DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–1035–NC]

Medicare Program; Schedules of Per-Visit and Per-Beneficiary Limitations on Home Health Agency Costs for Cost Reporting Periods Beginning On or After October 1, 1998

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

ACTION: Notice with comment period.

SUMMARY: This notice with comment period sets forth revised schedules 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, 1998. These limitations replace the limitations that were set forth in our January 2, 1998 notice with comment period (63 FR 89) and our March 31, 1998 final rule with comment period (63 FR 15718).

DATES: *Effective Date:* These schedules of limitations are effective for cost reporting periods beginning on or after October 1, 1998.

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 October 13, 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–1035–NC, 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, DC 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: HCFA1035NC@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–1035NC. 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, DC, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (Phone: (202) 690–7890).

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

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I. Background

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) costs since 1979. Additional statutory provisions specifically governing the limitations applicable to HHAs are contained at section 1861(v)(1)(L) of the Act.

Section 1861(v)(1)(L)(i)(IV) of the Act specifies that the per-visit limits shall not exceed 105 percent of the median of the labor-related and nonlabor per-visit costs for freestanding HHAs. The reasonable costs used in the per-visit calculations will be updated by the home health market basket excluding any change 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.

Section 1861(v)(1)(L)(v)(I) of the Act 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 fiscal 1994, the per-beneficiary limitation will be a national per-beneficiary limitation which 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.

Payments by Medicare under this 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.

This notice with comment period sets forth cost limitations for cost reporting periods beginning on or after October 1, 1998. As required by section 1861(v)(1)(L)(iii) of the Act, we are

using the area wage index applicable under section 1886(d)(3)(E) of the Act 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 rendered. For purposes of this notice, the HHA wage index is based on the most recent published final hospital wage index, that is, the preclassified hospital wage index effective for hospital discharges on or after October 1, 1997, which uses FY 1994 wage data. As the statute also specifies, in applying the hospital wage index to HHAs, no adjustments are to be made to account for hospital reclassifications under section 1886(d)(8)(B) of the Act, decisions of the Medicare Geographic Classification Board (MGCRB) under section 1886(d)(10) of the Act, or decisions by the Secretary.

II. Analysis of and Responses to Public Comments to the January 2, 1998 Per-Visit Limitation Notice

We received 24 items of timely correspondence on the January 2, 1998 notice with comment period. A large percentage of the commenters also expressed concern over various aspects of the BBA '97 including the per-beneficiary limitations and the surety bond requirement which are not pertinent to the January 2, 1998 notice. Nonetheless, we will address the comments regarding the per-beneficiary limitations under section IV. of this notice. The issues not related to the limitations will be taken into account under separate notices specific to those issues. The comments pertaining to the per-visit limitations and our responses are discussed below.

Comment: The hospital wage indices do not include wages and wage-related data for home health services. The most appropriate measure would be a home health agency specific wage index by geographic area.

Response: The use of the hospital wage indices is required by statute. Section 1861(v)(1)(L)(iii) of the Act specifically states, in part, ''the Secretary shall establish limits under this subparagraph for cost reporting periods beginning on or after such date by utilizing the area wage index applicable under section 1886 (d)(3)(E) 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 * * * '' Furthermore, in 1989 we published a schedule of per-visit limitations using a home health agency-specific wage index in the **Federal Register** (54 FR 27742). Even though we placed a limit of 20 percent on the amount that HHAs cost limitation may increase or decrease when compared to the prior year's cost limitation which applied the hospital wage indices, the HHA industry questioned the validity of the data used in developing the HHA-specific wage indices. A change in legislation was pursued to prohibit the use of a HHA-specific wage index. In 1991 we had to republish the 1989 per-visit limitations in the **Federal Register** at 56 FR 12934 using the hospital wage indices as required by section 6222 of the Budget Reconciliation Act of 1989, Pub. L. 99–239. From that time forward we have been required to use the hospital wage indices in developing the per-visit limitations.

Comment: Agencies may be forced into more stringent evaluations of what patients are suitable for home care, rejecting those whose needs are going to make them candidates for lengthy and expensive visits. Overall quality of care to patients will fall as field staff are placed under greater pressure to perform more visits in a given time at a lower cost.

Response: We recognize that there will be valid circumstances not anticipated by the per-visit limitation methodology that will cause an agency to incur cost in excess of that allowed by the per-visit limitation. We provide for those unique situations through the exceptions process as ''atypical'' home health services at 42 CFR 413.30(f)(1). It is desirable for all agencies to monitor continually the cost of providing each discipline and to take steps to control the cost of any discipline as soon as there are indications that costs are increasing. We believe that a per-visit limitation of 105 percent of the median will give all agencies an added incentive to improve their management controls with immediate and ongoing benefit to the Medicare program and its beneficiaries through a reduction in cost and a moderation in the future rate of increase in costs.

Comment: There are additional costs which the home health industry must bear in order to meet new HCFA requirements such as implementation of the home health patient Outcome and Assessment Information Set (OASIS). There should be an add-on to the per-visit limitations in recognition of the costs associated with implementing OASIS requirements.

Response: We recognize that when agencies are required to implement OASIS, the agencies will incur training costs that they would not have otherwise incurred for this activity. These costs are almost exclusively associated with training staff in the disciplines (skilled nursing, physical, speech pathology, and occupational therapy) that will be performing OASIS assessments at the start of care and on a continuing basis. Accordingly, we have calculated for these disciplines an adjustment factor to be applied to the labor portion of the per-visit limitations applicable to these disciplines. This adjustment is intended as an offset to foregone patient care time that will be required for the necessary OASIS training and for gaining experience in performing assessments during the year of implementation. This offset is applied as an adjustment factor to be applied to the labor portion of the affected disciplines. See section III.G. for a discussion of the methodology used to calculate the adjustment factor.

Comment: The rise in utilization of home health has been due, in part, to the implementation of the hospital prospective payment system by hospitals which now discharge the patient quicker and sicker knowing that the patient can be treated adequately at home and the realization by physicians that home health care is useful, desirable, and economical alternative to institutionalization.

Response: There are several reasons why home health utilization has grown. Although it has been said that the hospital prospective payment system has resulted in patients being discharged sicker and quicker, and transferred to the home health setting, this is not the case overall. A study published in The New England Journal of Medicine in August 1996 found, ''less than a quarter of home health visits (22 percent) were preceded by a hospital stay within 30 days. Nearly half the visits (43 percent.) were unassociated with an inpatient stay in the previous six months.'' Also, the hospital prospective payment system has been in existence since October 1983. Any impact on the costs of services of providing home health care should have already been reflected in our data base which is approximately ten years after the implementation of the hospital prospective payment system.

Comment: The per-visit limitations should not be published and applied on a retroactive basis.

Response: The statute is quite explicit in establishing both the effective date of the per-beneficiary limitation, as well as the date by which the per-visit limitations were to be published. As much information as possible was disseminated to the home health trade organizations regarding the impact of the limitations without jeopardizing our rulemaking process. We were aware that

these home health trade organizations had been forwarding this information to their home health care members as quickly as possible so that agencies could estimate the effect of the per-visit on their financial operations. To the extent possible we made as much information available to the home health industry as we could for preparation to the revised per-visit limitations.

Comment: The update factors proposed by HCFA appear to be understated by approximately 4.5 percent.

Response: The update factors displayed in the notice which are applied to the data used in developing the per-visit limitations are reduced update factors as mandated by the statute. Section 1861(v)(1)(L)(iv) of the Act specifically 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, the update factors displayed in the notice do not include the changes for this period of time.

Comment: A seventh discipline should be established to set out chronic illness (such as insulin dependent diabetic and wound care) skilled nursing services from other skilled nursing visits. This would assist the definition of patient acuity and would create significant savings to the Medicare program by developing a lower level of skilled nursing visit category that would account for reduced time and effort associated with chronic illness.

Response: The home health benefit as set forth in 1861(m) of the Act sets forth the disciplines covered for home health services and does not provide for a seventh discipline along the lines suggested by the commenter.

Comment: The total impact on home health agencies of the reduction in per-visit cost limitations has been understated due to HCFA's separate analysis of the per-visit and the per-beneficiary limitations.

Response: The impact analysis on the revised per-visit limitation notice is correct in that the analysis can only address the limitations addressed in that notice. At the time the notice was published, the per-beneficiary limitations were not calculated and the impact of both the per-visit and the per-beneficiary limitations was unknown. We did, however, address the dual impact of the revised per-visit limitations and the new per-beneficiary limitations in the final rule with comment for the per-beneficiary limitation which was published on March 31, 1998. This impact is addressed in the **Federal Register** published on March 31, 1998 at 63 FR 15736.

Comment: After the adjustment of the labor and nonlabor portions from 112 percent of the mean to 105 percent of the median, the amount that would be paid under the labor portion is significantly smaller than what the 1982 wage-index would indicate. Therefore, in order to remain budget neutral, it would appear that a significantly larger budget neutrality factor should be applied to raise the labor-related portion back up to be in line with the 1982 wage-index base.

Response: Budget neutrality with respect to the wage index requires that aggregate Medicare payments to home health agencies be equal to the payments that would have been made had the 1982 wage index been used. Because the level of the per-visit limitations was adjusted downward from the previous per-visit limitations that were in effect, a different distribution of HHAs are under the revised per-visit limitations. These are the HHAs that largely affect the budget neutrality adjustment factor. These HHAs would have been only slightly better off using the 1982 wage index. Therefore, the adjustment factor reflects the slight increase in payments to obtain budget neutrality.

Comment: HCFA has stated that fiscal year 1994 is the most current information available for computation of the home health per-visit limitations. Excluding the results of cost reports finalized after October 10, 1995 from the data base seriously skews the cost per-visit limitation calculations with older cost and per-visit data, artificially lowering the median.

Response: Unlike the per-beneficiary limitations which require the use of Federal FY 1994 as the base period for establishing the limitations, neither the statute nor the Medicare regulations dictate the data base to be used in establishing the per-visit limitations. Moreover, we update the data base by rates of increase in the home health market basket from the end of the FYs of the cost report data used in the data base to the FY end to which the per-visit limitations apply. In keeping with past practices, we updated the data base used for the July 1997 notice in establishing the per-visit limitations. We believe the per-visit limitations reflect the per-visit costs reported by HHAs and these per-visit limitations have been updated appropriately in accordance with the statute.

Comment: The home health market-basket index does not measure specific costs.

Response: The home health market-basket is a measurement of costs and inflation overall and is not a measurement of increase in agency-specific costs.

III. Update of Per-Visit Limitations

The methodology used to develop the schedule of per-visit limitations in this notice is the same as that used in setting the limitations effective October 1, 1997. We are using the latest settled cost report data from freestanding HHAs to develop the per-visit cost limitations. We have updated the per-visit cost limitations to reflect the expected cost increases between the cost reporting periods in the data base and September 30, 1999 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.

A. Data Used

To develop the schedule of per-visit limitations effective for cost reporting periods beginning on or after October 1, 1998, we extracted actual cost per-visit data from the most recent settled Medicare cost reports for periods beginning on or after January 1, 1994 and settled by May 1998. The majority of the cost reports were from Federal fiscal year 1996. We then adjusted the data using the latest available market basket indexes to reflect expected cost increases occurring between the cost reporting periods contained in our data base and September 30, 1999, 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. Therefore, we excluded this time period when we adjusted the database for the market basket increases.

