem-Easton, PA; Carbon, PA; Lehigh, PA; Northampton, PA	1.0086
0280	Altoona, PA; Blair, PA	0.9137
0320	Amarillo, TX; Potter, TX; Randall, TX	0.9425
0380	AK Anchorage, AK; Anchorage	1.2842
0440	Ann Arbor, MI; Lenawee, MI; Livingston, MI; Washtenaw, MI	1.1785
0450	Anniston, AL; Calhoun, AL	0.8266
0460	Appleton-Oshkosh-Neenah, WI; Calumet, WI; Outagamie, WI; Winnebago, WI	0.8996
0470	Arecibo, PR; Arecibo, PR; Camuy, PR; Hatillo, PR	0.4218
0480	Asheville, NC; Buncombe, NC; Madison, NC	0.9072
0500	Athens, GA; Clarke, GA; Madison, GA; Oconee, GA	0.9087
0520	Atlanta, GA; Barrow, GA; Bartow, GA; Carroll, GA; Cherokee, GA; Clayton, GA; Cobb, GA; Coweta, GA; DeKalb, 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.	0.9823
0560	Atlantic City-Cape May, NJ; Atlantic City, NJ; Cape May, NJ	1.1155
0600	Augusta-Aiken, GA–SC; Columbia, GA; McDuffie, GA; Richmond, GA; Aiken, SC; Edgefield, SC	0.9333
0640	Austin-San Marcos, TX; Bastrop, TX; Caldwell, TX; Hays, TX; Travis, TX; Williamson, TX	0.9133
0680	Bakersfield, CA; Kern, CA	1.0014
0720	Baltimore, MD; Anne Arundel, MD; Baltimore, MD; Baltimore City, MD; Carroll, MD; Harford, MD; Howard, MD; Queen Anne, MD.	0.9689
0733	Bangor, ME; Penobscot, ME	0.9478
0743	Barnstable-Yarmouth, MA; Barnstable, MA	1.4291
0760	Baton Rouge, LA; Ascension, LA; East Baton Rouge, LA; Livingston, LA; West Baton Rouge, LA	0.8382
0840	Beaumont-Port Arthur, TX; Hardin, TX; Jefferson, TX; Orange, TX	0.8593
0860	Bellingham, WA; Whatcom, WA	1.1221
0870	Benton Harbor, MI; Berrien, MI	0.8634
0875	Bergen-Passaic, NJ; Bergen, NJ; Passaic, NJ	1.2156
0880	Billings, MT; Yellowstone, MT	0.9783
0920	Biloxi-Gulfport-Pascagoula, MS; Hancock, MS; Harrison, MS; Jackson, MS	0.8415
0960	Binghamton, NY; Broome, NY; Tioga, NY	0.8914
1000	Birmingham, AL; Blount, AL; Jefferson, AL; St. Clair, AL; Shelby, AL	0.9005
1010	Bismarck, ND; Burleigh, ND; Morton, ND	0.7695
1020	Bloomington, IN; Monroe, IN	0.9128
1040	Bloomington-Normal, IL; McLean, IL	0.8733

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

	Urban area (constituent counties or county equivalents)	Wage index
1080	Boise City, ID; Ada, ID; Canyon, ID	0.8856
1123	Boston-Worcester Lawrence-Lowell-Brockton, MA–NH; Bristol, MA; Essex, MA; Middlesex, MA; Norfolk, MA; Plymouth, MA; Suffolk, MA; Worcester, MA; Hillsborough, NH; Merrimack, NH; Rockingham, NH; Strafford, NH.	1.1506
1125	Boulder-Longmont, CO; Boulder, CO	1.0015
1145	Brazoria, TX; Brazoria, TX	0.9341
1150	Bremerton, WA; Kitsap, WA	1.0999
1240	Brownsville-Harlingen-San Benito, TX; Cameron, TX	0.8740
1260	Bryan-College Station, TX; Brazos, TX	0.8571
1280	Buffalo-Niagara Falls, NY; Erie, NY; Niagara, NY	0.9272
1303	Burlington, VT; Chittenden, VT; Franklin, VT; Grand Isle, VT;	1.0142
1310	Caguas, PR; Caguas, PR; Cayey, PR; Cidra, PR; Gurabo, PR; San Lorenzo, PR	0.4459
1320	Canton-Massillon, OH; Carroll, OH; Stark, OH	0.8961
1350	Casper, WY; Natrona, WY	0.9013
1360	Cedar Rapids, IA; Linn, IA	0.8529
1400	Champaign-Urbana, IL; Champaign, IL	0.8824
1440	Charleston-North Charleston, SC; Berkeley, SC; Charleston, SC; Dorchester, SC	0.8807
1450	Charleston, WV; Kanawha, WV; Putnam, WV	0.9142
1520	Charlotte-Gastonia-Rock Hill, NC–SC; Cabarrus, NC; Gaston, NC; Lincoln, NC; Mecklenburg, NC; Rowan, NC; Union, NC; York, SC.	0.9710
1540	Charlottesville, VA; Albemarle, VA; Charlottesville City, VA; Fluvanna, VA; Greene, VA	0.9051
1560	Chattanooga, TN–GA; Catoosa, GA; Dade, GA; Walker, GA; Hamilton, TN; Marion, TN	0.8658
1580	Cheyenne, WY; Laramie, WY	0.7555
1600	Chicago, IL; Cook, IL; DeKalb, IL; DuPage, IL; Grundy, IL; Kane, IL; Kendall, IL; Lake, IL; McHenry, IL; Will, IL	1.0860
1620	Chico-Paradise, CA; Butte, CA	1.0429
1640	Cincinnati, OH-KY-IN; Dearborn, IN; Ohio, IN; Boone, KY; Campbell, KY; Gallatin, KY; Grant, KY; Kenton, KY; Pendleton, KY; Brown, OH; Clermont, OH; Hamilton, OH; Warren, OH.	0.9474
1660	Clarksville-Hopkinsville, TN–KY; Christian, KY; Montgomery, TN	0.7852
1680	Cleveland-Lorain-Elyria, OH; Ashtabula, OH; Cuyahoga, OH; Geauga, OH; Lake, OH; Lorain, OH; Medina, OH	0.9804
1720	Colorado Springs, CO; El Paso, CO	0.9316
1740	Columbia, MO; Boone, MO	0.9001
1760	Columbia, SC; Lexington, SC; Richland, SC	0.9192
1800	Columbus, GA-AL; Russell, AL; Chattanoochee, GA; Harris, GA; Muscogee, GA	0.8288
1840	Columbus, OH; Delaware, OH; Fairfield, OH; Franklin, OH; Licking, OH; Madison, OH; Pickaway, OH	0.9793
1880	Corpus Christi, TX; Nueces, TX; San Patricio, TX	0.8945
1900	Cumberland, MD-WV; Allegany, MD; Mineral, WV	0.8822
1920	Dallas, TX; Collin, TX; Dallas, TX; Denton, TX; Ellis, TX; Henderson, TX; Hunt, TX; Kaufman, TX; Rockwall, TX	0.9703
1950	Danville, VA; Danville City, VA; Pittsylvania, VA	0.8146
1960	Davenport-Rock Island-Moline, IA–IL; Scott, IA; Henry, IL; Rock Island, IL	0.8405
2000	Dayton-Springfield, OH; Clark, OH; Greene, OH; Miami, OH; Montgomery, OH	0.9584
2020	Daytona Beach, FL; Flagler, FL; Volusia, FL	0.8375
2030	Decatur, AL; Lawrence, AL; Morgan, AL	0.8286
2040	Decatur, IL; Macon, IL	0.7915
2080	Denver, CO; Adams, CO; Arapahoe, CO; Denver, CO; Douglas, CO; Jefferson, CO	1.0386
2120	Des Moines, IA; Dallas, IA; Polk, IA; Warren, IA	0.8837
2160	Detroit, MI; Lapeer, MI; Macomb, MI; Monroe, MI; Oakland, MI; St. Clair, MI; Wayne, MI	1.0825
2180	Dothan, AL; Dale, AL; Houston, AL	0.8070
2190	Dover, DE; Kent, DE	0.9303
2200	Dubuque, IA; Dubuque, IA	0.8088
2240	Duluth-Superior, MN–WI; St. Louis, MN; Douglas, WI	0.9779
2281	Dutchess County, NY; Dutchess, NY	1.0632
2290	Eau Claire, WI; Chippewa, WI; Eau Claire, WI	0.8764
2320	El Paso, TX; El Paso, TX	1.0123
2330	Elkhart-Goshen, IN; Elkhart, IN	0.9081
2335	Elmira, NY; Chemung, NY	0.8247
2340	Enid, OK; Garfield, OK	0.7962
2360	Erie, PA; Erie, PA	0.8862
2400	Eugene-Springfield, OR; Lane, OR	1.1435
2440	Evansville-Henderson, IN-KY; Posey, IN; Vanderburgh, IN; Warrick, IN; Henderson, KY	0.8641
2520	Fargo-Moorhead, ND-MN; Clay, MN; Cass, ND	0.8837
2560	Fayetteville, NC; Cumberland, NC	0.8734
2580	Fayetteville-Springdale-Rogers, AR; Benton, AR; Washington, AR	0.7461
2620	Flagstaff, AZ-UT; Coconino, AZ; Kane, UT	0.9115
2640	Flint, MI; Genesee, MI	1.1171
2650	Florence, AL; Colbert, AL; Lauderdale, AL	0.7551
2655	Florence, SC; Florence, SC	0.8711
2670	Fort Collins-Loveland, CO; Larimer, CO	1.0248
2680	Ft. Lauderdale, FL; Broward, FL	1.0448
2700	Fort Myers-Cape Coral, FL; Lee, FL	0.8788
2710	Fort Pierce-Port St. Lucie, FL; Martin, FL; St. Lucie, FL	1.0257
2720	Fort Smith, AR–OK; Crawford, AR; Sebastian, AR; Sequoyah, OK	0.7769
2750	Fort Walton Beach, FL; Okaloosa, FL	0.8765
2760	Fort Wayne, IN; Adams, IN; Allen, IN; DeKalb, IN; Huntington, IN; Wells, IN; Whitley, IN	0.8901

