Federal Register

Wednesday,
May 7, 2008

Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 413

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 413

[CMS–1534–P]

RIN 0938–AP11

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

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2009. In addition, it would recalibrate the case-mix indexes so that they more accurately reflect parity in expenditures related to the implementation of case-mix refinements in January 2006. It also discusses our ongoing analysis of nursing home staff time measurement data collected in the Staff Time and Resource Intensity Verification (STRIVE) project. Finally, the proposed rule would make technical corrections in the regulations text with respect to Medicare bad debt payments to SNFs and the reference to the definition of urban and rural as applied to SNFs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 30, 2008.

ADDRESSES: In commenting, please refer to file code CMS–1534–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' and enter the file code to find the document accepting comments.

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1534–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1534–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses.

a. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

b. 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments mailed to the address indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Ellen Berry, (410) 786–4528 (for information related to clinical issues). Jeanette Kranacs, (410) 786–9385 (for information related to the development of the payment rates and case-mix indexes). Bill Ullman, (410) 786–5667 (for information related to level of care determinations, consolidated billing, and general information).

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–1534–P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Electronic Comments on CMS Regulations'' on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

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

Table of Contents

I. Background
A. Current System for Payment of SNF Services Under Part A of the Medicare Program
B. Requirements of the Balanced Budget Act of 1997 (BBA) for Updating the Prospective Payment System for Skilled Nursing Facilities
C. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA)
D. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)
E. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
F. Skilled Nursing Facility Prospective Payment—General Overview
1. Payment Provisions—Federal Rate
2. Rate Updates Using the Skilled Nursing Facility Market Basket Index
II. Annual Update of Payment Rates Under the Prospective Payment System for Skilled Nursing Facilities
A. Federal Prospective Payment System
1. Costs and Services Covered by the Federal Rates
2. Methodology Used for the Calculation of the Federal Rates
B. Case-Mix Adjustments
1. Background
2. Development of the Case-Mix Indexes
C. Wage Index Adjustment to Federal Rates
1. Clarification of New England Deemed Counties
2. Multi-Campus Hospital Wage Index Data
D. Updates to Federal Rates
E. Relationship of RUG–III Classification System to Existing Skilled Nursing Facility Level-of-Care Criteria
F. Example of Computation of Adjusted PPS Rates and SNF Payment

G. Other Issues
1. Staff Time and Resource Intensity Verification (STRIVE) Project
2. Minimum Data Set (MDS) 3.0
3. Integrated Post Acute Care Payment
H. Miscellaneous Technical Corrections and Clarifications
1. Bad Debt Payments
2. Additional Clarifications
III. The Skilled Nursing Facility Market Basket Index
A. Use of the Skilled Nursing Facility Market Basket Percentage
B. Market Basket Forecast Error Adjustment
C. Federal Rate Update Factor
IV. Consolidated Billing
V. Application of the SNF PPS to SNF Services Furnished by Swing-Bed Hospitals
VI. Provisions of the Proposed Rule
VII. Collection of Information Requirements
VIII. Regulatory Impact Analysis
A. Overall Impact
B. Anticipated Effects
C. Alternatives Considered
D. Accounting Statement
E. Conclusion
Regulation Text
Addendum: FY 2009 CBSA-Based Wage Index Tables (Tables 8 & 9)

Abbreviations

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

AIDS Acquired Immune Deficiency Syndrome
ARD Assessment Reference Date
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
CAH Critical Access Hospital
CARE Continuity Assessment Record and Evaluation
CBSA Core-Based Statistical Area
CFR Code of Federal Regulations
CMI Case-Mix Index
CMS Centers for Medicare & Medicaid Services
DRA Deficit Reduction Act of 2005, Pub. L. 109–171
FQHC Federally Qualified Health Center
FR Federal Register
FY Fiscal Year
GAO Government Accountability Office
HAC Hospital-Acquired Condition
HCPCS Healthcare Common Procedure Coding System
HIPPS Health Insurance Prospective Payment System
HIT Health Information Technology
IFC Interim Final Rule with Comment Period
IPPS Hospital Inpatient Prospective Payment System
MDS Minimum Data Set
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub.L. 108–173
MSA Metropolitan Statistical Area
MS–DRG Medicare Severity Diagnosis-Related Group
NRST Non-Resident Specific Time
NTA Non-Therapy Ancillary
OIG Office of the Inspector General
OMB Office of Management and Budget
OMRA Other Medicare Required Assessment
PAC–PRD Post-Acute Care Payment Reform Demonstration
PPS Prospective Payment System
RAI Resident Assessment Instrument
RAP Resident Assessment Protocol
RAVEN Resident Assessment Validation Entry
RFA Regulatory Flexibility Act, Pub. L. 96–354
RHC Rural Health Clinic
RIA Regulatory Impact Analysis
RUG–III Resource Utilization Groups, Version III
RUG–53 Refined 53–Group RUG–III Case-Mix Classification System
RST Resident Specific Time
SCHIP State Children's Health Insurance Program
SNF Skilled Nursing Facility
STM Staff Time Measurement
STRIVE Staff Time and Resource Intensity Verification
UMRA Unfunded Mandates Reform Act, Pub. L. 104–4
VBP Value-Based Purchasing

I. Background

[If you choose to comment on issues in this section, please include the caption ''BACKGROUND'' at the beginning of your comments.]