B. Wage Index

A wage index is used to adjust the labor-related portion of the per-visit limitation to reflect differing wage levels among areas. In establishing the per-visit 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 most recently published 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 per-visit 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 per-visit 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) 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 recently published 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. The wage-index, as applied to the labor portion of the per-visit 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.

C. Updating the Wage Index on a Budget-Neutral Basis

Section 4207(d)(2) of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) (Public Law 101–508) requires that, in updating the wage index, aggregate payments to HHAs will remain the same as they would have been if the wage index had not been updated. Therefore, overall payments to HHAs are not affected by changes in the wage index values.

To comply with the requirements of section 4207(d)(2) of OBRA '90 that updating the wage index be budget neutral, we determined that it is necessary to apply a budget neutrality adjustment factor of 1.03 to the labor-related portion of the per-visit limitations effective for cost reporting periods beginning on or after October 1, 1998. This adjustment ensures that aggregate payments to HHAs are not affected by the change to a wage index based on the hospital wage index published on August 29, 1997.

To determine the adjustment factor, we analyzed both the data obtained from the freestanding agencies used to determine the per-visit limitations and the settled cost report data covering the same time period for the provider-based agencies. For each agency in this data base, we replaced their current wage index with the one corresponding to the 1982 hospital wage index. Some Metropolitan Statistical Areas (MSAs) that currently exist did not exist at the time this index was created and therefore have no matching 1982 wage index. In the data base we are currently using, these unmatchable MSAs represented 1.3 percent of the total visits. Since this percentage was small, we deleted these agencies from the analysis. We then determined what Medicare program payments would be using the 1982 wage index. Next, we determined payments using the new wage index and adjusted the labor portion of the payment by the factor necessary to match program payments if the 1982 wage index was used. (See the example in section VIII.B. of this notice regarding the adjustment of per-visit limitations by the wage index and the budget neutrality factor.)

D. Standardization for Wage Levels

After adjustment by the market basket index, we divided each HHA's per-visit costs into labor and nonlabor portions. The labor portion of cost (77.668 percent as determined by the market basket) represents the employee wage and benefit factor plus the contract services factor from the market basket. We then divided the labor portion of per-visit cost by the wage index applicable to the HHA's location to arrive at an adjusted labor cost.

E. Adjustment for ''Outliers'

We transformed all per-visit cost data into their natural logarithms and grouped them by type of service and MSA, NECMA, or non-MSA location, in order to determine the median cost and standard deviation for each group. We then eliminated all ''outlier'' costs which were all per-visit costs less than 10 dollars and per-visit costs more than 800 dollars, retaining only those per-visit costs within two standard deviations of the median in each service.

F. Basic Service Limitation

We calculate a basic service limitation to 105 percent of the median labor and nonlabor portions of the per-visit costs of freestanding HHAs for each type of service. (See Table 3a in section VIII.)

G. Offset Adjustment for the Implementation of the Home Health Outcome Assessment Information (OASIS)

When HHAs are required to use an assessment tool, such as OASIS, for ongoing collection of quality of care data, they will incur costs associated with this requirement. Any costs associated with a new type of reporting system are not reflected in the database used to calculate the per-visit limitations. We have, therefore, decided to provide an offset adjustment factor to be applied to the labor-related component of the per-visit limitations for skilled nursing, physical therapy, speech pathology, and occupational therapy which should be the only disciplines affected by this new requirement.

Since any new assessment performance tool will replace or be integrated into an agency's existing assessment activities, we believe that there will be no permanent ongoing incremental costs associated with these types of assessment systems. This has been shown through data derived from the ongoing Medicare Quality and Improvement Demonstration using OASIS as an assessment tool. This demonstration shows that the OASIS assessment requires either the same amount of time or less time than the

patient assessment methods currently in use.

Absent other types of data, we are using the information from this demonstration to derive an offset adjustment for any new assessment tool that may be imposed on the HHAs effective during the per-visit limitations effective for cost reporting periods beginning on or after October 1, 1998. Data from the OASIS demonstration show that OASIS implementation burden consists of foregone staff time that would otherwise be devoted to patient care activities. There are three types of costs associated with staff time for a typical 18-person staff. The first would be training time for an agency coordinator who conducts training or supervision of the clinical staff. This individual would probably need to spend four hours reading the assessment tool training manual and eight hours attending an assessment tool training session. Training would also be necessary for staff who will be performing the assessment process. The affected disciplines are skilled nursing, physical therapy, speech pathology, and occupational therapy. Each member of these disciplines would probably require four to six hours of training. Since agencies currently conduct inservices for clinical staff, usually on a monthly basis, the training for a new assessment tool would replace at least one of these sessions. The incremental training costs would be approximately half of the total costs, or two to three hours per trained staff member.

The second type of costs would be increases in assessment time during initial implementation. Experience from the demonstration indicates that total visit time increases by approximately 15 minutes during the first six to seven visits when newly trained staff have begun to perform OASIS assessments. After this initial period of becoming familiar with and acquiring experience with the new assessment tool, there is no net increase in visit duration.

The third type of costs would be the costs associated with the staff time to revise assessment forms and integrate OASIS elements. For a typical 18-person professional staff this is estimated to require sixteen hours of staff time: twelve hours of professional staff time (skill nursing, physical therapy, etc. * * *) and 4 hours of clerical time.

The adjustment factor is calculated in terms of per-FTE foregone staff time spent on these training and form revision activities as follows: (a) One hour for the agency coordinator—based on twelve hours total training time allocated over an 18-person professional staff, (b) three hours per staff for training, (c) two hours for increased assessment time during the initial implementation—based on fifteen minutes additional time for each of the first eight visits (rounded up from 7) during which the assessments are performed, and (d) one hour of supervisory time—based on sixteen hours of time spent revising assessment forms allocated over an 18-person professional staff. These four items total seven hours of time per-FTE during the year of OASIS implementation. Using a normal work year of 2000 hours (50 weeks times 40 hours) less the seven hours for additional training time for a new assessment program, the offset adjustment for foregone patient care would be .35 percent (2000 hours divided by 1993 hours less one equals .003513). This offset factor will be applied to the labor portion of the skilled nursing, physical therapy, speech pathology and occupational therapy per-visit limitations for both urban and nonurban areas. This factor will only be applied to the labor portion of these per-visit limitations for cost reporting periods beginning on or after October 1, 1998 if HHAs are required to implement OASIS.

In addition to training and forms revision, agencies will incur printing costs for the revised assessment forms. Data from the OASIS demonstration show that for the typical HHA, i.e., one that has 486 admissions per year and an 18-person professional staff, printing the new assessment forms will cost $280. Cost report data for 1994 and 1995 show that an HHA with 486, plus or minus 50, admissions, provides a total of thirty thousand visits of all types annually to patients. Allocating the $280 over 30 thousand visit yields an incremental cost of .93 cents per visit, which for estimation purposes is rounded up to one cent per visit for all disciplines.

The total offset adjustment is applied by first multiplying the labor portion of the per-visit limitation for skill nursing, physical therapy, speech pathology, and occupational therapy by the factor of 1.003513 for training and forms revision (the labor-portion is also adjusted by the appropriate wage index and budget neutrality factor), second, the non-labor portion is added to the adjusted labor-portion, and third, one cent is added for printing costs. The OASIS adjustment is only done after the implementation of OASIS is effective.

Because we believe that there will be no ongoing incremental costs to perform assessments under a new protocol, this adjustment offset will only apply to the labor component of the specified per-visit limitations in the first year of implementation of a new assessment tool.

While we have based this adjustment on the best data we have available to us, we are concerned that we may not have captured all relevant costs, particularly ongoing and automation costs. In part, this is because our data is based on agencies whose costs in this regard may not have been fully representative of agency costs generally. Therefore, we are asking for specific comments, including documented data, which would inform future decision making on this issue.

IV. Analysis of and Responses to Public Comments to the March 31, 1998 Per-Beneficiary Final Rule

We received 125 comments with respect to the March 31, 1998 **Federal Register** final rule with comment addressing the implementation of the per-beneficiary limitations. A number of comments were on the statutory requirements for which we do not have discretionary authority to change or not implement. These included comments such as: do not apply the per-beneficiary limitations for cost reporting periods beginning on or after October 1, 1997, delay implementation of the per-beneficiary limitations to October 1, 1998, repeal the statutory provisions requiring the application of the per-beneficiary limitations, and the use of fiscal year 1994 as a base year for establishing the per-beneficiary limitations is inadequate and should not be used in establishing the per-beneficiary limitations. These comments cannot be adopted without legislative amendments to the Act pertaining to the per-beneficiary limitations. The remaining comments are given below.

Comment: Agencies that have a per-beneficiary limitation lower than the national per-beneficiary limitation should be allowed to have the higher national per-beneficiary limitation apply.

Response: The statute is very specific with respect to how the per-beneficiary limitations are to be calculated for agencies that have a 12-month cost reporting period ending in Federal fiscal year 1994 (''clause v'' agencies) and new agencies (''clause vi'' agencies). Once the agency is classified as either a ''clause v'' or ''clause vi'' provider, the per-beneficiary limitation is established by statute. We have no discretion to apply a most beneficial test.

Comment: The requirement to prorate the unduplicated census count of Medicare beneficiaries when a beneficiary is serviced by more than one HHA for cost reporting periods beginning on or after October 1, 1997

should also apply in determining the unduplicated census count of Medicare beneficiaries for the base year, i.e., cost reporting periods ending during Federal FY 1994.

Response: The statute does not provide for this. Section 1861(v)(1)(L)(vi)(II) of the Act, as added by section 4602(c) of the BBA '97, states, ''For beneficiaries who use services furnished by more than one home health agency, the per-beneficiary limitation shall be prorated among the agencies.'' This provision is specific for services furnished by HHAs for cost reporting periods beginning on or after October 1, 1997. It applies to the application of the per-beneficiary limitation and not the calculation of the per-beneficiary limitation.

Comment: Many agencies were required to operate under a new system of reimbursement for a full six months before being told precisely what the system was. HCFA should provide some form of leniency for those agencies which have large overpayments due to the delay in publishing the new limitations.

Response: We recognize that providers with cost reporting periods that began prior to the publication of the per-beneficiary limitations may have experienced some uncertainty in budgeting their costs. Nonetheless, the BBA '97 is quite explicit in establishing both the effective date of these provisions and the date by which these limitations needed to be established. We made as much information as possible available to the home health industry prior to the publication of the limitations. We tried to make a smooth transition into the interim payment system (IPS) for HHAs by providing such information through major home health trade organizations. The IPS was highly publicized through home health trade news articles such that the effect of the IPS should have been anticipated by the home health industry. While there were certain technical issues which could only be addressed through the publication of the limitations, agencies could, to a large degree, estimate the effect of the new limitations on the financial operations. In fact, a trade organization developed computer software packages for estimating the impact of the IPS. Even though the limitations were not available prior to publication, we believe the home health industry had sufficient advanced knowledge to properly react to an estimated impact of the limitations on their operations. If an agency had suspected that overpayments might result from the interim payments received prior to the publication of the limitations, a prudent agency would set the estimated overpayment aside as a potential liability. This way, the agency would not put itself in a financial hardship to pay back any overpayments resulting from the newly published limitations.

Comment: The 1994 base period is not reflective of the sicker patients being released from the hospitals due to the hospital prospective payment system.