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

	Urban area (constituent counties or county equivalents)	Wage index
2800	Forth Worth-Arlington, TX; Hood, TX; Johnson, TX; Parker, TX; Tarrant, TX	0.9979
2840	Fresno, CA; Fresno, CA; Madera, CA	1.0607
2880	Gadsden, AL; Etowah, AL	0.8815
2900	Gainesville, FL; Alachua, FL	0.9616
2920	Galveston-Texas City, TX; Galveston, TX	1.0564
2960	Gary, IN; Lake, IN; Porter, IN	0.9633
2975	Glens Falls, NY; Warren, NY; Washington, NY	0.8386
2980	Goldsboro, NC; Wayne, NC	0.8443
2985	Grand Forks, ND–MN; Polk, MN; Grand Forks, ND	0.8745
2995	Grand Junction, CO; Mesa, CO	0.9090
3000	Grand Rapids-Muskegon-Holland, MI; Allegan, MI; Kent, MI; Muskegon, MI; Ottawa, MI	1.0147
3040	Great Falls, MT; Cascade, MT	0.8803
3060	Greeley, CO; Weld, CO	1.0097
3080	Green Bay, WI; Brown, WI	0.9097
3120	Greensboro-Winston-Salem-High Point, NC; Alamance, NC; Davidson, NC; Davie, NC; Forsyth, NC Guilford, NC; Randolph, NC; Stokes, NC; Yadkin, NC.	0.9351
3150	Greenville, NC; Pitt, NC	0.9064
3160	Greenville-Spartanburg-Anderson, SC; Anderson, SC; Cherokee, SC; Greenville, SC; Pickens, SC; Spartanburg, SC.	0.9059
3180	Hagerstown, MD; Washington, MD	0.9681
3200	Hamilton-Middletown, OH; Butler, OH	0.8767
3240	Harrisburg-Lebanon-Carlisle, PA; Cumberland, PA; Dauphin, PA; Lebanon, PA; Perry, PA	1.0187
3283	Hartford, CT; Hartford, CT; Litchfield, CT; Middlesex, CT; Tolland, CT	1.2562
3285	Hattiesburg, MS; Forrest, MS; Lamar, MS	0.7192
3290	Hickory-Morganton-Lenoir, NC; Alexander, NC; Burke, NC; Caldwell, NC; Catawba, NC	0.8686
3320	Honolulu, HI; Honolulu, HI	1.1816
3350	Houma, LA; Lafourche, LA; Terrebonne, LA	0.7854
3360	Houston, TX; Chambers, TX; Fort Bend, TX; Harris, TX; Liberty, TX; Montgomery, TX; Waller, TX	0.9855
3400	Huntington-Ashland, WV–KY–OH; Boyd, KY; Carter, KY; Greenup, KY; Lawrence, OH; Cabell, WV; Wayne, WV	0.9160
3440	Huntsville, AL; Limestone, AL; Madison, AL	0.8485
3480	Indianapolis, IN; Boone, IN; Hamilton, IN; Hancock, IN; Hendricks, IN; Johnson, IN; Madison, IN; Marion, IN; Morgan, IN; Shelby, IN.	0.9848
3500	Iowa City, IA; Johnson, IA	0.9413
3520	Jackson, MI; Jackson, MI	0.9052
3560	Jackson, MS; Hinds, MS; Madison, MS; Rankin, MS	0.7760
3580	Jackson, TN; Madison, TN; Chester, TN	0.8522
3600	Jacksonville, FL; Clay, FL; Duval, FL; Nassau, FL; St. Johns, FL	0.8969
3605	Jacksonville, NC; Onslow, NC	0.6973
3610	Jamestown, NY; Chautaqua, NY	0.7552
3620	Janesville-Beloit, WI; Rock, WI	0.8824
3640	Jersey City, NJ; Hudson, NJ	1.1412
3660	Johnson City-Kingsport-Bristol, TN–VA; Carter, TN; Hawkins, TN; Sullivan, TN; Unicoi, TN; Washington, TN; Bristol City, VA; Scott, VA; Washington, VA.	0.9114
3680	Johnstown, PA; Cambria, PA; Somerset, PA	0.8378
3700	Jonesboro, AR; Craighead, AR	0.7443
3710	Joplin, MO; Jasper, MO; Newton, MO	0.7510
3720	Kalamazoo-Battlecreek, MI; Calhoun, MI; Kalamazoo, MI; Van Buren, MI	1.0668
3740	Kankakee, IL; Kankakee, IL	0.8653
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.	0.9564
3800	Kenosha, WI; Kenosha, WI	0.9196
3810	Killeen-Temple, TX; Bell, TX; Coryell, TX	1.0252
3840	Knoxville, TN; Anderson, TN; Blount, TN; Knox, TN; Loudon, TN; Sevier, TN; Union, TN	0.8831
3850	Kokomo, IN; Howard, IN; Tipton, IN	0.8416
3870	La Crosse, WI–MN; Houston, MN; La Crosse, WI	0.8749
3880	Lafayette, LA; Acadia, LA; Lafayette, LA; St. Landry, LA; St. Martin, LA	0.8206
3920	Lafayette, IN; Clinton, IN; Tippecanoe, IN	0.9174
3960	Lake Charles, LA; Calcasieu, LA	0.7776
3980	Lakeland-Winter Haven, FL; Polk, FL	0.8806
4000	Lancaster, PA; Lancaster, PA	0.9481
4040	Lansing-East Lansing, MI; Clinton, MI; Eaton, MI; Ingham, MI	1.0088
4080	Laredo, TX; Webb, TX	0.7325
4100	Las Cruces, NM; Dona Ana, NM	0.8646
4120	Las Vegas, NV–AZ; Mohave, AZ; Clark, NV; Nye, NV	1.0592
4150	Lawrence, KS; Douglas, KS	0.8608
4200	Lawton, OK; Comanche, OK	0.9045
4243	Lewiston-Auburn, ME; Androscoggin, ME	0.9536
4280	Lexington, KY; Bourbon, KY; Clark, KY; Fayette, KY; Jessamine, KY; Madison, KY; Scott, KY; Woodford, KY	0.8390
4320	Lima, OH; Allen, OH; Auglaize, OH	0.9185
4360	Lincoln, NE; Lancaster, NE	0.9231
4400	Little Rock-North Little Rock, AR; Faulkner, AR; Lonoke, AR; Pulaski, AR; Saline, AR	0.8490
4420	Longview-Marshall, TX; Gregg, TX; Harrison, TX; Upshur, TX	0.8613