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

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

Section 4432 of the BBA amended section 1888 of the Act to provide for the implementation of a per diem PPS for SNFs, covering all costs (routine, ancillary, and capital-related) of covered SNF services furnished to beneficiaries under Part A of the Medicare program, effective for cost reporting periods beginning on or after July 1, 1998. In this proposed rule, we propose to update the per diem payment rates for SNFs for FY 2009. Major elements of the SNF PPS include:

- *Rates.* As discussed in section I.F.1. of this proposed rule, we established per diem Federal rates for urban and rural areas using allowable costs from FY 1995 cost reports. These rates also included an estimate of the cost of services that, before July 1, 1998, had been paid under Part B but were furnished to Medicare beneficiaries in a SNF during a Part A covered stay. We adjust the rates annually using a SNF market basket index, and we adjust them by the hospital inpatient wage index to account for geographic variation in wages. We also apply a case-mix adjustment to account for the relative resource utilization of different patient types. This adjustment utilizes a refined, 53-group version of the Resource Utilization Groups, version III (RUG–III) case-mix classification system, based on information obtained from the required resident assessments using the Minimum Data Set (MDS) 2.0. Additionally, as noted in the August 4, 2005 final rule (70 FR 45028), the payment rates at various times have also reflected specific legislative provisions, including section 101 of the BBRA, sections 311, 312, and 314 of the BIPA, and section 511 of the MMA.
- *Transition.* Under sections 1888(e)(1)(A) and (e)(11) of the Act, the SNF PPS included an initial, three-phase transition that blended a facility-specific rate (reflecting the individual facility's historical cost experience) with the Federal case-mix adjusted rate. The transition extended through the facility's first three cost reporting periods under the PPS, up to and including the one that began in FY 2001. Thus, the SNF PPS is no longer operating under the transition, as all facilities have been paid at the full Federal rate effective with cost reporting periods beginning in FY 2002. As we now base payments entirely on the adjusted Federal per diem rates, we no longer include adjustment factors related to facility-specific rates for the coming FY.
- *Coverage.* The establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because the RUG–III classification is based, in part, on the beneficiary's need for skilled nursing

care and therapy, we have attempted, where possible, to coordinate claims review procedures with the output of beneficiary assessment and RUG–III classifying activities. This approach includes an administrative presumption that utilizes a beneficiary's initial classification in one of the upper 35 RUGs of the refined 53-group system to assist in making certain SNF level of care determinations, as discussed in greater detail in section II.E. of this proposed rule.

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

• *Application of the SNF PPS to SNF services furnished by swing-bed hospitals.* Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF services furnished under a swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, these services furnished by non-CAH rural hospitals are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002. A more detailed discussion of this provision appears in section V. of this proposed rule.

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

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

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

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

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

In the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the RUG–III classification structure (see section II.E. of this proposed rule for a discussion of the relationship between the case-mix classification system and SNF level of care determinations).

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

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

There were several provisions in the BBRA that resulted in adjustments to the SNF PPS. We described these provisions in detail in the final rule that we published in the **Federal Register** on July 31, 2000 (65 FR 46770). In particular, section 101(a) of the BBRA provided for a temporary 20 percent increase in the per diem adjusted payment rates for 15 specified RUG–III groups. In accordance with section 101(c)(2) of the BBRA, this temporary payment adjustment expired on January 1, 2006, upon the implementation of case-mix refinements (see section I.F.1. of this proposed rule). We included further information on BBRA provisions that affected the SNF PPS in Program Memorandums A–99–53 and A–99–61 (December 1999).

Also, section 103 of the BBRA designated certain additional services for exclusion from the consolidated billing requirement, as discussed in section IV. of this proposed rule. Further, for swing-bed hospitals with more than 49 (but less than 100) beds, section 408 of the BBRA provided for the repeal of certain statutory restrictions on length of stay and aggregate payment for patient days, effective with the end of the SNF PPS transition period described in section 1888(e)(2)(E) of the Act. In the July 31, 2001 final rule (66 FR 39562), we made conforming changes to the regulations at § 413.114(d), effective for services furnished in cost reporting periods beginning on or after July 1, 2002, to reflect section 408 of the BBRA.

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

The BIPA also included several provisions that resulted in adjustments to the SNF PPS. We described these provisions in detail in the final rule that we published in the **Federal Register** on July 31, 2001 (66 FR 39562). In particular:

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

• Section 311 of the BIPA revised the statutory update formula for the SNF market basket, and also directed us to conduct a study of alternative case-mix classification systems for the SNF PPS. In 2006, we submitted a report to the Congress on this study, which is available online at *http://www.cms.hhs.gov/SNFPPS/Downloads/RC__2006_PC__PPSSNF.pdf.*

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

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

• Section 314 of the BIPA corrected an anomaly involving three of the RUGs that the BBRA had designated to receive the temporary payment adjustment discussed above in section I.C. of this proposed rule. (As noted previously, in accordance with section 101(c)(2) of the BBRA, this temporary payment adjustment expired upon the implementation of case-mix refinements on January 1, 2006.)

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

would be required to improve the quality of that data.