Response: As stated in the comments addressing the per-visit limitations, although it has been said that the hospital prospective payment system has resulted in patients being discharged quicker and sicker and transferred to a home health setting, this is not the case overall. A study published in The New England Journal of Medicine in August 1996 found , ''less than a quarter of home health visits (22 percent) were preceded by a hospital stay within 30 days. Nearly half the visits (43 percent) were unassociated with an inpatient stay in the previous six months.'' Also, the hospital prospective payment system has been in existence since October 1983. Any impact on the costs of services of providing home health care should have already been reflected in our data base which is approximately ten years after the implementation of the hospital prospective payment system.

Comment: The IPS per-beneficiary limitation puts a cap on the expenses a beneficiary can receive in one year.

Response: We cannot stress enough that the per-beneficiary limitation is not a cap on an individual beneficiary's amount of services or the costs of services. The per-beneficiary limitation is an aggregate limitation on each agency's total costs. Agencies now have a global budget that increases with the number of beneficiaries served and promotes efficiency in planning and delivering total services to all patients throughout the entire home health episodes. Applying the per-beneficiary limitation in the aggregate, not just to an individual patient, allows HHAs to balance the costs of caring for one patient against the cost of caring for other patients. HHAs have the flexibility to provide the appropriate amount of care (duration of visits, number of visits, and skill level of care given) for all patients within the aggregate per-beneficiary limitation.

Comment: Do not apply the freeze to inflation for the 1994–1996 period. This freeze should only apply to the per-visit limitations.

Response: The statute applies the freeze to both the per-visit and the per-beneficiary limitations. Section 1861(v)(1)(L)(iv) of the Act states, ''In establishing limits under this subparagraph for cost reporting periods beginning after September 30,1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.'' The amendment in section 4601 of the B.B.A. '97 to amend section 1861(v)(1)(L) of the Act encompasses all limits established under section 1861(v)(1)(L) of the Act, including the per-beneficiary limitations. Therefore, the application of the freeze in the market basket increases to both the per-visit limitations and the per-beneficary limitations is in accordance with the statutory language.

Comment: The requirement to apply the wage-index based on the location of the service furnished rather than the location of the HHA should only apply to the per-visit limitations.

Response: Again the statute requires the wage index based upon the location of the service furnished be applied to both the per-visit and the per-beneficiary limitations. Section 1861(v)(1)(L) of the Act, states in part, ''* * * the Secretary shall establish limits under this subparagraph for cost reporting periods beginning on or after such date by utilizing the area wage index applicable under section 1886(d)(3)(E) 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 * * *'' This language encompasses all the limitations noted under section 1861(v)(1)(L) of the Act, which includes both the per-visit and the per-beneficiary limitations.

Comment: HCFA should utilize the median amount for each census region for new providers. This will be the best reflection of both wages and utilization for agencies in a given area.

Response: Section 1861(v)(1)(L)(vi) of the Act as added by section 4602(c) of the B.B.A. '97, states, ''For new providers and those providers without a 12-month cost reporting period ending in fiscal year 1994, the per beneficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary.'' The statute clearly contemplates the use of a single, and therefore national, median as the basis for the new provider limitation. The statute requires the per-beneficiary limitation to be ''the median'' of all the per-beneficiary limitations applied to the other HHAs, i.e., the per-beneficiary

limitations of the old providers. The statutory language refers to a single median and not several medians, which would be the case if the statute required a regional system suggested by commenters. Moreover, in direct contrast to the language governing the per-beneficiary limitation for old providers, section 1861(v)(1)(L)(vi) does not contain any reference to a calculation based upon the home health agency's census division.

Comment: The base year for the surviving provider number should be utilized in computing the per-beneficiary limitation. Because the agency still carries assets and liabilities of the agency it purchased, the base year and resulting per-beneficiary limitation should be considered an asset or a liability, as applicable.

Response: The per-beneficiary limitation is neither an asset nor a liability for an HHA. The per-beneficiary limitation is a limit on the amount of payments made by Medicare. The limitations are not intended to be used as bargaining tools for selling or buying agencies.

Comment: Extend authorizations for exceptions to the new interim payment system per-beneficiary limitations as well as the per-visit limitations.

Response: As we stated in the March 31, 1998 **Federal Register**, we do not believe that Congress intended the general rules at 42 CFR 413.30 to apply to the establishment of the per-beneficiary limitations. The statute does not provide any such exceptions or exemptions to the per-beneficiary limitations.

Comment: On page 15725 of the **Federal Register** the example references index levels for the period of July 1998 through December 1998 from Table 6 for calculating the market basket increase. Table 6 in the March 31, 1998 **Federal Register** stops at November 1997.

Response: We apologize for the inadvertent omission of the index levels for the months of December 1997 through September 1999. Table 6 at 63 FR 103 published on January 2, 1998 contains the same index levels that are appropriate in calculating the applicable market basket increase and the index levels for the months of December 1997 through September 1999 can be obtained from that table.

Comment: Under section 112 of the Provider Reimbursement Manual, Part I, State health department home health agencies with subunits or branches are permitted to file a combined cost report under the 7800 series of provider numbers. (1) How will those subunits and branches that have separate provider numbers and separately bill that previously filed a combined cost report be treated if some decide to no longer file with the combined cost report? (2) How will the remaining agencies that wish to file a combined report be treated? As clause ''v'' or clause ''vi'', and will there be any adjustment to costs for the agency-specific portion? (3) If combined State department home health agencies that file a combined cost report has subunits, and a beneficiary moves from one subunit to another, is that beneficiary counted as one beneficiary in each of the subunits, or is it prorated?

Response: (1) State health departments with subunits are allowed to file a combined Medicare cost report because of the administrative and financial burden in filing separate Medicare cost reports for all the agencies within the department. The State health departments were allowed to obtain subunit provider numbers for the purposes of tracking revenue and claims processing. Also, it is our understanding that the State health departments did have the capability to segregate the costs for each individual agency within the department. If State health departments decide to start submitting individual Medicare cost reports for the agencies within their department, they will not be allowed to pick and choose individual agencies for which they would like to report separately. The State agency health would have to rescind the 7800 series number and submit separate cost reports for all the agencies.

(2) Since the State health department filed a single cost report for all the agencies under a 7800 number series, and the individual subunits did not file a separate Medicare cost report for which an agency-specific per-beneficiary limitation can be calculated, if the units start filing separate Medicare cost reports under their own numbers, they will be considered clause ''vi'' type providers. Therefore, they will be subject to the national per-beneficiary limitation.

(3) State health departments that file a single cost report under the 7800 number for all its units will count a single beneficiary in its unduplicated census count for the cost reporting period regardless of the number of units that service that beneficiary. However, if the subunits report separately and the beneficiary is serviced by more than one subunit, the beneficiary must be prorated among the subunits servicing the beneficiary.

Comment: How do you determine prorating between agencies when you have one agency that was working hard and saw a patient on a limited basis versus the other agency who maximized visits to reach the ceiling of the beneficiary limitation and then discharged the patient?

Response: We cannot emphasize enough that the per-beneficiary limitation is not a limitation on the amount of services a beneficiary may receive or a limitation on the costs of an individual beneficiary. The per-beneficiary limitation is applied to the total unduplicated census count of the agency and compared to the lesser of the agency's actual costs or per-visit limitation in the aggregate plus nonroutine medical supplies. If an agency discharges a beneficiary with the assumption that the beneficiary has exhausted its per-beneficiary limitation and that beneficiary receives services from another agency, each agency will have less than one beneficiary in its unduplicated census count. For example, if agency ''A'' treats a Medicare beneficiary and after 60 visits, discharges the patient and subsequently the patient receives 40 visits from agency ''B'', agency ''A'' will count the beneficiary as .60 in its unduplicated census count and agency ''B'' will count the beneficiary as .40 in its unduplicated census count. Under a system based on medians and averages, such as the per-beneficiary limitations, it should be expected that some patients' costs and amount of services will be under the average and some patients' costs and amounts of services will be above the average.

Comment: The blend of an agency-specific component and a regional census division component rewards agencies that had high costs in Federal FY 1994 and penalizes agencies that had low costs in Federal FY 1994.

Response: By basing the per-beneficiary limitation on the HHA's own cost experience, the per-beneficiary limitation should reflect the mix of patients that the agency has been caring for in the past. This mix of patients should not change drastically as compared to the mix of patients for whom the HHA is currently providing care. While variation does exist between agencies, it is a reflection of their actual cost experience. All agencies were subject to the lower of their actual costs or the aggregate per-visit limitation in FY 1994. It is the lower of these amounts that is incorporated into the calculation of the per-beneficiary limitations. If two agencies existing in the same area with 1994 base periods did not have a competitive advantage over each other in 1994, it does not follow that one would have a competitive advantage due to the application of a per-beneficiary

limitation. As stated before, the average per-beneficiary cost is a reflection of the mix of patients that the HHA serviced in the base period.

Comment: Home health agencies that have reclassified branches to subunits should be allowed to use the parent agency's FY 1994 cost report as the base for establishing the per-beneficiary limitation for the new subunit.

Response: Branches within home health agencies are not providers as recognized under Medicare principles of reimbursement. Branches within home health agencies are part of and under the administrative control of the parent home health agency. The branch itself does not have its own administrative function or control. They are not independently certified by Medicare as a provider nor are they required to file a Medicare cost report. Because branches are not providers of service but an intricate part of a provider, they will be considered new providers if they become certified by Medicare as an independent provider of home health services subsequent to Federal FY 1994.

Comment: HCFA should allow agencies which filed more than one cost report during Federal FY 1994 to combine the cost reporting periods when they equal or exceed a 12-month cost reporting period for establishing the agency-specific per-beneficiary limitation.

Response: We do not agree. Medicare has always applied the terminology of a 12-month cost reporting period as being twelve consecutive months as reported in the Medicare cost report.

Comment: The impact analysis seems almost entirely focused on total Medicare expenditures. It gives short shrift to the problems that will be experienced by patients, HHAs, and other payers such as Medicaid. In order to maintain costs below the per-beneficiary limitation, HHAs will need to reduce the average number of visits provided to Medicare beneficiaries below the levels patients received in 1997. The size of this reduction was not estimated or its impact on Medicare beneficiaries.

Response: The impact analysis did not discuss the impact on beneficiaries because this payment system does not limit the amount of services a beneficiary may receive from an agency. It is designed to provide more efficient delivery of services. No beneficiary should be denied services as a result of this payment system. These beneficiaries continue to be eligible for Medicare home health benefits without a specific day limit.

Comment: The use of a two-thirds offset in estimating the impact of the aggregate per-beneficiary limitation on HHAs was not explained adequately. What analysis was performed to justify such an offset?

Response: An impact analysis requires that we estimate the impact of a change in policy. While there are questions about whether such an impact analysis is needed for a notice that announces rates for a statutorily mandated policy for which there is virtually no discretion, if we are to estimate the impact of the home health policy, we need to consider not just changes in Medicare payments that would be involved, but also the incentives created by the new policy and how providers are likely to react to the change in policy.

Home health is the highest cost Medicare service category which has no cost-sharing. As a result, there is no direct financial consequences to beneficiaries for use of home health services. Combined with the fact that home health services are non-invasive and the patient does not have to leave home to receive them, there are not the same kinds of constraints on their use as with other medical services.