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

	Urban area (constituent counties or county equivalents)	Wage index
4480	Los Angeles-Long Beach, CA; Los Angeles, CA	1.2232
4520	Louisville, KY–IN; Clark, IN; Floyd, IN; Harrison, IN; Scott, IN; Bullitt, KY; Jefferson, KY; Oldham, KY	0.9507
4600	Lubbock, TX; Lubbock, TX	0.8400
4640	Lynchburg, VA; Amherst, VA; Bedford, VA; Bedford City, VA; Campbell, VA; Lynchburg City, VA	0.8228
4680	Macon, GA; Bibb, GA; Houston, GA; Jones, GA; Peach, GA; Twiggs, GA	0.9227
4720	Madison, WI; Dane, WI	1.0055
4800	Mansfield, OH; Crawford, OH; Richland, OH	0.8639
4840	Mayaguez, PR; Anasco, PR; Cabo Rojo, PR; Hormigueros, PR; Mayaguez, PR; Sabana Grande, PR; San German, PR.	0.4475
4880	McAllen-Edinburg-Mission, TX; Hidalgo, TX	0.8371
4890	Medford-Ashland, OR; Jackson, OR	1.0354
4900	Melbourne-Titusville-Palm Bay, FL; Brevard, Fl	0.8819
4920	Memphis, TN–AR–MS; Crittenden, AR; DeSoto, MS; Fayette, TN; Shelby, TN; Tipton, TN	0.8589
4940	Merced, CA; Merced, CA	1.0947
5000	Miami, FL; Dade, FL	0.9859
5015	Middlesex-Somerset-Hunterdon, NJ; Hunterdon, NJ; Middlesex, NJ; Somerset, NJ	1.1059
5080	Milwaukee-Waukesha, WI; Milwaukee, WI; Ozaukee, WI; Washington, WI; Waukesha, WI	0.9819
5120	Minneapolis-St. Paul, MN–WI; 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.	1.0733
5160	Mobile, AL; Baldwin, AL; Mobile, AL	0.8455
5170	Modesto, CA; Stanislaus, CA	1.0794
5190	Monmouth-Ocean, NJ; Monmouth, NJ; Ocean, NJ	1.0934
5200	Monroe, LA; Ouachita, LA	0.8414
5240	Montgomery, AL; Autauga, AL; Elmore, AL; Montgomery, AL	0.7671
5280	Muncie, IN; Delaware, IN	0.9173
5330	Myrtle Beach, SC; Horry, SC	0.8072
5345	Naples, FL; Collier, FL	1.0109
5360	Nashville, TN; Cheatham, TN; Davidson, TN; Dickson, TN; Robertson, TN; Rutherford TN; Sumner, TN; Williamson, TN; Wilson, TN.	0.9182
5380	Nassau-Suffolk, NY; Nassau, NY; Suffolk, NY	1.3807
5483	New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT; Fairfield, CT; New Haven, CT	1.2618
5523	New London-Norwich, CT; New London, CT	1.2013
5560	New Orleans, LA; Jefferson, LA; Orleans, LA; Plaquemines, LA; St. Bernard, LA; St. Charles, LA; St. James, LA; St. John Baptist, LA; St. Tammany, LA.	0.9566
5600	New York, NY; Bronx, NY; Kings, NY; New York, NY; Putnam, NY; Queens, NY; Richmond, NY; Rockland, NY; Westchester, NY.	1.4449
5640	Newark, NJ; Essex, NJ; Morris, NJ; Sussex, NJ; Union, NJ; Warren, NJ	1.1980
5660	Newburgh, NY–PA; Orange, NY; Pike, PA	1.1283
5720	Norfolk-Virginia Beach-Newport News, VA–NC; 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.	0.8316
5775	Oakland, CA; Alameda, CA; Contra Costa, CA	1.5068
5790	Ocala, FL; Marion, FL	0.9032
5800	Odessa-Midland, TX; Ector, TX; Midland, TX	0.8660
5880	Oklahoma City, OK; Canadian, OK; Cleveland, OK; Logan, OK; McClain, OK; Oklahoma, OK; Pottawatomie, OK	0.8481
5910	Olympia, WA; Thurston, WA	1.0901
5920	Omaha, NE–IA; Pottawattamie, IA; Cass, NE; Douglas, NE; Sarpy, NE; Washington, NE	0.9421
5945	Orange County, CA; Orange, CA	1.1605
5960	Orlando, FL; Lake, FL; Orange, FL; Osceola, FL; Seminole, FL	0.9397
5990	Owensboro, KY; Daviess, KY	0.7480
6015	Panama City, FL; Bay, FL	0.8337
6020	Parkersburg-Marietta, WV–OH; Washington, OH; Wood, WV	0.8046
6080	Pensacola, FL; Escambia, FL; Santa Rosa, FL	0.8193
6120	Peoria-Pekin, IL; Peoria, IL; Tazewell, IL; Woodford, IL	0.8571
6160	Philadelphia, PA–NJ; Burlington, NJ; Camden, NJ; Gloucester, NJ Salem, NJ; Bucks, PA; Chester, PA; Delaware, PA; Montgomery, PA; Philadelphia, PA.	1.1398
6200	Phoenix-Mesa, AZ; Maricopa, AZ; Pinal, AZ	0.9606
6240	Pine Bluff, AR; Jefferson, AR	0.7826
6280	Pittsburgh, PA; Allegheny, PA; Beaver, PA; Butler, PA; Fayette, PA; Washington, PA; Westmoreland, PA	0.9725
6323	Pittsfield, MA; Berkshire, MA	1.0960
6340	Pocatelo, ID; Bannock ID	0.9586
6360	Ponce, PR; Guayanilla, PR; Juana Diaz, PR; Penuelas, PR; Ponce, PR; Villalba, PR; Yauco, PR	0.4589
6403	Portland, ME; Cumberland, ME; Sagadahoc, ME; York, ME	0.9627
6440	Portland-Vancouver, OR–WA; Clackamas, OR; Columbia, OR; Multnomah, OR; Washington, OR; Yamhill, OR; Clark, WA.	1.1344
6483	Providence-Warwick-Pawtucket, RI; Bristol, RI; Kent, RI; Newport, RI; Providence, RI; Washington, RI; Statewide, RI.	1.1049
6520	Provo-Orem, UT; Utah, UT	1.0073
6560	Pueblo, CO; Pueblo, CO	0.8450
6580	Punta Gorda, FL; Charlotte, FL	0.8725
6600	Racine, WI; Racine, WI	0.8934