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

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

The MMA included a provision that results in a further adjustment to the SNF PPS. Specifically, section 511 of the MMA amended section 1888(e)(12) of the Act, to provide for a temporary increase of 128 percent in the PPS per diem payment for any SNF resident with Acquired Immune Deficiency Syndrome (AIDS), effective with services furnished on or after October 1, 2004. This special AIDS add-on was to remain in effect until ''* * * such date as the Secretary certifies that there is an appropriate adjustment in the case mix. * * *'' The AIDS add-on is also discussed in Program Transmittal #160 (Change Request #3291), issued on April 30, 2004, which is available online at *http://www.cms.hhs.gov/transmittals/downloads/r160cp.pdf.* As discussed in the SNF PPS final rule for FY 2006 (70 FR 45028, August 4, 2005), we did not address the certification of the AIDS add-on with the implementation of the case-mix refinements, thus allowing the temporary add-on payment created by section 511 of the MMA to continue in effect.

For the limited number of SNF residents that qualify for the AIDS add-on, implementation of this provision results in a significant increase in payment. For example, using FY 2006 data, we identified less than 2,700 SNF residents with a diagnosis code of 042 (Human Immunodeficiency Virus (HIV) Infection). For FY 2009, an urban facility with a resident with AIDS in RUG group ''SSA'' would have a case-mix adjusted payment of almost $246.55 (see Table 4) before the application of the MMA adjustment. After an increase of 128 percent, this urban facility would receive a case-mix adjusted payment of approximately $562.13.

In addition, section 410 of the MMA contained a provision that excluded from consolidated billing certain practitioner and other services furnished to SNF residents by rural health clinics (RHCs) and Federally Qualified Health Centers (FQHCs). (Further information on this provision appears in section IV. of this proposed rule.)

F. Skilled Nursing Facility Prospective Payment—General Overview

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

1. Payment Provisions—Federal Rate

The PPS uses per diem Federal payment rates based on mean SNF costs in a base year updated for inflation to the first effective period of the PPS. We developed the Federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in FY 1995. The data used in developing the Federal rates also incorporated an estimate of the amounts that would be payable under Part B for covered SNF services furnished to individuals during the course of a covered Part A stay in a SNF.

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

The Federal rate also incorporates adjustments to account for facility case-mix, using a classification system that accounts for the relative resource utilization of different patient types. The RUG–III classification system uses beneficiary assessment data from the Minimum Data Set (MDS) completed by SNFs to assign beneficiaries to one of 53 RUG–III groups. The original RUG–III case-mix classification system included 44 groups. However, under refinements that became effective on January 1, 2006, we added nine new groups—comprising a new Rehabilitation plus Extensive Services category—at the top of the RUG hierarchy. The May 12, 1998 interim final rule (63 FR 26252) included a detailed description of the original 44-group RUG–III case-mix classification system. A comprehensive description of the refined 53-group RUG–III case-mix classification system (RUG–53) appeared in the proposed and final rules for FY 2006 (70 FR 29070, May 19, 2005, and 70 FR 45026, August 4, 2005).

Further, in accordance with section 1888(e)(4)(E)(ii)(IV) of the Act, the Federal rates in this proposed rule reflect an update to the rates that we published in the August 3, 2007 final rule for FY 2008 (72 FR 43412) and the associated correction notices (on September 28, 2007, 72 FR 55085, and November 30, 2007, 72 FR 67652), equal to the full change in the SNF market basket index. A more detailed discussion of the SNF market basket index and related issues appears in sections I.F.2. and III. of this proposed rule.

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

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

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

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

TABLE 1.—DIFFERENCE BETWEEN THE FORECASTED AND ACTUAL MARKET BASKET INCREASES FOR FY 2007

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

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

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

[If you choose to comment on issues in this section, please include the caption ''Annual Update'' at the beginning of your comments.]

A. Federal Prospective Payment System

This proposed rule sets forth a schedule of Federal prospective payment rates applicable to Medicare Part A SNF services beginning October 1, 2008. The schedule incorporates per diem Federal rates that provide Part A payment for all costs of services furnished to a beneficiary in a SNF during a Medicare-covered stay.

1. Costs and Services Covered by the Federal Rates

In accordance with section 1888(e)(2)(B) of the Act, the Federal rates apply to all costs (routine, ancillary, and capital-related) of covered SNF services other than costs associated with approved educational activities as defined in § 413.85. Under section 1888(e)(2)(A)(i) of the Act, covered SNF services include post-hospital SNF services for which benefits are provided under Part A (the hospital insurance program), as well as all items and services (other than those services excluded by statute) that, before July 1, 1998, were paid under Part B (the supplementary medical insurance program) but furnished to Medicare beneficiaries in a SNF during a Part A covered stay. (These excluded service categories are discussed in greater detail in section V.B.2. of the May 12, 1998 interim final rule (63 FR 26295 through 26297)).