We believe that it is prudent to assume that because of the incentives created by the B.B.A. '97 policy and the demonstrated ability of the industry to respond, that there would be a response. This does not necessarily mean that agencies will go out of business or substitute care of Medicare beneficiaries from other payers or sources of funds. It does mean that there would be changes in behavior to recoup some of the financial effects that would otherwise occur with the policy, such as an increase in users serving particularly low users, or reducing the intensity of care in marginal cases, or reducing services that should not be covered by Medicare. For the purposes of this impact analysis, it is our judgement that a 50 percent offset for the per-visit limitations and a 66 percent offset for the per-beneficiary limitations is reasonable. To the extent that actual expenditures differ from projections, after adjusting for other factors affecting expenditure growth, we will review the offsets used for future impact analysis.

Comment: Using HCFA's own analysis it is clear that agencies will either have to go out of business or subsidize care of Medicare beneficiaries from other payers or sources of funds. Layoffs of staff and closures of HHAs will have a direct impact on access to care that HCFA did not address.

Response: We did not address the impact on access to care due to agency closures because we were not expecting this to be a necessary reaction to the limitations as stated in the above response. We are currently receiving many new applications from agencies wanting to become Medicare certified. If there are any closures as a result of this payment system, it is expected other new agencies or agency expansions will offset these closures.

Comment: HCFA mentions that 15 percent of the Medicare savings are attributable to payments to managed care plans in FY 1998 and 20 percent in FY 1999. It is unclear what this means. Are home health services to managed care enrollees included in projected expenditures? Does HCFA expect managed care organizations to reduce home health services even though it is far below fee-for-service utilization?

Response: The impact notice mentions that some of the savings from this system are attributable to payments to managed care plans. Payments to Medicare managed care plans are based on fee-for-service Medicare benefits. If we expect to pay less to home health agencies on a fee-for-service basis, then the managed care rates will decrease. Managed care payments, in total, are included as part of our cost projections. Since payments to managed care plans are based on fee-for-service use, there is no need to project managed care payments by type. Since the B.B.A. '97 is directed toward changes in fee-for-service, managed care plans are not expected to reduce home health services as a result of this notice.

Comment: The impact section did not address the impact on per-visit costs of reducing the average number of visits provided per patient. It would seem logical that agencies' per-visit costs would increase as the average reimbursed cost per patient decreases. This impact on per-visit costs will drive agency per-visit costs higher which will result in a greater proportion of agencies exceeding the per-visit cost limitations than HCFA anticipates in its analysis.

Response: We believe that this system was implemented, in part, because the number of visits per beneficiary had been increasing at double-digit growth rate until 1996. However, the cost per-visit was not increasing at a similar level. The impact of these limitations was not expected to reduce the cost per-visit significantly.

Comment: The impact analysis is incomplete for two reasons. First, the Regulatory Flexibility Act is insufficient since it does not consider alternative interpretations of the HHA Interim Payment System provision. Second, section 202 of the Unfunded Mandates Reform Act requires its own assessment of costs and benefits.

Response: The HHA Interim Payment System provision, generally section 4602 of the Balanced Budget Act of 1997, is narrowly constructed such that it does not provide for exceptions or consideration of options that reduce the burden on small entities. We did not prepare a separate assessment of costs and benefits for purposes of Section 202 of the Unfunded Mandates Reform Act because we believe that this regulation did not meet the threshold requirement of an annual expenditure by State, local, or tribal governments, in the aggregate, or by private sector, of $100 million (adjusted annually for inflation).

Comment: HCFA describes 1,158 new providers on the database as those with December 1994 or December 1995 FY ends. These agencies may not be representative of all new agencies and thus the database may be limited in its use as a measure of the impact on new agencies.

Response: In order to meet the statutory dates for establishing the limitation, we had a very limited time in which to collect data, but obtained the most recent data available to assess the impact on new agencies. Because of how new providers are defined, we are limited by our resources in identifying all types of new providers. We believe that the data base was sufficient to conduct a valid impact analysis.

Comment: We see no justification for the additional two percent reduction to the per-beneficiary limitation for new agencies when determining a specific agency's per-beneficiary limitation as shown on page 15726 of the notice.

Response: The national per-beneficiary calculations at 63 FR 15726 should not be multiplied by 98 percent. The two percent reduction to the per-beneficiary limitations has already been taken into account in the calculations of the national per-beneficiary limitation. The examples of the national per-beneficiary calculations at 63 FR 15726 should be $3,279.26 for the Dallas MSA and $2,679.89 for rural Texas. We apologize for any inconveniences this may have caused.

Comment: The example of two merged agencies at 63 FR 15721 does not explain the new November 1, 1997 beginning cost reporting period. The date does not match either the agencies' previous cost reporting periods or the merger date.

Response: The date in the example of the two merged agencies should state that the weighted per-beneficiary limitation applies to the cost reporting period which began December 1, 1997.

Comment: The counties listed for MSA region 8840—Washington, DC in the March 31, 1998 **Federal Register** includes Charles County but those in the January 2, 1998 **Federal Register** do not. Is Charles County, Maryland in the Washington, DC region for the wage index for both the per-beneficiary limitations and the per-visit limitations?

Response: Both **Federal Register**s at 63 FR 102 and 63 FR 15733 show Charles, MD as part of the Washington, DC MSA.

Comment: Step 2 of the example at 63 FR 15725 depicts a divisor of seven instead of six. Shouldn't the divisor be six?

Response: Yes, the divisor at step 2 of the example at 63 FR 15725 should be six.

Comment: HCFA should have made the database available when the notice was published and should do so for all future cost limit or payment rate notices. The database should be available for the full comment period.

Response: We made every attempt to make the data available shortly after the notice was published. Due to the limited time available after finalizing the limits, we were unable to post the data to the Internet until one month after the notice was published. We believe this allowed sufficient time for analysis.

Comment: HCFA should make provider numbers and other requested data available immediately.

Response: We believe it is not necessary to identify individual providers in order to calculate the per-beneficiary limitations and therefore did not include this information in our data base on the public use file.

Comment: HCFA should provide a detailed explanation of how the database was constructed. The discussion should include the method for choosing agencies to include/exclude, the editing and verification process, and an explanation of how denied claims were matched to claims-based unduplicated census counts.

Response: We believe the calculations were explained fully in the notice. Because the statute is very explicit about how the per-beneficiary limitations are determined, we believe the explanations provided in the notice are adequate.

Comment: All outlying areas, such as Guam, Puerto Rico, and the Virgin Islands, should be combined into one category for purposes of calculating the census division components.

Response: The statute did not refer specifically to Guam, Puerto Rico, or the Virgin Islands in establishing per-beneficiary limitations. These areas do not fall within any of the existing census region divisions which are required by statute in establishing the regional per-beneficiary limitations. In order to avoid advantaging or disadvantaging any of the census division regions, we treated these areas as separate areas in establishing the regional per-beneficiary limitations. Puerto Rico and the Virgin Islands were combined as one area and Guam as a separate area. We note that the wage indices for the Virgin Islands and Guam were inadvertently omitted from the notice. The wage index for the Virgin Islands is .4588 and the wage index for Guam is .6516.

Comment: The standardization of the census division average per-beneficiary costs by the appropriate wage indices should only be applied to the labor-related component of the per-beneficiary rates.

Response: The standardization of the per-beneficiary limitations was applied to the labor-related component of the average costs per beneficiary. This adjustment methodology is explained on page 15723 of the notice with respect to how the adjusted unduplicated census counts of Medicare beneficiaries are used in the calculation of the per-beneficiary limitations. We applied the labor-related component percentage before calculating the wage-index weighted unduplicated beneficiary counts.

Comment: Unless HCFA can provide a reasonable explanation for including nonroutine supplies in the costs that were standardized by the wage index, the cost of nonroutine supplies should have been excluded from the standardization of these costs.

Response: When doing the standardization of the per-beneficiary limitations, we do not separate out each individual component of costs to determine the labor and nonlabor components. The labor-related and nonlabor percentages are determined with respect to all costs incurred by an HHA, and are applied to total costs accordingly.

Comment: HCFA should explain the reasons for not computing urban and rural costs separately and weighting by patient rather than agency.

Response: The statute does not provide for establishing urban and rural per-beneficiary limitations. Since the wage-index is applied based on the location of the services rendered to the beneficiaries, the standardization was done through a weighting of the beneficiaries rather than the location of the HHA.

Comment: HCFA should ensure that HHAs are reimbursed for additional costs associated with new regulatory requirements, such as OASIS costs.

Response: The statute requires the per-beneficiary limitations to be based

upon the costs incurred during a particular base year, the Federal FY 1994, and does not contemplate adjustments due to costs incurred subsequent to the base year.

Comment: We received numerous comments concerning the definition of new providers under the IPS. In particular, there are concerns over the application of national per-beneficiary limitations when there are mergers and consolidations of unlike agencies, i.e. provider-based and freestanding or agencies without a FY ending during Federal year 1994 with agencies with a FY ending during Federal FY 1994. Various scenarios were written in with respect to whether HCFA would find if such scenarios constituted a merger or consolidation which took place since Federal FY 1994. It was recommended that HCFA limit new provider status to those agencies without a 12-month cost reporting ending during Federal FY 1994 and providers that did not exist at the time of passage of the B.B.A. '97.

Response: We do not believe the policies set forth in the **Federal Register** were unreasonable with respect to new provider status under the interim payment system. The policies are not intended to redefine or impose new policies regarding HCFA's long standing policies regarding mergers and consolidations. With respect to provider-based agencies or freestanding agencies, we have always made a distinction between the two types of providers. In May 1998 we issued a Program Memorandum (Transmittal No. A–98–15) which clarified our policies regarding provider-based and freestanding designation. In that memorandum we state that the main purpose of provider or facility-based designation is to accommodate the appropriate accounting and allocation of costs where there is more than one type of provider activity taking place within the same facility/organization. This cost allocation and cost reimbursement more often than not results in Medicare program payments that exceed what would have been paid for if the same services were rendered by a free-standing entity.

Even though we believe our policies as stated in the March 31, 1998 **Federal Register** with respect to what is a ''clause vi'' agency are reasonable, we have reevaluated our position based on comments and are revising our interpretation as to what constitutes a new provider by adding an alternative reading. In determining whether an agency is a new or old provider, we will consider whether the agency's provider number existed with a 12-month cost reporting period ending during Federal FY 1994. In such a case, that agency can be considered an old provider/clause v provider regardless of any changes that took place in subsequent years. However, those agencies that did not have a 12-month cost reporting period ending during Federal FY 1994 and those agencies that were certified under Medicare with provider numbers that did not exist with a 12-month cost reporting period ending during Federal FY 1994 will continue to be considered new providers/clause vi providers. For greater detail on new providers, see section V.C. ''New Providers.''

V. Update of the Per-Beneficiary Limitations

The methodologies and data used to develop the schedule of per-beneficiary limitations set forth in this notice are the same as that used in setting the per-beneficiary limitations that were effective for cost reporting periods beginning on or after October 1, 1997. We have updated the per-beneficiary limitations to reflect the expected cost increases occurring between the cost reporting periods ended during Federal FY 1994 and September 30, 1999, 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. Therefore, we excluded this time period when we adjusted the database for the market basket increases.

A. Data Used

The cost report data used to develop the schedule of per-beneficiary limitations set forth in this notice are for cost reporting periods ending in Federal FY 1994, as required by section 1861(v)(1)(L) of the Act. 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, 1999 (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 system 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, 1998, and is based on where the home health services are rendered.

B. Wage Index

A wage index is used to adjust the labor-related portion of the standardized regional average per-beneficiary limitation and the national per-beneficiary limitation to reflect differing wage levels among areas. In establishing the regional average per-beneficiary limitation and national 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 schedules of standardized regional average per-beneficiary limitations and the national per-beneficiary limitation reflects the MSA definitions that are currently in effect under the hospital prospective payment system.