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

	Urban area (constituent counties or county equivalents)	Wage index
6640	Raleigh-Durham-Chapel Hill, NC; Chatham, NC; Durham, NC; Franklin, NC; Johnston, NC; Orange, NC; Wake, NC.	0.9818
6660	Rapid City, SD; Pennington, SD	0.8345
6680	Reading, PA; Berks, PA	0.9516
6690	Redding, CA; Shasta, CA	1.1790
6720	Reno, NV; Washoe, NV	1.0768
6740	Richland-Kennewick-Pasco, WA; Benton, WA; Franklin, WA	0.9918
6760	Richmond-Petersburg, VA; Charles City County, VA; Chesterfield, VA; Colonial Heights City, VA; Dinwiddie, VA; Goochland, VA; Hanover, VA; Henrico, VA; Hopewell City, VA; New Kent, VA; Petersburg City, VA; Powhatan, VA; Prince George, VA; Richmond City, VA.	0.9152
6780	Riverside-San Bernardino, CA; Riverside, CA; San Bernardino, CA	1.1307
6800	Roanoke, VA; Botetourt, VA; Roanoke, VA; Roanoke City, VA; Salem City, VA	0.8402
6820	Rochester, MN; Olmsted, MN	1.0502
6840	Rochester, NY; Genesee, NY; Livingston, NY; Monroe, NY; Ontario, NY; Orleans, NY; Wayne, NY	0.9524
6880	Rockford, IL; Boone, IL; Ogle, IL; Winnebago, IL	0.9081
6895	Rocky Mount, NC; Edgecombe, NC; Nash, NC	0.9029
6920	Sacramento, CA; El Dorado, CA; Placer, CA; Sacramento, CA	1.2202
6960	Saginaw-Bay City-Midland, MI; Bay, MI; Midland, MI; Saginaw, MI	0.9564
6980	St. Cloud, MN; Benton, MN; Stearns, MN	0.9544
7000	St. Joseph, MO; Andrews, MO; Buchanan, MO	0.8366
7040	St. Louis, MO–IL; 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.	0.9130
7080	Salem, OR; Marion, OR; Polk, OR	0.9935
7120	Salinas, CA; Monterey, CA	1.4513
7160	Salt Lake City-Ogden, UT; Davis, UT; Salt Lake, UT; Weber, UT	0.9857
7200	San Angelo, TX; Tom Green, TX	0.7780
7240	San Antonio, TX; Bexar, TX; Comal, TX; Guadalupe, TX; Wilson, TX	0.8499
7320	San Diego, CA; San Diego, CA	1.2193
7360	San Francisco, CA; Marin, CA; San Francisco, CA; San Mateo, CA	1.4180
7400	San Jose, CA; Santa Clara, CA	1.4332
7440	San Juan-Bayamon, PR; 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.	0.4625
7460	San Luis Obispo-Atascadero-Paso Robles, CA; San Luis Obispo, CA	1.1374
7480	Santa Barbara-Santa Maria-Lompoc, CA; Santa Barbara, CA	1.0688
7485	Santa Cruz-Watsonville, CA; Santa Cruz, CA	1.4187
7490	Santa Fe, NM; Los Alamos, NM; Santa Fe, NM	1.0332
7500	Santa Rosa, CA; Sonoma, CA	1.2815
7510	Sarasota-Bradenton, FL; Manatee, FL; Sarasota, FL	0.9757
7520	Savannah, GA; Bryan, GA; Chatham, GA; Effingham, GA	0.8638
7560	Scranton—Wilkes-Barre—Hazleton, PA; Columbia, PA; Lackawanna, PA; Luzerne, PA; Wyoming, PA	0.8539
7600	Seattle-Bellevue-Everett, WA; Island, WA; King, WA; Snohomish, WA	1.1339
7610	Sharon, PA; Mercer, PA	0.8783
7620	Sheboygan, WI; Sheboygan, WI	0.7862
7640	Sherman-Denison, TX; Grayson, TX	0.8499
7680	Shreveport-Bossier City, LA; Bossier, LA; Caddo, LA; Webster, LA	0.9381
7720	Sioux City, IA–NE; Woodbury, IA; Dakota, NE	0.8031
7760	Sioux Falls, SD; Lincoln, SD; Minnehaha, SD	0.8712
7800	South Bend, IN; St. Joseph, IN	0.9868
7840	Spokane, WA; Spokane, WA	1.0486
7880	Springfield, IL; Menard, IL; Sangamon, IL	0.8713
7920	Springfield, MO; Christian, MO; Greene, MO; Webster, MO	0.7989
8003	Springfield, MA; Hampden, MA; Hampshire, MA	1.0740
8050	State College, PA; Centre, PA	0.9635
8080	Steubenville-Weirton, OH–WV; Jefferson, OH; Brooke, WV; Hancock, WV	0.8645
8120	Stockton-Lodi, CA; San Joaquin, CA	1.1496
8140	Sumter, SC; Sumter, SC	0.7842
8160	Syracuse, NY; Cayuga, NY; Madison, NY; Onondaga, NY; Oswego, NY	0.9464
8200	Tacoma, WA; Pierce, WA	1.1016
8240	Tallahassee, FL; Gadsden, FL; Leon, FL	0.8832
8280	Tampa-St. Petersburg-Clearwater, FL; Hernando, FL; Hillsborough, FL; Pasco, FL; Pinellas, FL	0.9103
8320	Terre Haute, IN; Clay, IN; Vermillion, IN; Vigo, IN	0.8614
8360	Texarkana, AR-Texarkana, TX; Miller, AR; Bowie, TX	0.8664
8400	Toledo, OH; Fulton, OH; Lucas, OH; Wood, OH	1.0390
8440	Topeka, KS; Shawnee, KS	0.9438
8480	Trenton, NJ; Mercer, NJ	1.0380
8520	Tucson, AZ; Pima, AZ	0.9180
8560	Tulsa, OK; Creek, OK; Osage, OK; Rogers, OK; Tulsa, OK; Wagoner, OK	0.8074
8600	Tuscaloosa, AL; Tuscaloosa, AL	0.8187
8640	Tyler, TX; Smith, TX	0.9567