2. Methodology Used for the Calculation of the Federal Rates

The proposed FY 2009 rates would reflect an update using the full amount of the latest market basket index. The proposed FY 2009 market basket increase factor is 3.1 percent. A complete description of the multi-step process used to calculate Federal rates initially appeared in the May 12, 1998 interim final rule (63 FR 26252), as further revised in subsequent rules. We note that in accordance with section 101(c)(2) of the BBRA, the previous temporary increases in the per diem adjusted payment rates for certain designated RUGs, as specified in section 101(a) of the BBRA and section 314 of the BIPA, are no longer in effect due to the implementation of case-mix refinements as of January 1, 2006. However, the temporary increase of 128 percent in the per diem adjusted payment rates for SNF residents with AIDS, enacted by section 511 of the MMA, remains in effect.

We used the SNF market basket to adjust each per diem component of the Federal rates forward to reflect cost increases occurring between the midpoint of the Federal FY beginning October 1, 2007, and ending September 30, 2008, and the midpoint of the Federal FY beginning October 1, 2008, and ending September 30, 2009, to which the payment rates apply. In accordance with section 1888(e)(4)(E)(ii)(IV) of the Act, we update the payment rates for FY 2009 by a factor equal to the full market basket index percentage increase. (We note, however, that the President's budget currently includes a provision that would establish a zero percent market basket update for FYs 2009 through 2011, and that the provisions outlined in this proposed rule would need to reflect any legislation that the Congress may enact to adopt that proposal.) We further adjust the rates by a wage index budget neutrality factor, described later in this section. Tables 2 and 3 reflect the updated components of the unadjusted Federal rates for FY 2009.

TABLE 2.—FY 2009 UNADJUSTED FEDERAL RATE PER DIEM—URBAN

Rate component	Nursing—Case-mix	Therapy—Case-mix	Therapy—Non-case-mix	Non-case-mix
Per Diem Amount	$151.30	$113.97	$15.00	$77.22

TABLE 3.—FY 2009 UNADJUSTED FEDERAL RATE PER DIEM—RURAL

Rate component	Nursing—Case-mix	Therapy—Case-mix	Therapy—Non-case-mix	Non-case-mix
Per Diem Amount	$144.55	$131.42	$16.04	$78.64

B. Case-Mix Adjustments

1. Background

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

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

When we developed the refined RUG–53 system, we constructed new case-mix indexes, using the Staff Time Measurement (STM) study data that was collected during the 1990s and originally used in creating the SNF PPS case-mix classification system and case-mix indexes. In section II.B.2 of this proposed rule, we discuss further adjustments to those new case-mix indexes.

2. Development of the Case-Mix Indexes

In the SNF PPS final rule for FY 2006 (70 FR 45032, August 4, 2005), we introduced two refinements to the SNF PPS: nine new case-mix groups to account for the care needs of beneficiaries requiring both extensive medical and rehabilitation services, and an adjustment to reflect the variability in the use of non-therapy ancillaries (NTAs). We made these refinements by using the resource minute data from the original 44-group RUG–III model to create a new set of relative weights, or case-mix indexes (CMIs), for the 53-group RUG–III model. We then compared the CMIs for the two models to ensure that estimated total payments under the 53-group model would maintain parity to those that would have been made under the 44-group model.

In conducting this analysis, we used FY 2001 claims data (the most current data available at the time) to compare the distribution of payment days by RUG category in the original, 44-group model with anticipated payments by RUG category in the refined 53-group model. Based on the results of this analysis, we adjusted the new CMIs upward by applying a parity adjustment factor, in order to ensure that the RUG–III model was expanded in a budget-neutral manner. We then applied a second adjustment to the CMIs to account for the variability in the use of NTA services. These two adjustments resulted in a combined 17.9 percent increase in the CMIs that went into effect on January 1, 2006, as part of the case-mix refinement implementation. A detailed description of the methods used to make these two adjustments to the CMIs appears in the SNF PPS proposed rule for FY 2006 (70 FR 29077 through 29078, May 19, 2005). However, we recognized that utilization patterns change over time, and in the FY 2006 final rule (70 FR 45031, August 4, 2005), we committed to monitoring the accuracy and effectiveness of the CMIs used in the 53-group model.

In monitoring recent claims data, we observed that actual utilization patterns differed significantly from those we had projected using the 2001 data. In particular, the proportion of patients grouped in the highest paying RUG categories—combining high therapy with extensive services—greatly exceeded our projections. We have, therefore, used actual claims data to recalibrate both of the adjustments to the CMIs: the parity adjustment designed to make the change from the 44-group model to the 53-group model in a budget-neutral manner, and the factor used to recognize the variability in NTA utilization.

To determine the parity adjustment factor needed to re-establish budget neutrality, we compared simulated CY 2006 payments (using the most recent data available) for the 44-group and 53-group RUG–III models using the same methodology that we described in the SNF PPS proposed rule for FY 2006 (70 FR 29077 through 29078, May 19, 2005). Once we had identified the recalibrated parity adjustment factor necessary to re-establish budget neutrality, we then determined the recalibrated percentage adjustment that would be needed to reset the NTA component of the CMIs at the appropriate level specified in the SNF PPS final rule for FY 2006 (70 FR 45031, August 4, 2005). Under our proposed recalibration, these two adjustments, which had initially produced a combined increase of 17.9 percent in the FY 2006 refinement, would instead result in an overall 9.68 percent increase for FY 2009. Thus, for FY 2009, the aggregate impact of this proposed recalibration would be the difference between the original, FY 2006 total increase of 17.9 percent and the recalibrated total increase of 9.68 percent, or a negative $770 million.