As we did for the per-visit limitations, 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 and the national per-beneficiary limitation. 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) 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. The wage-index, as applied to the labor portion of the regional per-beneficiary limitation and the labor portion of the national per-beneficiary limitation, must be based on the geographic location in which the home health service is actually furnished.

C. New Providers

Section III. C. at 63 FR 15721 through 15722 provides the policy with respect to the determination of whether an agency is a new agency or an old agency for applying the per-beneficiary limitations. Considering the number of comments and inquiries we have received concerning the policies set forth in this section, particularly with respect to what a ''clause vi'' provider is under the IPS, we have reevaluated our position on this issue and are modifying some of the policies.

In considering this policy we recognize there are many changes an HHA may undergo including changes due to mergers, consolidations, and changes in ownership. Regardless of what constitutes the change there will be a surviving entity resulting from the change and the status of the surviving entity will dictate how the agency will be treated under the per-beneficiary limitations. We believe that providers fall within the following groupings: (a) An HHA with an existing provider number with a provider agreement with HCFA, (b) an HHA accepts assignment of the provider agreement and provider number which had a FY 1994 base year through a change in ownership after the FY 1994 base year, or, (c) an HHA has gone through the certification process since the FY 1994 base period as a new provider and has a new provider number assigned after the applicable FY 1994 base year. Under (a) or (b), if the provider number existed as an HHA with a 12-month cost reporting period ending during Federal FY 1994, that 12-month cost reporting period will be the cost reporting period for calculating the agency-specific component of the per-beneficiary limitation and considered an old provider with an agency-specific per-beneficiary limitation. Under (c), the agency will be a new provider and subject to the national per-beneficiary limitation.

We are permitting providers that would be determined to be new providers under the policies set forth in the March 31, 1998 final notice, to elect to be considered an old provider under the policies set forth above. Furthermore, providers that were determined to be new providers under the March 31, 1998 policies may likewise choose to continue to be considered new providers. These choices must be made and conveyed to the agency's fiscal intermediary by October 1, 1998. We note these designations of provider status is solely for purposes of determining the per-beneficiary limitation. However, those providers that elect to continue to be new providers pursuant to the March 31, 1998 final notice are subject to that continued new provider status for so long as there are no changes after their October 1, 1998 election that would affect their elected new provider option.

Our policy addressing HHA branches that become subunits set forth at 63 FR 15722 is not affected by the change addressed above.

VI. 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

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 & Stationary 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 Owner's Equivalent.
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	

VII. Update of Data Base

The data used to develop the cost per-visit limitations, the census region per-beneficiary limitations and the national per-beneficiary limitation were 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, 1999, 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 per-visit, the census region per-beneficiary limitations, and national per-beneficiary limitations:

TABLE 2.—FACTORS FOR INFLATING DATABASE DOLLARS TO SEPTEMBER 30,1999

[Inflation Adjustment Factors [1]]

FY end	1993	1994	1995	1996	1997
October 31	1.11846	1.08387	1.08361	1.08169	1.05773
November 30	1.11568	1.08773	1.08361	1.08073	1.05507
December 31	1.11291	1.08650	1.08361	1.07955	1.05241
January 31	.....	1.11015	1.08553	1.08361	1.07816
February 28	.....	1.10741	1.08483	1.08361	1.07656
March 31	.....	1.10475	1.08428	1.08361	1.07477
April 30	.....	1.10215	1.08387	1.08361	1.07279
May 31	.....	1.09963	1.08361	1.08361	1.07064
June 30	.....	1.09709	1.08361	1.08361	1.06820
July 31	.....	1.09480	1.08361	1.08342	1.06566
August 31	.....	1.09276	1.08361	1.08304	1.06303
September 30	.....	1.09090	1.08361	1.08246	1.06039

[1] Source: The Home Health Agency Price Index, produced by HCFA. The forecasts are from Standard and Poor's DRI 1st QTR 1998; @USSIM/TREND25YR0298@CISSIM/Control981 forecast exercise which has historical data through 1998:1.

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.

A. 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, 1998 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. The data used in calculating the limitations were updated to September 30, 1999. Therefore, the cost limitations published in this notice are for a 12-month cost reporting period beginning October 1, 1998 and ending September 30, 1999. For 12-month cost reporting periods beginning after October 1, 1998 and before October 1, 1999, 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 of the cost reporting 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, an HHA that had a 1994 base year changed its FY end from June 30 to December 31. Therefore, the HHA had a short cost reporting period beginning on July 1, 1999 and ending on December 31, 1999. The cost reporting period ending during Federal FY 1994 would have been the cost reporting period ending on June 30, 1994. The limitations that apply to this short period must be adjusted as follows:

Step 1—From Table 6, sum the index levels for the months of July 1999 through December 1999: 6.82716.

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

6.82716÷6=1.13787.

Step 3—From Table 6, sum the index levels for the months in the common period of October 1998 through September 1999: 13.45836.

Step 4—Divide the results in Step 3 by the number of months in the common period:

13.45836÷12=1.12153.

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-visit and per-beneficiary limitations:

1.13787÷1.12153=1.0145693.

Step 6—Apply the results from Step 5 to the published limitations.

For example:

a. Urban skilled nursing per-visit labor portion

$88.44×1.0145693=$89.73.

b. Urban skilled nursing per-visit nonlabor portion

$19.73×.0145693=$20.02.

c. West South Central Census region division labor portion per-beneficiary limitation
$4,588.26×1.0145693=$4,655.11.

d. West South Central Census region division nonlabor portion per-beneficiary limitation
$1,319.27×1.0145693=$1,338.49.

Step 7. Also apply the results from Step 5 to the calculated agency-specific per-beneficiary amount which has been updated to September 30, 1999 using Table 2.

B. Adjustment Factor for Reporting Year Beginning After October 1, 1998 and Before October 1, 1999

If an HHA has a 12-month cost reporting period beginning on or after November 1, 1998, the per-visit limitation and the adjusted census region division per-beneficiary limitation and the agency-specific per-beneficiary limitation or the adjusted national per-beneficiary limitations are 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 will increase the agency-specific per-beneficiary limitation to September 30, 1999. That way when the limitations need to be further adjusted for the cost reporting period, all elements of the limitation calculations can be adjusted by the same factor. For example, if an HHA providing services in the Dallas MSA only and has a cost reporting period beginning January 1, 1999, its occupational therapy per-visit limitation and its per-beneficiary limitation would be further adjusted as follows:

COMPUTATION OF REVISED PER-VISIT FOR OCCUPATIONAL THERAPY

Adjusted per-visit limitation	$123.05 [1]
Adjustment from Table 5	1.00720
Revised per-visit limitation	$123.94

[1] Adjusted by appropriate wage index applicable to the Dallas MSA and the budget neutrality adjustment factor of 1.03.

COMPUTATION OF REVISED PER-BENEFICIARY LIMITATIONS FOR AN HHA WITH A 1994 BASE PERIOD

Agency-specific component inflated through December 31, 1999:	
$5400.00 × .98 × .75	$3,969.00
West south central division component adjusted by the Dallas MSA wage index:	
$5,771.26 × .98 × .25	1,413.96
Blended per-beneficiary limitation for Dallas-MSA	$5,382.96
Adjustment factor from Table 5	1.00720
Adjusted blended per-beneficiary limitation for Dallas MSA	$5,521.72

COMPUTATION OF REVISED PER-BENEFICIARY LIMITATION FOR A NEW PROVIDER IN THE DALLAS MSA

National per-beneficiary limitation for Dallas MSA	$3,376.61 [1]
Adjustment factor from Table 5	1.00720
Adjusted national per-beneficiary limitation	$3,400.92

[1] Published limitation reflects 98 percent factor.

VIII. Schedules of Per-visit and Per-beneficiary Limitations

The schedules of limitations set forth below apply to cost reporting periods beginning on or after October 1, 1998. The intermediaries will compute the adjusted 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 limitations for the area(s) where the HHA furnishes HHA services to Medicare beneficiaries. Each HHA's aggregate limitations cannot be determined prospectively, but depends on each HHA's Medicare utilization (visits and unduplicated census count) 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, 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, 1999, 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, 1999.

The HHA costs that are subject to the per-visit limitations include the cost of medical supplies routinely furnished in conjunction with patient care. Durable medical equipment orthotic, prosthetic, and other medical supplies directly identifiable as services to an individual patient are excluded from the per-visit costs and are paid without regard to the per-visit schedule of limitations. (See Chapter IV of the Home Health Agency Manual (HCFA Pub. II).) The HHA costs that are subject to the per-beneficiary limitations include the costs of medical supplies routinely furnished and nonroutine medical supplies furnished in conjunction with patient care. Durable medical equipment 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 limitations for each HHA according to the location where the services are furnished by the HHA. Medicare payment is based on the lower of the HHA's total allowable Medicare costs plus the allowable Medicare costs of nonroutine medical supplies, the aggregate per-visit limitation plus the allowable Medicare costs of nonroutine medical supplies, or the aggregate per-beneficiary limitation. An example of how the aggregate limitations are computed for an HHA providing HHA service to Medicare beneficiaries in both Dallas, Texas and rural Texas are as follows:

Example: HHA X, an HHA located in Dallas, TX, has 11,500 skilled nursing visits, 4,300 physical therapy visits, 8,900 home health aide visits and an unduplicated census count of 400 Medicare beneficiaries in the Dallas MSA and 5,000 skilled nursing visits, 2,300 physical therapy visits, 4,300 home health aide visits and an unduplicated census count of 200 Medicare beneficiaries in rural Texas during its 12-month cost reporting period ending September 30, 1999. The unadjusted agency-specific per-beneficiary amount for the base period (cost reporting period ending September 30, 1994) is $4,825.00. The aggregate limitations are calculated as follows:

DETERMINING THE AGGREGATE PER-BENEFICIARY LIMITATION

MSA/Non-MSA area	Per beneficiary limitation	Unduplicated census count of Medicare beneficiaries	Total per beneficiary limitation
Dallas, TX	(4,825.00 × 1.09090 × .98 × .75) plus ((4,588.36 × .9703) plus 1,319.21)) × .98 × .25	400	2,113,080
Rural, TX	(4,825.00 × 1.09090 × .98 × .75) plus ((4,588.36 × .7404) plus 1,319.21)) × .98 × .25	200	1,004,852
Aggregate Limitation			3,117,932

DETERMINING THE AGGREGATE PER-VISIT LIMITATION

Area/type of visit	Number of visits	Per-visit limit [1]	Total limit
Dallas-MSA:.			
Skilled nursing	11,550	108.12	1,248,786
Physical therapy	4,300	121.08	520,644
Home health aide	8,900	45.14	401,746
Rural Texas:			
Skilled nursing	5,000	77.37	386,850
Physical therapy	2,300	88.95	204.585
Home health aide	4,300	43.06	185,158
Aggregate limitation			2,947,769

[1] The per-visit has been adjusted by the appropriate wage-index and the budget neutrality adjustment factor of 1.03.

For the cost reporting period ending September 30, 1999, the HHA incurred $2,850,000 in Medicare costs for the discipline services and $325,000 for the costs of Medicare nonroutine medical supplies. Medicare reimbursement for this HHA would be $3,117,932, which is the lesser of the actual costs of $2,850,000 plus the costs of nonroutine medical supplies of $325,000 ($3,175,000) or the aggregate per-visit limitation of $2,947,769 plus the costs of nonroutine medical supplies of $325,000 ($3,272,769) or the aggregate per-beneficiary limitation of $3,117,932.