TABLE 4A.—WAGE INDEX FOR URBAN AREAS—Continued

	Urban area (constituent counties or county equivalents)	Wage index
8680	Utica-Rome, NY; Herkimer, NY; Oneida, NY	0.8398
8720	Vallejo-Fairfield-Napa, CA; Napa, CA; Solano, CA	1.3754
8735	Ventura, CA; Ventura, CA	1.0946
8750	Victoria, TX; Victoria, TX	0.8474
8760	Vineland-Millville-Bridgeton, NJ; Cumberland, NJ	1.0110
8780	Visalia-Tulare-Porterville, CA; Tulare, CA	0.9924
8800	Waco, TX; McLennan, TX	0.7696
8840	Washington, DC–MD–VA–WV; 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.	1.0911
8920	Waterloo-Cedar Falls, IA; Black Hawk, IA	0.8640
8940	Wausau, WI; Marathon, WI	1.0545
8960	West Palm Beach-Boca Raton, FL; Palm Beach, FL	1.0372
9000	Wheeling, OH–WV; Belmont, OH; Marshall, WV; Ohio, WV	0.7707
9040	Wichita, KS; Butler, KS; Harvey, KS; Sedgwick, KS	0.9403
9080	Wichita Falls, TX; Archer, TX; Wichita, TX	0.7646
9140	Williamsport, PA; Lycoming, PA	0.8548
9160	Wilmington-Newark, DE–MD; New Castle, DE; Cecil, MD	1.1538
9200	Wilmington, NC; New Hanover, NC; Brunswick, NC	0.9322
9260	Yakima, WA; Yakima, WA	1.0102
9270	Yolo, CA; Yolo, CA	1.1431
9280	York, PA; York, PA	0.9415
9320	Youngstown-Warren, OH; Columbiana, OH; Mahoning, OH; Trumbull, OH	0.9937
9340	Yuba City, CA; Sutter, CA; Yuba, CA	1.0324
9360	Yuma, AZ; Yuma, AZ	0.9732

TABLE 4B.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage Index
Alabama	0.7260
Alaska	1.2302
Arizona	0.7989
Arkansas	0.6995
California	0.9977
Colorado	0.8129
Connecticut	1.2617
Delaware	0.8925
Florida	0.8838
Georgia	0.7761
Hawaii	1.0229
Idaho	0.8221
Illinois	0.7644
Indiana	0.8161
Iowa	0.7391
Kansas	0.7203
Kentucky	0.7772
Louisiana	0.7383
Maine	0.8468
Maryland	0.8617
Massachusetts	1.0718
Michigan	0.8923
Minnesota	0.8179
Mississippi	0.6911
Missouri	0.7205
Montana	0.8302
Nebraska	0.7401
Nevada	0.8914
New Hampshire	0.9717
New Jersey [1]	
New Mexico	0.8070
New York	0.8401
North Carolina	0.7937
North Dakota	0.7360
Ohio	0.8434
Oklahoma	0.7072
Oregon	0.9975

TABLE 4B.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage Index
Pennsylvania	0.8421
Puerto Rico	0.3939
Rhode Island [1]	
South Carolina	0.7921
South Dakota	0.6983
Tennessee	0.7353
Texas	0.7404
Utah	0.8926
Vermont	0.9314
Virginia	0.7782
Washington	1.0221
West Virginia	0.7938
Wisconsin	0.8471
Wyoming	0.8247

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

TABLE 5.—COST REPORTING YEAR—ADJUSTMENT FACTOR [1]

If the HHA cost reporting period begins	The adjustment factor is
November 1, 1997	1.00260
December 1, 1997	1.00521
January 1, 1998	1.00781
February 1, 1998	1.01042
March 1, 1998	1.01302
April 1, 1998	1.01563
May 1, 1998	1.01823
June 1, 1998	1.02086
July 1, 1998	1.02353
August 1, 1998	1.02626

TABLE 5.—COST REPORTING YEAR—ADJUSTMENT FACTOR [1]—Continued

If the HHA cost reporting period begins	The adjustment factor is
September 1, 1998	1.02901

[1] Based on compounded projected market basket inflation rates.

Source: The Home Health Agency Input Price Index, produced by HCFA for the period between 1983:1 and 2008:4. The forecasts are from Standard and Poor's DRI 3rd QTR 1997: @USSIM/TREND25YR0897@CISSIM/Control973 forecast exercise which has historical data through 1997:2.