It is extremely important to note that this adjustment, as proposed, would be made prospectively. However, we are responsible for maintaining the fiscal integrity of the SNF PPS, and by using the actual claims data, the SNF PPS would better reflect the resources used, resulting in more accurate payment. To that end, we have developed our proposed recalibration of the parity and NTA adjustments to the CMIs using actual claims distribution data. Although the 2001 data were the best source available at the time the FY 2006 refinements were introduced, the 2006 data provide the most recent and a more accurate source of RUG–53 utilization. (We also note that pursuant to our ongoing commitment to monitoring the accuracy and effectiveness of the CMIs under the refined case-mix system, there may be further revisions to the recalibration as we develop the FY 2009 final rule, based on the data available at that time.)

We note that the negative $770 million adjustment described above would be largely offset by the FY 2009 market basket adjustment factor of 3.1 percent, or $710 million, with a net result of a negative annual update of approximately $60 million. We are, nevertheless, confident that this proposed recalibration would achieve the goals of the refinement provision implemented in January 2006, and that, as a result, payments would better reflect those policies. We also wish to note that after it conducted a thorough review of SNF profit margins, MedPAC concluded that, in the aggregate, SNFs are operating on a sound financial basis. As evidenced by MedPAC's recent recommendation for a zero percent update for SNFs in FY 2009, we believe that this recalibration could be made without creating undue hardship on providers.

We list the case-mix adjusted payment rates separately for urban and rural SNFs in Tables 4 and 5, with the corresponding case-mix values. These tables do not reflect the AIDS add-on enacted by section 511 of the MMA, which we apply only after making all other adjustments (wage and case-mix).

TABLE 4.—RUG–53 CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—URBAN

RUG–III category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUX	1.77	2.25	267.80	256.43		77.22	601.45
RUL	1.31	2.25	198.20	256.43		77.22	531.85
RVX	1.44	1.41	217.87	160.70		77.22	455.79
RVL	1.24	1.41	187.61	160.70		77.22	425.53
RHX	1.33	0.94	201.23	107.13		77.22	385.58
RHL	1.27	0.94	192.15	107.13		77.22	376.50
RMX	1.80	0.77	272.34	87.76		77.22	437.32
RML	1.57	0.77	237.54	87.76		77.22	402.52
RLX	1.22	0.43	184.59	49.01		77.22	310.82
RUC	1.20	2.25	181.56	256.43		77.22	515.21
RUB	0.92	2.25	139.20	256.43		77.22	472.85
RUA	0.78	2.25	118.01	256.43		77.22	451.66
RVC	1.14	1.41	172.48	160.70		77.22	410.40
RVB	1.01	1.41	152.81	160.70		77.22	390.73
RVA	0.77	1.41	116.50	160.70		77.22	354.42
RHC	1.13	0.94	170.97	107.13		77.22	355.32
RHB	1.03	0.94	155.84	107.13		77.22	340.19
RHA	0.88	0.94	133.14	107.13		77.22	317.49
RMC	1.07	0.77	161.89	87.76		77.22	326.87
RMB	1.01	0.77	152.81	87.76		77.22	317.79
RMA	0.97	0.77	146.76	87.76		77.22	311.74
RLB	1.06	0.43	160.38	49.01		77.22	286.61
RLA	0.79	0.43	119.53	49.01		77.22	245.76
SE3	1.72		260.24		15.00	77.22	352.46
SE2	1.38		208.79		15.00	77.22	301.01
SE1	1.17		177.02		15.00	77.22	269.24
SSC	1.14		172.48		15.00	77.22	264.70
SSB	1.05		158.87		15.00	77.22	251.09
SSA	1.02		154.33		15.00	77.22	246.55
CC2	1.13		170.97		15.00	77.22	263.19
CC1	0.99		149.79		15.00	77.22	242.01
CB2	0.91		137.68		15.00	77.22	229.90
CB1	0.84		127.09		15.00	77.22	219.31
CA2	0.83		125.58		15.00	77.22	217.80
CA1	0.75		113.48		15.00	77.22	205.70
IB2	0.69		104.40		15.00	77.22	196.62
IB1	0.67		101.37		15.00	77.22	193.59
IA2	0.57		86.24		15.00	77.22	178.46
IA1	0.53		80.19		15.00	77.22	172.41
BB2	0.68		102.88		15.00	77.22	195.10
BB1	0.65		98.35		15.00	77.22	190.57
BA2	0.56		84.73		15.00	77.22	176.95
BA1	0.48		72.62		15.00	77.22	164.84
PE2	0.79		119.53		15.00	77.22	211.75
PE1	0.77		116.50		15.00	77.22	208.72
PD2	0.72		108.94		15.00	77.22	201.16
PD1	0.70		105.91		15.00	77.22	198.13
PC2	0.66		99.86		15.00	77.22	192.08
PC1	0.65		98.35		15.00	77.22	190.57
PB2	0.52		78.68		15.00	77.22	170.90
PB1	0.50		75.65		15.00	77.22	167.87
PA2	0.49		74.14		15.00	77.22	166.36
PA1	0.46		69.60		15.00	77.22	161.82