Before the limitations are applied during settlement of the cost report, the HHA's actual costs are reduced by the amount of individual items of costs (for example, administrative compensation and contract services) that are found to be excessive under the Medicare principles of provider payment. That is, the intermediary reviews the various reported costs, taking into account all the Medicare payment principles, for example, the cost guidelines for physical therapy furnished under arrangements (see 42 CFR 413.106) and the limitation on costs that are substantially out of line with those of comparable HHAs (see 42 CFR 413.9).

TABLE 3A.—PER-VISIT LIMITATIONS

Type of Visit	Per-visit limitation	Labor portion	Nonlabor portion [1]
MSA(NECMA) location:			
Skilled nursing care	108.17	$88.4	$19.73
Physical therapy	$121.14	98.82	22.32
Speech therapy	126.52	103.01	23.51
Occupational therapy	123.10	99.81	23.29
Medical social services	167.78	136.78	31.00
Home health aide	45.16	36.88	8.28
NonMSA location:			
Skilled nursing care	94.97	74.13	20.84
Physical therapy	107.26	83.56	23.70
Speech therapy	107.97	83.99	23.98
Occupational therapy	108.15	84.05	24.10

TABLE 3A.—PER-VISIT LIMITATIONS—Continued

Type of Visit	Per-visit limitation	Labor portion	Nonlabor portion [1]
Medical social services	130.69	101.38	29.31
Home health aides	43.84	34.21	9.63

[1] Nonlabor portion of per-visit limitations for HHAs located in Alaska, Hawaii, Puerto Rico, and the Virgin Islands are increased by multiplying them by the following cost-of-living adjustment factors.

Location	Adjustment factor
Alaska	1.150
Hawaii:	
County of Hawaii	1.225
County of Hawaii	1.150
County of Kauai	1.200
County of Maui	1.2225
County of Kalawao	1.225
Puerto Rico	1.100
Virgin Islands	1.125

TABLE 3B.—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)	$2,749.52	$790.58
Middle Atlantic (NJ, NY, PA)	2,037.88	585.96
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	3,073.90	883.84
East North Central (IL, IN, MI, OH, WI)	2,492.70	716.73
East South Central (AL, KY, MS, TN)	4,726.25	1,358.95
West North Central (IA, KS, MN, MO, NE, ND, SD)	2,394.14	688.39
West South Central (AR, LA, OK, TX)	4,588.26	1,319.27
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	3,023.85	869.45
Pacific (AK, CA, HI, OR, WA)	2,342.45	673.53

TABLE 3C.—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	$2,684.47	$771.87

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

	Labor component	Nonlabor component
Puerto Rico	$1,996.22	$573.97
Guam	1,929.22	554.71

IX. Wage Indexes

TABLE 4a.—WAGE INDEX FOR URBAN AREAS

Urban area (Constituent counties or county equivalents)	Wage index
0040 Abilene, TX	0.8287
Taylor, TX	
0060 Aguadilla, PR	0.4188
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9772

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

Urban area (Constituent counties or county equivalents)	Wage index
Portage, OH	
Summit, OH	
0120 Albany, GA	0.7914
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY	0.8480
Albany, NY	
Montgomery, NY	

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

Urban area (Constituent counties or county equivalents)	Wage index
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9309
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.8162

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

Urban area (Constituent counties or county equivalents)	Wage index
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	1.0086
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9137
Blair, PA	
0320 Amarillo, TX	0.9425
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2842
Anchorage, AK	
0440 Ann Arbor, MI	1.1785
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8266
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.8996
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4218
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9072
Buncombe, NC	
Madison, NC	
0500 Athens, GA	0.9087
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA	0.9823
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	
0560 Atlantic City-Cape May, NJ	1.1155
Atlantic City, NJ	
Cape May, NJ	
0600 Augusta-Aiken, GA–SC	0.9333
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX	0.9133
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA	1.0014
Kern, CA	
0720 Baltimore, MD	0.9689
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne, MD	
0733 Bangor, ME	0.9478
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.4291
Barnstable, MA	
0760 Baton Rouge, LA	0.8382
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8593
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1221
Whatcom, WA	
0870 Benton Harbor, MI	0.8634
Berrien, MI	
0875 Bergen-Passaic, NJ	1.2156
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9783
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8415
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY	0.8914
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.9005
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7695
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.9128
Monroe, IN	
1040 Bloomington-Normal, IL	0.8733
McLean, IL	
1080 Boise City, ID	0.8856
Ada, ID	
Canyon, ID	
1123 Boston-Worcester Lawrence-Lowell-Brockton, MA–NH	1.1506
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	1.0015
Boulder, CO	
1145 Brazoria, TX	0.9341
Brazoria, TX	
1150 Bremerton, WA	1.0999
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.8740
Cameron, TX	
1260 Bryan-College Station, TX	0.8571
Brazos, TX	
1280 Buffalo-Niagara Falls, NY	0.9272
Erie, NY	
Niagara, NY	
1303 Burlington, VT	1.0142
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4459
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.8961
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9013
Natrona, WY	
1360 Cedar Rapids, IA	0.8529
Linn, IA	
1400 Champaign-Urbana, IL	0.8824
Champaign, IL	
1440 Charleston-North Charleston, SC	0.8807
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1450 Charleston, WV	0.9142
Kanawha, WV	
Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC–SC	0.9710
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	0.9051
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN–GA	0.8658
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY	0.7555
Laramie, WY	
1600 Chicago, IL	1.0860
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	

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

Urban area (Constituent counties or county equivalents)	Wage index
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	1.0429
Butte, CA	
1640 Cincinnati, OH–KY–IN	0.9474
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN–KY	0.7852
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH	0.9804
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9316
El Paso, CO	
1740 Columbia, MO	0.9001
Boone, MO	
1760 Columbia, SC	0.9192
Lexington, SC	
Richland, SC	
1800 Columbus, GA–AL	0.8288
Russell, AL	
Chattanoochee, GA	
Harris, GA	
Muscogee, GA	
1840 Columbus, OH	0.9793
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8945
Nueces, TX	
San Patricio, TX	
1900 Cumberland, MD–WV	0.8822
Allegany, MD	
Mineral, WV	
1920 Dallas, TX	0.9703
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.8146
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Rock Island-Moline, IA–IL	0.8405
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9584
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.8375
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8286
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL	0.7915
Macon, IL	
2080 Denver, CO	1.0386
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.8837
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI	1.0825
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.8070
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9303
Kent, DE	
2200 Dubuque, IA	0.8088
Dubuque, IA	
2240 Duluth-Superior, MN–WI	0.9779
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0632
Dutchess, NY	
2290 Eau Claire, WI	0.8764
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	1.0123
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9081
Elkhart, IN	
2335 Elmira, NY	0.8247
Chemung, NY	
2340 Enid, OK	0.7962
Garfield, OK	
2360 Erie, PA	0.8862
Erie, PA	
2400 Eugene-Springfield, OR	1.1435
Lane, OR	
2440 Evansville-Henderson, IN–KY	0.8641
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND–MN	0.8837
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8734
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.7461
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ–UT	0.9115
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.1171
Genesee, MI	
2650 Florence, AL	0.7551
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8711
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0248
Larimer, CO	
2680 Ft. Lauderdale, FL	1.0448
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.8788
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	1.0257
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR–OK	0.7769
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.8765
Okaloosa, FL	
2760 Fort Wayne, IN	0.8901
Adams, IN	
Allen, IN	
DeKalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Forth Worth-Arlington, TX	0.9979
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0607
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8815
Etowah, AL	
2900 Gainesville, FL	0.9616
Alachua, FL	
2920 Galveston-Texas City, TX	1.0564
Galveston, TX	
2960 Gary, IN	0.9633
Lake, IN	
Porter, IN	
2975 Glens Falls, NY	0.8386
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8443
Wayne, NC	
2985 Grand Forks, ND–MN	0.8745
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9090
Mesa, CO	
3000 Grand Rapids-Muskegon-Holland, MI	1.0147
Allegan, MI	

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

Urban area (Constituent counties or county equivalents)	Wage index
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.8803
Cascade, MT	
3060 Greeley, CO	1.0097
Weld, CO	
3080 Green Bay, WI	0.9097
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC	0.9351
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9064
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9059
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9681
Washington, MD	
3200 Hamilton-Middletown, OH	0.8767
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	1.0187
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT	1.2562
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 Hattiesburg, MS	0.7192
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.8686
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1816
Honolulu, HI	
3350 Houma, LA	0.7854
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX	0.9855
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV–KY–OH	0.9160
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8485
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN	0.9848
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9413
Johnson, IA	
3520 Jackson, MI	0.9052
Jackson, MI	
3560 Jackson, MS	0.7760
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.8522
Madison, TN	
Chester, TN	
3600 Jacksonville, FL	0.8969
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC	0.6973
Onslow, NC	
3610 Jamestown, NY	0.7552
Chautaqua, NY	
3620 Janesville-Beloit, WI	0.8824
Rock, WI	
3640 Jersey City, NJ	1.1412
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN–VA	0.9114
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8378
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7443
Craighead, AR	
3710 Joplin, MO	0.7510
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0668
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	0.8653
Kankakee, IL	
3760 Kansas City, KS–MO	0.9564
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9196
Kenosha, WI	
3810 Killeen-Temple, TX	1.0252
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8831
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.8416
Howard, IN	
Tipton, IN	
3870 La Crosse, WI–MN	0.8749
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8206
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.9174
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7776
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.8806
Polk, FL	
4000 Lancaster, PA	0.9481
Lancaster, PA	
4040 Lansing-East Lansing, MI	1.0088
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.7325
Webb, TX	
4100 Las Cruces, NM	0.8646
Dona Ana, NM	
4120 Las Vegas, NV–AZ	1.0592
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.8608
Douglas, KS	
4200 Lawton, OK	0.9045
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9536
Androscoggin, ME	
4280 Lexington, KY	0.8390
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9185
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	0.9231

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

Urban area (Constituent counties or county equivalents)	Wage index
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8490
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8613
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA	1.2232
Los Angeles, CA	
4520 Louisville, KY–IN	0.9507
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8400
Lubbock, TX	
4640 Lynchburg, VA	0.8228
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.9227
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0055
Dane, WI	
4800 Mansfield, OH	0.8639
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4475
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8371
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0354
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.8819
Brevard, Fl	
4920 Memphis, TN–AR–MS	0.8589
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	1.0947
Merced, CA	
5000 Miami, FL	0.9859
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ	1.1059
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 Milwaukee-Waukesha, WI	0.9819
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St. Paul, MN–WI	1.0733
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	
5160 Mobile, AL	0.8455
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0794
Stanislaus, CA	
5190 Monmouth-Ocean, NJ	1.0934
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8414
Ouachita, LA	
5240 Montgomery, AL	0.7671
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.9173
Delaware, IN	
5330 Myrtle Beach, SC	0.8072
Horry, SC	
5345 Naples, FL	1.0109
Collier, FL	
5360 Nashville, TN	0.9182
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY	1.3807
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT	1.2618
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT	1.2013
New London, CT	
5560 New Orleans, LA	0.9566
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John Baptist, LA	
St. Tammany, LA	
5600 New York, NY	1.4449
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ	1.1980
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY–PA	1.1283
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA–NC	0.8316
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City, VA	
Williamsburg City, VA	
York, VA	
5775 Oakland, CA	1.5068
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9032
Marion, FL	
5800 Odessa-Midland, TX	0.8660
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK	0.8481
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.0901
Thurston, WA	
5920 Omaha, NE–IA	0.9421
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA	1.1605
Orange, CA	
5960 Orlando, FL	0.9397
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.7480
Daviess, KY	
6015 Panama City, FL	0.8337