TABLE 6.—MONTHLY INDEX LEVELS FOR CALCULATING INFLATION FACTORS TO BE APPLIED TO HOME HEALTH AGENCY

Per-beneficiary limitations—Month	Index level
October 1992	.98566
November 1992	.98800
December 1992	.99099
January 1993	.99399
February 1993	.99700
March 1993	.99933
April 1993	1.00166
May 1993	1.00400
June 1993	1.00666
July 1993	1.00933
August 1993	1.01200
September 1993	1.01400
October 1993	1.01600
November 1993	1.01800
December 1993	1.02099
January 1994	1.02399

TABLE 6.—MONTHLY INDEX LEVELS FOR CALCULATING INFLATION FACTORS TO BE APPLIED TO HOME HEALTH AGENCY—Continued

Per-beneficiary limitations—Month	Index level
February 1994	1.02700
March 1994	1.02866
April 1994	1.03033
May 1994	1.03200
June 1994	1.03499
July 1994	1.03499
August 1994	1.03499
September 1994	1.03499
October 1994	1.03499
November 1994	1.03499
December 1994	1.03499
January 1995	1.03499
February 1995	1.03499
March 1995	1.03499
April 1995	1.03499
May 1995	1.03499
June 1995	1.03499
July 1995	1.03499
August 1995	1.03499
September 1995	1.03499
October 1995	1.03499
November 1995	1.03499
December 1995	1.03499
January 1996	1.03499
February 1996	1.03499
March 1996	1.03499
April 1996	1.03499
May 1996	1.03499
June 1996	1.03499
July 1996	1.03720
August 1996	1.03941
September 1996	1.04162
October 1996	1.04383
November 1996	1.04604
December 1996	1.04856
January 1997	1.05108
February 1997	1.05361
March 1997	1.05582
April 1997	1.05803
May 1997	1.06024
June 1997	1.06276
July 1997	1.06528
August 1997	1.06781
September 1997	1.07064
October 1997	1.07348
November 1997	1.07633

XI. Regulatory Impact Statement

A. Introduction

HCFA has examined the impacts of this final rule with comment period as required by Executive Order 12866, the Regulatory Flexibility Act (RFA) (Pub. L. 96–354), and the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4). Executive Order 12866 directs agencies to assess all 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). The RFA requires agencies to analyze options for regulatory relief for small businesses. For purposes of the RFA, States and individuals are not considered small entities. However, most providers, physicians, and health care suppliers are small entities, either by nonprofit status or by having revenues of 5 million or less annually. Approximately 25 percent of HHAs are identified as Visiting Nurse Associations, combined in government and voluntary, and official health agency, and therefore, are considered small entities. Since the aggregate per-beneficiary limitation will reduce payments by approximately nine percent, we anticipate this rule will have a significant impact on a substantial number of small entities. We have examined the options for lessening the burden on small entities, however, the statute does not allow for any exceptions to the aggregate per-beneficiary limitation based on size of entity. Therefore, we are unable to provide any regulatory relief for small entities.

Section 202 of the Unfunded Mandates Reform Act requires agencies to prepare an assessment of anticipated costs and benefits before proposing any rule that may result in an annual expenditure by State, local, or tribal governments, in the aggregate, or by private sector, of $100 million (adjusted annually for inflation). We believe that the costs associated with this final rule with comment fall below $100 million both in the governmental and private sectors. Therefore, we are not preparing an assessment.

We estimate that the impact of this final rule with comment period will be to decrease payments to home health agencies by approximately $1.06 billion in Federal FY 1998 and $2.14 billion in FY 1999, compared to the payment that would have been made in Federal FY 1998 if BBA '97 had not been enacted. Therefore, this rule is a major rule as defined in Title 5, United States Code, section 804(2) and is a significant rule under Executive Order 12866.

It is clear that the changes being made in this document will affect both a substantial number of small HHAs as well as other classes of HHAs, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule with comment period, constitutes a combined regulatory impact analysis and regulatory flexibility analysis. Nevertheless, in some markets new agency limits may be higher than the limit for older agencies as a result of the per-beneficiary limitation methodology required by the statute.

B. Explanation of Aggregate Beneficiary Limit

HHA limits are set forth at sections 1861(v)(1)(A) and 1861(v)(1)(L)of the Act. Section 1861(v)(1)(L)(v), as added to the Act by section 4602 of BBA '97, requires the Secretary to establish an interim system of limits before the implementation of a prospective payment system for home health services. Payments by Medicare under this interim system of limits will be the lower of an HHA's actual reasonable allowable costs, per visit limits in the aggregate, or a per-beneficiary limit as described in sections 1861(v)(1)(L)(v)(I) and 1861(v)(1)(L)(vi)(I) of the Act.

Section 1861(v)(1)(L)(v)(I) requires that the aggregate per-beneficiary annual limit be determined as follows: blend of 75 percent on 98 percent of the reasonable costs (including nonroutine medical supplies) for the agency's 12-month cost reporting period ending during Federal FY 1994, and 25 percent on 98 percent of the standardized regional average of such costs for the agency's census division for cost reporting periods ending during Federal FY 1994 (both updated by the home health market basket excluding any changes in the home health market basket with respect to cost reporting periods which began on or after July 1, 1994 and before July 1, 1996). The results will be multiplied by the agency's unduplicated census count of beneficiaries (entitled to benefits under Medicare) for the cost reporting period subject to the limit. As stated in section II.A. of this preamble, we determined the unduplicated census count as reported on the Medicare cost report by HHA providers was not reliable. As a result, we generated an unduplicated census count from our Standard Analytical File which is generated from our National Claims History File.

In regards to the home health market basket, section 1861(v)(1)(L)(iv) was added to the Act by section 4601(a) of BBA '97, and requires the Secretary not to take into account any changes in the home health market basket with respect to cost reporting periods which began on or after July 1, 1994 and before July 1, 1996 in establishing the limitations for cost reporting periods beginning after September 30, 1997.

In regards to the wage index, the appropriate census region per-beneficiary limitation will be the applicable census region where the beneficiary received services from the HHA and the applicable wage index will be the geographic area where the beneficiary received home health services.

For new providers and providers without a 12-month cost reporting period ending in Federal FY year 1994, the per-beneficiary limitation will be equal to the median of these limits applied to other HHAs as determined in this document.

For Medicare beneficiaries using more than one HHA, the per-beneficiary limitation will be prorated among the agencies.

C. Effect on Home Health Agencies

The following quantitative analysis presents the projected effects of the statutory changes effective for Federal FY 1998. As discussed below, the impact of this final rule with comment period will decrease payments to HHAs by approximately $1.06 billion in Federal FY 1998 compared to payment that would have been made in Federal FY 1998 if BBA '97 had not been enacted. This is a reduction of approximately nine percent. This final rule with comment period is necessary to implement the provisions of section 1861(v)(1)(L) of the Act, as amended by BBA '97.

The settled cost report data that we are using have been adjusted by the most recent market basket factors, excluding market basket increases for cost reporting periods beginning on or after July 1, 1994 and before July 1, 1996, to reflect the expected cost increases occurring between the cost reporting periods for the data contained in the database and September 30, 1998.