TABLE 5.—RUG–53 CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—RURAL

RUG–III category	Nursing Index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUX	1.77	2.25	255.85	295.70		78.64	630.19
RUL	1.31	2.25	189.36	295.70		78.64	563.70
RVX	1.44	1.41	208.15	185.30		78.64	472.09
RVL	1.24	1.41	179.24	185.30		78.64	443.18
RHX	1.33	0.94	192.25	123.53		78.64	394.42
RHL	1.27	0.94	183.58	123.53		78.64	385.75
RMX	1.80	0.77	260.19	101.19		78.64	440.02
RML	1.57	0.77	226.94	101.19		78.64	406.77
RLX	1.22	0.43	176.35	56.51		78.64	311.50

TABLE 5.—RUG–53 CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—RURAL—Continued

RUG–III category	Nursing Index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUC	1.20	2.25	173.46	295.70		78.64	547.80
RUB	0.92	2.25	132.99	295.70		78.64	507.33
RUA	0.78	2.25	112.75	295.70		78.64	487.09
RVC	1.14	1.41	164.79	185.30		78.64	428.73
RVB	1.01	1.41	146.00	185.30		78.64	409.94
RVA	0.77	1.41	111.30	185.30		78.64	375.24
RHC	1.13	0.94	163.34	123.53		78.64	365.51
RHB	1.03	0.94	148.89	123.53		78.64	351.06
RHA	0.88	0.94	127.20	123.53		78.64	329.37
RMC	1.07	0.77	154.67	101.19		78.64	334.50
RMB	1.01	0.77	146.00	101.19		78.64	325.83
RMA	0.97	0.77	140.21	101.19		78.64	320.04
RLB	1.06	0.43	153.22	56.51		78.64	288.37
RLA	0.79	0.43	114.19	56.51		78.64	249.34
SE3	1.72		248.63		16.04	78.64	343.31
SE2	1.38		199.48		16.04	78.64	294.16
SE1	1.17		169.12		16.04	78.64	263.80
SSC	1.14		164.79		16.04	78.64	259.47
SSB	1.05		151.78		16.04	78.64	246.46
SSA	1.02		147.44		16.04	78.64	242.12
CC2	1.13		163.34		16.04	78.64	258.02
CC1	0.99		143.10		16.04	78.64	237.78
CB2	0.91		131.54		16.04	78.64	226.22
CB1	0.84		121.42		16.04	78.64	216.10
CA2	0.83		119.98		16.04	78.64	214.66
CA1	0.75		108.41		16.04	78.64	203.09
IB2	0.69		99.74		16.04	78.64	194.42
IB1	0.67		96.85		16.04	78.64	191.53
IA2	0.57		82.39		16.04	78.64	177.07
IA1	0.53		76.61		16.04	78.64	171.29
BB2	0.68		98.29		16.04	78.64	192.97
BB1	0.65		93.96		16.04	78.64	188.64
BA2	0.56		80.95		16.04	78.64	175.63
BA1	0.48		69.38		16.04	78.64	164.06
PE2	0.79		114.19		16.04	78.64	208.87
PE1	0.77		111.30		16.04	78.64	205.98
PD2	0.72		104.08		16.04	78.64	198.76
PD1	0.70		101.19		16.04	78.64	195.87
PC2	0.66		95.40		16.04	78.64	190.08
PC1	0.65		93.96		16.04	78.64	188.64
PB2	0.52		75.17		16.04	78.64	169.85
PB1	0.50		72.28		16.04	78.64	166.96
PA2	0.49		70.83		16.04	78.64	165.51
PA1	0.46		66.49		16.04	78.64	161.17

C. Wage Index Adjustment to Federal Rates

Section 1888(e)(4)(G)(ii) of the Act requires that we adjust the Federal rates to account for differences in area wage levels, using a wage index that we find appropriate. Since the inception of a PPS for SNFs, we have used hospital wage data in developing a wage index to be applied to SNFs. We propose to continue that practice for FY 2009, as we continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index is appropriate and reasonable for the SNF PPS. As explained in the update notice for FY 2005 (69 FR 45786, July 30, 2004), the SNF PPS does not use the hospital area wage index's occupational mix adjustment, as this adjustment serves specifically to define the occupational categories more clearly in a hospital setting; moreover, the collection of the occupational wage data also excludes any wage data related to SNFs. Therefore, we believe that using the updated wage data exclusive of the occupational mix adjustment continues to be appropriate for SNF payments.

Since the implementation of the SNF PPS, as set forth in § 413.337(a)(1)(ii), a SNF's wage index is determined based on the location of the SNF in an urban or rural area as defined in § 413.333 and further defined in § 412.62(f)(1)(ii) and § 412.62(f)(1)(iii) as urban and rural areas, respectively. In the FY 2006 SNF PPS final rule (70 FR 45041, August 4, 2005), we adopted revised labor market area definitions based on CBSAs. At the time, we noted that these were the same labor market area definitions (based on OMB's new CBSA designations) implemented under the Hospital Inpatient Prospective Payment System (IPPS) at § 412.64(b), which were effective for those hospitals beginning October 1, 2004, as discussed in the IPPS final rule for FY 2005 (69 FR at 49026 through 49034, August 11, 2004). In the FY 2006 SNF PPS final rule, we inadvertently omitted making a conforming regulation text change for § 413.333. However, no change was made to our decision to follow the IPPS definition of urban and rural. We are proposing to make that conforming regulation text change to revise the definitions for rural and urban areas

effective for services provided on or after October 1, 2005, to reference the regulations at § 412.64(b)(1)(ii)(A) through (C), consistent with the revision under the IPPS.