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

Urban area (Constituent counties or county equivalents)	Wage index
Bay, FL	
6020 Parkersburg-Marietta, WV–OH	0.8046
Washington, OH	
Wood, WV	
6080 Pensacola, FL	0.8193
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8571
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA–NJ	1.1398
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ	0.9606
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7826
Jefferson, AR	
6280 Pittsburgh, PA	0.9725
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA	1.0960
Berkshire, MA	
6340 Pocatello, ID	0.9586
Bannock ID	
6360 Ponce, PR	0.4589
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9627
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR–WA	1.1344
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Pawtucket, RI	1.1049
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
Statewide, RI	
6520 Provo-Orem, UT	1.0073
Utah, UT	
6560 Pueblo, CO	0.8450
Pueblo, CO	

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

Urban area (Constituent counties or county equivalents)	Wage index
6580 Punta Gorda, FL	0.8725
Charlotte, FL	
6600 Racine, WI	0.8934
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC	0.9818
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8345
Pennington, SD	
6680 Reading, PA	0.9516
Berks, PA	
6690 Redding, CA	1.1790
Shasta, CA	
6720 Reno, NV	1.0768
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	0.9918
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9152
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 Riverside-San Bernardino, CA	1.1307
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8402
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.0502
Olmsted, MN	
6840 Rochester, NY	0.9524
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9081
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9029
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA	1.2202
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9564

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

Urban area (Constituent counties or county equivalents)	Wage index
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9544
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO	0.8366
Andrews, MO	
Buchanan, MO	
7040 St. Louis, MO–IL	0.9130
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	
7080 Salem, OR	0.9935
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4513
Monterey, CA	
7160 Salt Lake City-Ogden, UT	0.9857
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.7780
Tom Green, TX	
7240 San Antonio, TX	0.8499
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA	1.2193
San Diego, CA	
7360 San Francisco, CA	1.4180
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA	1.4332
Santa Clara, CA	
7440 San Juan-Bayamon, PR	0.4625
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	

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

Urban area (Constituent counties or county equivalents)	Wage index
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.1374
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0688
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.4187
Santa Cruz, CA	
7490 Santa Fe, NM	1.0332
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.2815
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9757
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.8638
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton—Wilkes-Barre—Hazleton, PA	0.8539
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA	1.1339
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA	0.8783
Mercer, PA	
7620 Sheboygan, WI	0.7862
Sheboygan, WI	
7640 Sherman-Denison, TX	0.8499
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.9381
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA–NE	0.8031
Woodbury, IA	
Dakota, NE	
17760 Sioux Falls, SD	0.8712
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9868
St. Joseph, IN	
7840 Spokane, WA	1.0486
Spokane, WA	
7880 Springfield, IL	0.8713
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.7989
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.0740
Hampden, MA	
Hampshire, MA	

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

Urban area (Constituent counties or county equivalents)	Wage index
8050 State College, PA	0.9635
Centre, PA	
8080 Steubenville-Weirton, OH–WV	0.8645
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.1496
San Joaquin, CA	
8140 Sumter, SC	0.7842
Sumter, SC	
8160 Syracuse, NY	0.9464
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1016
Pierce, WA	
8240 Tallahassee, FL	0.8832
Gadsden, FL	
Leon, FL	
8280 Tampa-St. Petersburg-Clearwater, FL	0.9103
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN	0.8614
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana, AR-Texarkana, TX	0.8664
Miller, AR	
Bowie, TX	
8400 Toledo, OH	1.0390
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9438
Shawnee, KS	
8480 Trenton, NJ	1.0380
Mercer, NJ	
8520 Tucson, AZ	0.9180
Pima, AZ	
8560 Tulsa, OK	0.8074
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8187
Tuscaloosa, AL	
8640 Tyler, TX	0.9567
Smith, TX	
8680 Utica-Rome, NY	0.8398
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3754
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.0946
Ventura, CA	
8750 Victoria, TX	0.8474
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0110
Cumberland, NJ	

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

Urban area (Constituent counties or county equivalents)	Wage index
8780 Visalia-Tulare-Porterville, CA	0.9924
Tulare, CA	
8800 Waco, TX	0.7696
McLennan, TX	
8840 Washington, DC–MD–VA–WV	1.0911
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpepper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 Waterloo-Cedar Falls, IA	0.8640
Black Hawk, IA	
8940 Wausau, WI	1.0545
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL	1.0372
Palm Beach, FL	
9000 Wheeling, OH–WV	0.7707
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9403
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.7646
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8548
Lycoming, PA	
9160 Wilmington-Newark, DE–MD	1.1538
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9322
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0102
Yakima, WA	
9270 Yolo, CA	1.1431
Yolo, CA	
9280 York, PA	0.9415
York, PA	
9320 Youngstown-Warren, OH	0.9937
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0324

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

Urban area (Constituent counties or county equivalents)	Wage index
Sutter, CA Yuba, CA 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
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
Guam	0.6516
Virgin Islands	0.4588

[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, 1998	1.00239
December 1, 1998	1.00478
January 1, 1999	1.00720
February 1, 1999	1.00964
March 1, 1999	1.01210
April 1, 1999	1.01456
May 1, 1999	1.01702
June 1, 1999	1.01948
July 1, 1999	1.02197
August 1, 1999	1.02448
September 1, 1999	1.02701

[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
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

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

Per-beneficiary limitations month	Index level
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	1.06370
July 1997	1.06717
August 1997	1.07065
September 1997	1.07317
October 1997	1.07569
November 1997	1.07822
December 1997	1.08074
January 1998	1.08327
February 1998	1.08580
March 1998	1.08769
April 1998	1.08958
May 1998	1.09148
June 1998	1.09494
July 1998	1.09841
August 1998	1.10189
September 1998	1.10441
October 1998	1.10693
November 1998	1.10946
December 1998	1.11230
January 1999	1.11514
February 1999	1.11798
March 1999	1.12019
April 1999	1.12240
May 1999	1.12461
June 1999	1.12776
July 1999	1.13091
August 1999	1.13408
September 1999	1.13660
October 1999	1.13912
November 1999	1.14165
December 1999	1.14480
January 2000	1.14795
February 2000	1.15112
March 2000	1.15332
April 2000	1.15553
May 2000	1.15774
June 2000	1.16120
July 2000	1.16467
August 2000	1.16816
September 2000	1.17099
October 2000	1.17383

X. Regulatory Impact Statement

A. Introduction

HCFA has examined the impacts of this notice with comment 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. We anticipate this notice, in total, will have a significant impact on a substantial number of small entities based on the estimates shown below. We have examined the options for lessening the burden on small entities, however, the statute does not allow for any exceptions to these limitations based on size of entity. Therefore, there are no options to lessen the regulatory burden that are consistent with the statute.

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 there are no costs associated with this notice with comment that apply to these governmental and private sectors. Therefore, the law does not apply.

1. Effect of This Notice

This notice is a part of the HHA IPS. As a result of rebasing the per-visit limitations, we estimate that there will be a cost to the Medicare program of approximately $70 million in Federal FY 1999. We estimate that the effect of the offset adjustment for the implementation of OASIS data collection, as discussed in section III.G. will result in negligible costs to the Medicare program. We note that this estimate differs from that published in the Paperwork Reduction Act section of the March 10, 1997 proposed rule on OASIS collection requirements (62 FR 11035). This is due to several factors. Unlike the OASIS proposed rule which calculated impacts based on total HHA costs on an agency basis, the offset adjustment factor in this notice is necessarily calculated on a per-visit, Medicare basis. Moreover, we have based these estimates on actual data collected from the home health PPS demonstration rather than using the general estimates of the proposed OASIS rule. We believe using actual data which was not available at the time the OASIS proposed rule was written produces a more accurate estimate of cost impact.

We should also note, however, that the adjustment only incorporates the incremental costs of data collection and not any incremental costs, if any, which may be incurred for OASIS reporting because no reliable cost data were available at this time. We are specifically requesting comments on these costs. Also, we cannot determine the number of providers affected by our revised new provider policy and therefore cannot determine what the financial impact, if any, will be.

2. Effect on March 31, 1998 Final Rule With Comment Period

As stated in the March 31, 1998 final rule with comment period (63 FR 15718) for Federal FY 1999, we estimate that the imposition of the per-beneficiary limitations will result in savings of $2.14 billion. However, the changes imposed through this notice to the per-visit limitations will result in savings of $670 million instead of $740 million as stated in the March 31, 1998 final rule with comment period (63 FR 15718). This is the result of rebasing the per-visit limitations. The total savings from both limitations for Federal FY 1999 will be $2.81 billion rather than $2.88 billion as stated in the March 31, 1998 rule.

This notice with comment is not a major rule as defined in Title 5, United States Code, section 804(2) and is not an economically significant rule under Executive Order 12866. However, we are preparing a regulatory impact statement because this notice with comment is an integral part of the HHA IPS.

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 notice with comment, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

B. Explanation of Per-Visit Limitations

Section 1861(v)(1)(L)(i) of the Act specifies that the per-visit limitations not exceed 105 percent of the median of the labor-related and nonlabor per-visit costs for freestanding HHAs. The reasonable costs used in the per-visit calculations will be updated by the home health market basket excluding any change 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.

The methodology used to develop the schedule of per-visit limitations in this notice with comment is the same as that used in setting the limitations effective October 1, 1997. We are using the latest settled cost report data (as described in Section III. Update of Per-Visit Limitations) from freestanding HHAs to develop the per-visit limitations.

C. Explanation of Per-Beneficiary Limitations

Section 1861(v)(1)(L) requires the per-beneficiary 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 FFY 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 FFY 1994, standardized by the hospital wage index. The reasonable costs used in the per-beneficiary limitation calculations in one and two 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 by multiplied by the agency's unduplicated census count of beneficiaries (entitled to benefits under Medicare) to calculate the HHA's 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 FFY 1994, the per-beneficiary limitation will be a national per-beneficiary limitation which 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.

The methodologies and data used to develop the schedule of per-beneficiary limitations set forth in this notice are the same as that used in setting the per-beneficiary limitations that were effective for cost reporting periods beginning on or after October 1, 1997. We have updated the per-beneficiary

limitations to reflect the expected cost increases occurring between the cost reporting periods ended during FFY 1994 and September 30, 1999, 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. Therefore, we excluded this time period when we adjusted the database for the market basket increases.

Payments by Medicare under this 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.

D. Effect on Home Health Agencies

This notice with comment period sets forth revised schedules 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, 1998. These limitations replace the limitations that were set forth in our January 2, 1998 notice with comment period, per-visit limitations, (63 FR 89) and our March 31, 1998 final rule with comment period, per-beneficiary limitations, (63 FR 15718).

The following quantitative analysis presents the projected effects of the statutory changes effective for FFY 1999. This notice with comment period is necessary to implement the provisions of section 1861(v)(1)(L) of the Act, as amended by B.B.A. '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, 1999.

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 revision in the schedule of the per-visit and per-beneficiary limitations. The total number of HHAs in this table, 6,414, is based on HHA cost reports with a FFY 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 B.B.A. '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 for the per-beneficiary limitations and a 50 percent reduction for the per-visit limitations.