The cost limits for HHAs are statutorily driven and the impact of decreases in payments to HHAs have been reflected in the current law baseline of the mid-session review of the President's Federal FY 98 budget.

We are unable to identify the effects of the changes to the cost limits on individual HHAs. However, Table 7 below illustrates the proportion of HHAs that are likely to be affected by the limits. This table is a model of our estimate of the effects of the aggregate per-beneficiary limit. The total number of HHAs in this table—6,414—is based on HHA cost reports with a Federal FY ending in 1994 and for new providers whose cost reports end on either December 31, 1994 or December 31, 1995. For both old and new providers, the length of the cost report is 12 months.

This table takes into account the behaviors that we believe HHAs will engage in order to reduce the adverse effects of section 4602 of BBA '97 on their allowable costs. We believe these behavioral offsets might include an increase in the number of low cost beneficiaries served, a general decrease in the number of visits provided, and earlier discharge of patients who are not eligible for Medicare home health benefits because they no longer need skilled services but have only chronic, custodial care needs. We believe that, on average, these behavioral offsets will result in a 65-percent reduction in the effects these limits might otherwise have on an individual HHA.

Our projected savings of $1.06 billion in Federal FY 1998 and $2.14 billion in Federal FY 1999 are the savings that occur as a result of implementing section 4602 of the BBA including the behavioral offsets noted above. Column one of this table divides HHAs by a number of characteristics including their ownership, whether they are old or new agencies, whether they are located in an urban or rural area, and the census region they are located in.

Column two shows the number of agencies that fall within each characteristic or group of characteristics, for example, there are 1,197 rural freestanding HHAs in our database. Column three shows the percent of HHAs within a group that are projected to exceed the aggregate per-beneficiary limit before the behavioral offsets are taken into account. Column four shows the average percent of costs over the limits for an agency in that cell, including behavioral offsets.

TABLE 7.—HHA LIMITS EFFECTIVE 10/1/97; EFFECTS OF THE PER–BENEFICIARY LIMIT

Area	Number of agencies	Percent exceeding per-beneficiary limit	Average percent of costs exceeding limit
BY: AGENCY TYPE			
ALL AGENCIES	6414	57.9	9.3
FREESTANDING	4308	65.8	10.8
HOSPITAL BASED	2106	41.8	6.2
OLD AGENCIES	5256	60.0	8.9
FREESTANDING	3245	71.3	10.4
HOSPITAL BASED	2011	41.8	6.1
NEW AGENCIES	1158	48.2	12.6
FREESTANDING	1063	48.8	12.8
HOSPITAL BASED	95	41.1	9.4
BY: GEOGRAPHIC AREA			
ALL URBAN	4137	62.3	9.5
FREESTANDING	3111	68.2	10.8
HOSPITAL BASED	1026	44.3	6.2
OLD AGENCIES	3272	65.5	9.1
FREESTANDING	2292	74.6	10.5
HOSPITAL BASED	980	44.4	6.2
NEW AGENCIES	865	49.9	12.4
FREESTANDING	819	50.3	12.6
HOSPITAL BASED	46	43.5	9.4
ALL RURAL	2277	49.9	8.8
FREESTANDING	1197	59.5	10.6
HOSPITAL BASED	1080	39.4	6.0
OLD AGENCIES	1984	51.0	8.3
FREESTANDING	953	63.5	10.1
HOSPITAL BASED	1031	39.4	5.9
NEW AGENCIES	293	43.0	13.3
FREESTANDING	244	43.9	13.6
HOSPITAL BASED	49	38.8	9.5
BY REGION:			

TABLE 7.—HHA LIMITS EFFECTIVE 10/1/97; EFFECTS OF THE PER–BENEFICIARY LIMIT—Continued

Area	Number of agencies	Percent exceeding per-beneficiary limit	Average percent of costs exceeding limit
OLD AGENCIES	5256	60.0	8.9
NEW ENGLAND	291	84.5	12.3
MIDDLE ATLANTIC	443	71.3	9.0
SOUTH ATLANTIC	739	62.7	9.2
EAST NORTH CENTRAL	866	65.4	9.6
EAST SOUTH CENTRAL	431	58.2	8.7
WEST NORTH CENTRAL	728	52.9	8.8
WEST SOUTH CENTRAL	936	54.1	8.2
MOUNTAIN	354	48.3	7.0
PACIFIC	428	52.3	6.9
NEW AGENCIES	1158	48.2	12.6
NEW ENGLAND	44	90.9	15.6
MIDDLE ATLANTIC	51	35.3	4.7
SOUTH ATLANTIC	44	40.9	7.1
EAST NORTH CENTRAL	151	23.2	4.4
EAST SOUTH CENTRAL	25	56.0	14.8
WEST NORTH CENTRAL	117	28.2	10.3
WEST SOUTH CENTRAL	484	60.3	16.6
MOUNTAIN	103	49.5	8.5
PACIFIC	138	41.3	10.4

D. Percent of Costs Exceeding Limit (Column Four)

Results from this column indicate that the average percent of costs exceeding the aggregate per-beneficiary limit for an HHA in the ''all agencies'' cell is 9.3 percent after the behavioral offset. This should not be surprising since the intent of section 4602 of the BBA is to control the soaring expenditures of the Medicare home health benefit which have been driven largely by increased utilization.

For the old agencies cell (HHAs that filed a 12-month cost report that ended during Federal FY 1994), the average percent of costs exceeding the aggregate per-beneficiary limit is 8.9 percent. For the new agencies cell (HHAs that did not have a 12-month cost reporting period ended in Federal FY 1994 or that entered the Medicare program after Federal FY 1994), the average percent of costs exceeding the aggregate per-beneficiary limit is 12.6 percent. Old agencies will not be affected as much as the new agencies, on average, because the new agencies have, in general, reported higher costs related to higher levels of utilization. Moreover, the statutory provision basing ¾ of old provider limits on their own cost experience would implicitly result in less of an impact than experienced by the new providers whose limits are based on a national median.

For the urban areas HHA cell, the average percent of costs exceeding the aggregate per-beneficiary limit is 9.5 percent, while the rural areas HHA cell is 8.8 percent. For the old agency census division cells the average percent of costs exceeding the aggregate per-beneficiary limit ranges from a low of 6.9 percent in the Pacific census region to a high of 12.3 percent in the New England census region. The other census regions fall between 7.0 percent and 9.2 percent. The differences between census regions reflect the pattern of highly disparate costs that have been reported historically between geographic areas which cannot be explained by differences in patient characteristics but appear related to patterns of HHA practices.

For the new agency census region cells the average percent of costs exceeding the aggregate per-beneficiary limit ranges from a low of 4.4 percent in the East North Central census region to a high of 16.6 percent in the West South Central census region. The other census regions fall between 4.7 percent and 15.6 percent. In general, newer agencies in census regions that have exceptionally high cost histories are more impacted by their being limited to the national median.