1. Clarification of New England Deemed Counties

We are taking this opportunity to address the change in the treatment of ''New England deemed counties'' (that is, those counties in New England listed in § 412.64(b)(1)(ii)(B) that were deemed to be part of urban areas under section 601(g) of the Social Security Amendments of 1983) that was made in the FY 2008 IPPS final rule with comment period (72 FR 47337 through 47338, August 22, 2007). These counties include the following: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Of these five ''New England deemed counties,'' three (York County, Sagadahoc County, and Newport County) are also included in metropolitan statistical areas defined by OMB and are considered urban under both the current IPPS and SNF PPS labor market area definitions in § 412.64(b)(1)(ii)(A). The remaining two, Litchfield County and Merrimack County, are geographically located in areas that are considered rural under the current IPPS (and SNF PPS) labor market area definitions, but have been previously deemed urban under the IPPS in certain circumstances, as discussed below.

In the FY 2008 IPPS final rule with comment period, § 412.64(b)(1)(ii)(B) was revised such that the two ''New England deemed counties'' that are still considered rural under the OMB definitions (Litchfield County, CT and Merrimack County, NH), are no longer considered urban effective for discharges occurring on or after October 1, 2007, and therefore, are considered rural in accordance with § 412.64(b)(1)(ii)(C). However, for purposes of payment under the IPPS, acute-care hospitals located within those areas are treated as being reclassified to their deemed urban area effective for discharges occurring on or after October 1, 2007 (see 72 FR 47337 through 47338). We note that the SNF PPS does not provide for such geographic reclassification. Also, in the FY 2008 IPPS final rule with comment period (72 FR 47338), we explained that we have limited this policy change for the ''New England deemed counties'' only to IPPS hospitals, and any change to non-IPPS provider wage indexes would be addressed in the respective payment system rules. Accordingly, we are taking this opportunity to clarify the treatment of ''New England deemed counties'' under the SNF PPS in this proposed rule.

As discussed above, the SNF PPS has consistently used the IPPS definition of ''urban'' and ''rural'' with regard to the wage index used in the SNF PPS. Historical changes to the labor market area/geographic classifications and annual updates to the wage index values under the SNF PPS are made effective October 1 each year. When we established the most recent SNF PPS payment rate update, effective for SNF services provided on or after October 1, 2007 through September 30, 2008, we considered the ''New England deemed counties'' (including Litchfield County, CT and Merrimack County, NH) as urban for FY 2008, as evidenced by the inclusion of Litchfield County as one of the constituent counties of urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT), and the inclusion of Merrimack County as one of the constituent counties of urban CBSA 31700 (Manchester-Nashua, NH)).

As noted above, § 413.333 indicates that the terms ''rural'' and ''urban'' are defined according to the definitions of those terms as used in the IPPS. Applying the IPPS definitions, Litchfield County, CT and Merrimack County, NH are not considered ''urban'' under § 412.64(b)(1)(ii)(A) through (B) as revised under the FY 2008 IPPS final rule and, therefore, are considered ''rural'' under § 412.64(b)(1)(ii)(C). Accordingly, reflecting our policy to use the IPPS definitions of ''urban'' and ''rural,'' these two counties will be considered ''rural'' under the SNF PPS effective with the next update of the SNF PPS payment rates on October 1, 2008, and will no longer be included in urban CBSA 25540 (Hartford-West Hartford-East Hartford, CT) and urban CBSA 31700 (Manchester-Nashua, NH), respectively. We note that this policy is consistent with our policy of not taking into account IPPS geographic reclassifications in determining payments under the SNF PPS. As indicated above, we are proposing to make a technical change to the regulations at § 413.333 to reflect the updated IPPS regulation reference.

2. Multi-Campus Hospital Wage Index Data

In the FY 2008 SNF PPS final rule (72 FR 43412, August 3, 2007), we established SNF PPS wage index values for FY 2008 calculated from the same data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2004) used to compute the FY 2008 acute care hospital inpatient wage index, without taking into account geographic reclassification under sections 1886(d)(8) and (d)(10) of the Act. However, the IPPS policy that apportions the wage data for multi-campus hospitals was not finalized before the SNF PPS final rule. The SNF PPS wage index values applicable for services provided on or after October 1, 2007 through September 30, 2008 are shown in Table 8 (for urban areas) and Table 9 (for rural areas) and in the Addendum to the FY 2008 SNF PPS final rule (72 FR 43437 through 43463).