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 per-visit limitation and therefore, not be affected by the per-beneficiary limitation, before the behavioral offsets are taken into account. Column four shows the average percent of costs over the per-visit limitation for an agency in that cell, including behavioral offsets. Column five shows the percent of HHAs within a group that are projected to exceed the per-beneficiary limitation and therefore, not be affected by the per-visit limitation, before the behavioral offsets are taken into account. Column six shows the average percent of costs over the per-beneficiary limitation for an agency in that category, including behavioral offsets. It is important to note that in determining the expected percentage of an agency's costs exceeding the cost limitations, column four (percent of costs exceeding visit limits) and column six (percent of costs exceeding beneficiary limits) are not to be added together. Either the per-visit limitation or the per-beneficiary limitation is exceeded, but not both.

IMPACT OF THE IPS HHA LIMITS, EFFECTIVE 10/1/98

	Number of agencies	Percent of agencies exceeding visit limits	Percent of costs exceeding visit limits	Percent of agencies exceeding beneficiary limits	Percent of costs exceeding beneficiary limits
BY: GEOGRAPHIC AREA:					
ALL AGENCIES	6414	29.8	4.1	60.2	9.8
FREESTANDING	4308	23.9	3.9	67.5	11.2
HOSPITAL BASED	2106	42.1	4.5	45.4	6.5
OLD AGENCIES	5256	25.7	2.2	62.7	9.4
FREESTANDING	3245	15.8	1.0	73.4	11.0
HOSPITAL BASED	2011	41.7	4.5	45.4	6.4
NEW AGENCIES	1158	48.6	19.5	49.3	12.6
FREESTANDING	1063	48.5	20.4	49.6	12.8
HOSPITAL BASED	95	49.5	5.3	46.3	9.2
ALL URBAN	4137	29.1	4.1	63.7	10.0
FREESTANDING	3111	23.6	3.8	69.3	11.3
HOSPITAL BASED	1026	46.0	5.0	46.5	6.6
OLD AGENCIES	3272	24.4	2.2	67.1	9.7
FREESTANDING	2292	15.2	1.0	75.9	11.1
HOSPITAL BASED	980	45.8	4.9	46.4	6.6
NEW AGENCIES	865	47.2	19.0	50.9	
12.3.					
FREESTANDING	819	47.0	19.7	51.0	12.5
HOSPITAL BASED	46	50.0	6.1	47.8	8.8
ALL RURAL	2277	31.1	3.9	54.0	9.1

IMPACT OF THE IPS HHA LIMITS, EFFECTIVE 10/1/98—Continued

	Number of agencies	Percent of agencies exceeding visit limits	Percent of costs exceeding visit limits	Percent of agencies exceeding beneficiary limits	Percent of costs exceeding beneficiary limits
FREESTANDING	1197	24.6	4.3	62.7	11.0
HOSPITAL BASED	1080	38.3	3.3	44.4	6.1
OLD AGENCIES	1984	27.9	1.9	55.4	8.5
FREESTANDING	953	17.2	0.9	67.4	10.5
HOSPITAL BASED	1031	37.8	3.3	44.3	6.0
NEW AGENCIES	293	52.9	21.1	44.7	13.8
FREESTANDING	244	53.7	22.7	44.7	14.1
HOSPITAL BASED	49	49.0	3.6	44.9	10.1
BY: REGION:					
OLD AGENCIES	5256	25.7	2.2	62.7	9.4
NEW ENGLAND	291	5.5	0.3	83.8	12.8
MIDDLE ATLANTIC	443	19.4	1.8	72.2	9.0
SOUTH ATLANTIC	739	24.1	1.7	65.4	9.9
EAST NORTH CENTRAL	866	21.6	1.6	68.6	10.3
EAST SOUTH CENTRAL	431	23.0	1.6	58.9	9.2
WEST NORTH CENTRAL	728	26.6	2.4	58.2	9.7
WEST SOUTH CENTRAL	936	30.1	3.1	56.3	8.6
MOUNTAIN	354	37.0	3.4	50.0	7.4
PACIFIC	428	39.3	4.9	56.8	7.3
NEW AGENCIES	1158	48.6	19.5	49.3	12.6
NEW ENGLAND	44	4.5	0.0	93.2	17.0
MIDDLE ATLANTIC	51	49.0	21.9	47.1	5.1
SOUTH ATLANTIC	44	56.8	25.5	43.2	7.3
EAST NORTH CENTRAL	151	74.2	36.1	25.2	4.4
EAST SOUTH CENTRAL	25	44.0	18.7	56.0	14.7
WEST NORTH CENTRAL	117	65.8	17.9	29.1	9.9
WEST SOUTH CENTRAL	484	39.3	16.4	59.9	16.5
MOUNTAIN	103	45.6	22.0	49.5	8.8
PACIFIC	138	52.9	19.8	43.5	10.1

E.1. Percent of Costs Exceeding Per Visit Limitations (Column Four)

Results from this column indicate that, for an HHA that reaches the per-visit limitation first, the average percent of costs exceeding the per-visit limitation for an HHA in the ''all agencies'' category is 4.1 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. All discussion of the analysis of the per-visit limitation is based on the fact that HHAs in these categories reached the per-visit limitation and therefore are not affected by the per-beneficiary limitation.

For the old agencies category, (HHAs that filed a 12-month cost report that ended during FFY 1994), the average percent of costs exceeding the per-visit limitation is 2.2 percent. For the new agencies category, (such as HHAs that did not have a 12-month cost reporting period ended in FFY 1994 or that entered the Medicare program after FFY 1994), the average percent of costs exceeding the per-visit limitation is 19.5 percent. Old agencies will not be affected as much by the per-visit limitation the new agencies, on average, because the new agencies have, in general, reported higher per-visit costs.

For the urban areas HHA category, the average percent of costs exceeding the per-visit limitation is 4.1 percent, while the rural areas HHA category is 3.9 percent. For the old agency census division categories the average percent of costs exceeding the per-visit limitation ranges from a low of 0.3 percent in the New England census region to a high of 4.9 percent in the Pacific census region. The other census regions fall between 1.6 percent and 3.4 percent.

For the new agency census region categories the average percent of costs exceeding the per-visit limitation ranges from a low of 0.0 percent in the New England census region to a high of 36.1 percent in the East North Central census region. The other census regions fall between 16.4 percent and 25.5 percent.

E.2. Percent of Costs Exceeding Per-Beneficiary Limitation (Column Six)

Results from this column indicate that, for an HHA that reaches the per-beneficiary limitation first, the average percent of costs exceeding the per-beneficiary limitation for an HHA in the ''all agencies'' category is 9.8 percent after the behavioral offset. All discussion of the analysis of the per-beneficiary limitation is based on the fact that HHAs in these categories reached the per-beneficiary limitation and therefore are not affected by the per-visit limitation.

For the old agencies category, (HHAs that filed a 12-month cost report that ended during FFY 1994), the average percent of costs exceeding the per-beneficiary limitation is 9.4 percent. For the new agencies category, (including 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 per-visit limitation is 12.6 percent. Old agencies will not be affected as much by the per-beneficiary limitations as the new agencies, on average, because the new agenices have, in general, reported higher costs related to higher levels of utilization. Moreover, the statutory provision for old providers which bases 75 percent of the limitation on their own cost experience would implicitly result in less of an impact than experienced by the new providers whose limitations are based on a national median. Also, 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.

For the urban areas HHA category, the average percent of costs exceeding the per-visit limitation is 10.0 percent, while the rural areas HHA category is 9.1 percent. For the old agency census division categories the average percent of costs exceeding the per-beneficiary limitation ranges from a low of 7.3 percent in the Pacific census region to a high of 12.8 percent in the New England census region. The other census regions fall between 7.4 percent and 10.3 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 more related to patterns of HHA practices.

For the new agency census region categories the average percent of costs exceeding the per-beneficiary limitation ranges from a low of 4.4 percent in the East North Central census region to a high of 17.0 percent in the New England census region. The other census regions fall between 5.1 percent and 16.5 percent. In general, newer agencies in census regions that have exceptionally high cost histories are more impacted due to their being limited to the national median.

Although there is considerable variation in these limitations, we believe this is a 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 limitations is an inherent result of beginning to draw unexplained variation among providers closer to 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 per-beneficiary limitation, we have estimated the combined impact of these limitations.

We estimate that in FFY 1999 and 2000, 30 percent of the HHAs will be limited by the per-visit limitation while 60 percent will be limited to the per-beneficiary limitation. It is important to note again that an HHA is affected either by the per-visit limitation or the per-beneficiary. They will not be affected by both.

Medicare payments to managed care plans are based on fee-for-service Medicare benefits. Although we do not know what home health services are supplied for these payments, we know how much we pay the plans as a result of fee-for-service home health payments. Thus, managed care payments are figured in as part of our cost/savings estimates. Managed care plans are not expected to reduce home health services as a result of this notice. For Federal FY 1999, we estimate that 20 percent of the Medicare cost will be for payments to managed care plans, our estimate for Federal FY 2000 is 26 percent.

We believe that the effect of this notice on State Medicaid programs overall will be small. However, because of the flexibility and variation in State Medicaid policies and service delivery systems as well as differences in provider behavior in reaction to these limits, it is impossible to predict which States will be affected or the magnitude of the impact.

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. This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

XI. Other Required Information

A. Waiver of Proposed Notice

In adopting notices such as this, we ordinarily publish a proposed notice in the **Federal Register** to provide a period for public comment before the provisions of the notice take effect. However, we may waive this procedure if for good cause we find that prior notice and comment are impracticable, unnecessary or contrary to public interest. 5 U.S.C 553(b)(B).

Section 1861(v)(1)(L) of the Act requires that the Secretary establish revised HHA cost limits for cost reporting periods beginning on or after July 1, 1991 and annually thereafter (except for cost reporting periods beginning on or after July 1, 1994 and before July 1, 1996). In accordance with the statute, we have used the same methodology to develop the schedules of limits that were used in setting the limits effective for cost reporting periods beginning on or after October 1, 1997. These cost limits have been updated by the appropriate market basket adjustment factor to reflect the cost increases occurring between the cost reporting periods for the data contained in the database and September 30, 1999, 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. In addition, as required under section 1861(v)(1)(L) of the Act, we have used the most recently published hospital wage index.

Therefore, for good cause we find that it was unnecessary to undertake notice and comment procedures. Generally, the methodology used to develop these schedules of limits is dictated by statute and does not require the exercise of discretion. These methodologies have also been previously published for public comment. It was also necessary to inform HHAs of their new cost limitations in a timely manner such that HHAs could benefit from the most recently published wage index and updated market basket adjustment factor.

We also find that it was impracticable to provide notice and comment procedures before publishing this notice. The per-beneficiary limitations were published on March 31, 1998 with a 60-day comment period. To fully respond to the comments and establish the limitation by August 1, 1998, it was impracticable to publish a proposed notice. Accordingly, for good cause, we waive prior notice and comment procedures. However, we are providing a 60-day comment period for public comment, as indicated at the beginning of this notice.

B. Public Comments

Because of the large number of items of correspondence we normally receive on a notice 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 notice that we receive by the date and time specified in the **DATES** section of this notice, and we will respond to those comments in a subsequent document.

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)).

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

Dated: July 28, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: July 30, 1998.

Donna E. Shalala,

Secretary.

[FR Doc. 98–20878 Filed 7–31–98; 3:03 pm]

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