Although there is considerable variation in these limits, we believe this is a natural reflection of the wide variation in payments that have been recognized under the present cost reimbursement system. Moreover, we believe the differing impacts of these limits is an inherent result of beginning to draw unexplained variation among providers closer to national norms which existed prior to the rapid increase in home health expenditures of the post '93–'94 period.

Because this rule limits payments to HHAs to the lesser of actual cost, the per-visit limitations, or the aggregate per-beneficiary limitation, we have estimated the combined impact of these limitations. (We note, that these estimates differ from those published on January 2, 1998 in our per-visit limitation notice (63 FR 89) because of the interaction of the two limitations, which we could not calculate until we developed the database used in this rule.)

We estimate that in both 1998 and 1999, 35 percent of the HHAs will be limited by the per-visit limitation and 58 percent of the HHAs will be limited by the per-beneficiary limitation. The estimated combined savings for 1998, however, will be $1.4 billion, of which $370 million is attributable to the per-visit limitation, and $1.06 billion is attributable to the per-beneficiary limitation. The estimated combined savings for 1999 will be $2.9 billion, of which $740 million is attributable to the per-visit limitation, and $2.14 billion is attributable to the per-beneficiary limitation.

For FY 1998, 15 percent of the Medicare savings are attributable to payments to managed care plans and for FY 1999, 20 percent of the savings will be from payments to managed care plans.

The per-beneficiary limitation may impact some State Medicaid programs. However, because of variation in State Medicaid policies and service delivery systems, it is impossible to predict which States will be affected or the magnitude of the impact, if any.

Under the Paperwork Reduction Act of 1995, agencies are required to provide a 60-day notice in the **Federal Register** and solicit public comments before a collection of information requirement is submitted to the Office of Management and Budget for review and approval. We do not believe this final rule has any collection of information issues associated with it. Any collection of information requirements would be associated with modifications to the Home Health Agency Cost Report (HCFA Form 1728–94). These modifications are being handled in a separate collection of information.

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

XII. Other Required Information

A. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of the rule take effect. However, pursuant to 5 U.S.C. (United States Code) 553(b)(B) we may waive a notice of proposed rulemaking if we find good cause that notice and comment are impracticable, unnecessary, or contrary to the public interest. For good cause we find that it was impracticable to undertake notice and comment procedures between the date of enactment of the BBA '97 (August 5, 1997) and the statutory deadline for establishing the per-beneficiary limitations (April 1, 1998). The BBA '97 required the per-beneficiary calculations be based on data obtained from HHA Medicare cost reports for cost reporting periods ending during the Federal FY '94. To comply with this statutory requirement we had to perform a special data collection from our fiscal intermediaries to obtain these cost report data.

In addition, the BBA '97 required HCFA to use an unduplicated census count to calculate the aggregate per-beneficiary limitations. The primary source for this count was also the provider cost report for Federal FY 1994. Because the unduplicated census count on the provider cost report was determined to be unreliable, it was necessary to generate an unduplicated census count from the National Claims History Standard Analytical File. In addition, we preformed a special data collection because a significant number of FY 1994 cost reports were not available. The internal calculation of unduplicated beneficiary counts from 17 million records was a time-consuming effort that was necessary to generate the information needed to calculate these limitations. These counts could not be performed prior to the completion of the special data collection effort and verification of the existing database. An extraordinary amount of resources was necessary to construct an entirely new database to compute the new per-beneficiary limitations. Significant programming efforts were necessary to match the individual beneficiaries to their applicable MSA areas. Specific matching efforts were also necessary to eliminate duplicate beneficiaries. These beneficiaries were then matched to the provider cost reports for each agency in the database.

These lengthy procedures could not be completed before February 1, 1998. Therefore, we believe in this instance, it was impracticable to publish a proposed rule and for good cause waive publication of a proposed regulation. We are however, providing a 60-day period for public comment.

B. Waiver of 30-Day Delay in Effective Date

Generally, the Administrative Procedure Act, 5 U.S.C. 553(d), requires us to provide a 30-day delay before effectuation of a final rule, unless we find good cause to dispense with that delay. To the extent this requirement applies to this final rule, for good cause we waive the 30-day delay in effective date.

As noted previously, these per-beneficiary limitations are effective for cost reporting periods beginning on or after October 1, 1997. Section 1861(v)(1)(L)(vii) of the Act requires the Secretary to establish these per-beneficiary limitations by April 1, 1998 and requires that they apply to cost reporting periods beginning on or after October 1, 1997. That statutory requirement is clear. A 30-day delay in implementing these per-beneficiary limitations is impracticable. Therefore, we find that it is impracticable to provide for a 30-day delay in effective date and for good cause we waive the delay in effective date.

C. Effect of the Contract with America Advancement Act, Pub. L. 104–121

Normally, under 5 U.S.C. 801, as added by section 251 of Pub. L. 104–121, the effective date of a major rule is delayed 60 days for Congressional review. This has been determined to be a major rule under 5 U.S.C. 804(2). However, as indicated in section XI.A. of the preamble to this final rule, for good cause, we find that prior notice and comment procedures are impracticable. Pursuant to 5 U.S.C. 808(2), a major rule shall take effect at such time as the Federal agency promulgating the rule determines if for good cause it finds that notice and public procedure is impracticable. Accordingly, under the exemption provided in 5 U.S.C. 808(2), these per-beneficiary limitations are effective for cost reporting periods beginning on or after October 1, 1997.

D. Public Comments

Because of the large number of items of correspondence we normally receive on a rule with comment period, we are not able to acknowledge or respond to them individually. However, we will consider all comments concerning the provisions of this rule that we receive by the date and time specified in the **DATES** section of this rule, and we will respond to those comments in a subsequent document.

List of Subjects in 42 CFR Part 413

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

For the reasons set out in the preamble, 42 CFR, chapter IV, subchapter B, part 413 is amended as set forth below.

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

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

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

§ 413.30 [Amended]

2. In § 413.30, the following amendments are made:

a. In paragraph (a)(1), in the first sentence, the reference to ''section 1861 (v)(1)(A)'' is revised to read ''sections 1861(v)(1)(A) and (v)(1)(L)''.

b. In paragraph (a)(2), in the last sentence, after ''may be calculated on a'' add ''per beneficiary,''.

c. In paragraph (c), in the first sentence, revise ''A provider'' to read ''Except for the per-beneficiary limitation that applies to HHAs, a provider''.

(Catalog of Federal Domestic Assistance Program No. 93.773 Medicare—Hospital Insurance)

Authority: Section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)); section 4207(d) of Pub. L. 101–508 (42 U.S.C. 1395x (note)).

Dated: March 15, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: March 24, 1998.

Donna E. Shalala,

Secretary.

[FR Doc. 98–8480 Filed 3–30–98; 8:45 am]

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