We are continuing to use IPPS wage data for FY 2009 because we believe that in the absence of SNF-specific wage data, using the hospital inpatient wage data is appropriate and reasonable for the SNF PPS. We note that the IPPS wage data used to determine the proposed FY 2009 SNF wage index values reflect our policy that was adopted under the IPPS beginning in FY 2008, which apportions the wage data for multi-campus hospitals located in different labor market areas, or Core-Based Statistical Areas (CBSAs), to each CBSA where the campuses are located (see the FY 2008 IPPS final rule with comment period (72 FR 47317 through 47320)). Specifically, for the proposed FY 2009 SNF PPS, the wage index was computed using IPPS wage data (published by hospitals for cost reporting periods beginning in 2005, as with the FY 2009 IPPS wage index), which allocated salaries and hours to the campuses of two multi-campus hospitals with campuses that are located in different labor areas; one is Massachusetts and the other is Illinois. The wage index values for the proposed FY 2009 SNF PPS in the following CBSAs are affected by this policy: Boston-Quincy, MA (CBSA 14484), Providence-New Bedford-Falls River, RI–MA (CBSA 39300), Chicago-Naperville-Joliet, IL (CBSA 16974) and Lake County-Kenosha County, IL–WI (CBSA 29404) (please refer to Table 8 in the Addendum of this proposed rule).

In summary, for FY 2009, we propose to use the FY 2009 wage index data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2005) to adjust SNF PPS payments beginning October 1, 2008. These data reflect the multi-campus and New England deemed counties policies discussed above.

Finally, we propose to continue using the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in which there are no hospitals and, thus, no hospital wage index data on

which to base the calculation of the FY 2009 SNF PPS wage index. For rural geographic areas that do not have hospitals and, therefore, lack hospital wage data on which to base an area wage adjustment, we would use the average wage index from all contiguous CBSAs as a reasonable proxy. This methodology is used to construct the wage index for rural Massachusetts. However, we would not apply this methodology to rural Puerto Rico due to the distinct economic circumstances that exist there, but instead would continue using the most recent wage index previously available for that area. For urban areas without specific hospital wage index data, we would use the average wage indexes of all of the urban areas within the State to serve as a reasonable proxy for the wage index of that urban CBSA. The only urban area without wage index data available is CBSA (25980) Hinesville-Fort Stewart, GA.

To calculate the SNF PPS wage index adjustment, we would apply the wage index adjustment to the labor-related portion of the Federal rate, which is 69.994 percent of the total rate. This percentage reflects the labor-related relative importance for FY 2009, using the revised and rebased FY 2004-based market basket. The labor-related relative importance for FY 2008 was 70.249, as shown in Table 11. We calculate the labor-related relative importance from the SNF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2009. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Accordingly, the relative importance figure more closely reflects the cost share weights for FY 2009 than the base year weights from the SNF market basket.

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

TABLE 6.—RUG–53 CASE-MIX ADJUSTED FEDERAL RATES FOR URBAN SNFS BY LABOR AND NON-LABOR COMPONENT

RUG-III category	Total rate	Labor portion	Non-labor portion
RUX	601.45	420.98	180.47
RUL	531.85	372.26	159.59
RVX	455.79	319.03	136.76
RVL	425.53	297.85	127.68
RHX	385.58	269.88	115.70
RHL	376.50	263.53	112.97
RMX	437.32	306.10	131.22
RML	402.52	281.74	120.78
RLX	310.82	217.56	93.26
RUC	515.21	360.62	154.59
RUB	472.85	330.97	141.88
RUA	451.66	316.13	135.53
RVC	410.40	287.26	123.14
RVB	390.73	273.49	117.24
RVA	354.42	248.07	106.35
RHC	355.32	248.70	106.62
RHB	340.19	238.11	102.08
RHA	317.49	222.22	95.27
RMC	326.87	228.79	98.08
RMB	317.79	222.43	95.36
RMA	311.74	218.20	93.54
RLB	286.61	200.61	86.00
RLA	245.76	172.02	73.74
SE3	352.46	246.70	105.76
SE2	301.01	210.69	90.32
SE1	269.24	188.45	80.79
SSC	264.70	185.27	79.43
SSB	251.09	175.75	75.34
SSA	246.55	172.57	73.98
CC2	263.19	184.22	78.97
CC1	242.01	169.39	72.62
CB2	229.90	160.92	68.98
CB1	219.31	153.50	65.81
CA2	217.80	152.45	65.35
CA1	205.70	143.98	61.72
IB2	196.62	137.62	59.00
IB1	193.59	135.50	58.09
IA2	178.46	124.91	53.55
IA1	172.41	120.68	51.73
BB2	195.10	136.56	58.54
BB1	190.57	133.39	57.18
BA2	176.95	123.85	53.10
BA1	164.84	115.38	49.46

TABLE 6.—RUG–53 CASE-MIX ADJUSTED FEDERAL RATES FOR URBAN SNFS BY LABOR AND NON-LABOR COMPONENT—Continued

RUG-III category	Total rate	Labor portion	Non-labor portion
PE2	211.75	148.21	63.54
PE1	208.72	146.09	62.63
PD2	201.16	140.80	60.36
PD1	198.13	138.68	59.45
PC2	192.08	134.44	57.64
PC1	190.57	133.39	57.18
PB2	170.90	119.62	51.28
PB1	167.87	117.50	50.37
PA2	166.36	116.44	49.92
PA1	161.82	113.26	48.56

TABLE 7.—RUG–53 CASE-MIX ADJUSTED FEDERAL RATES FOR RURAL SNFS BY LABOR AND NON-LABOR COMPONENT

RUG-III category	Total rate	Labor portion	Non-labor portion
RUX	630.19	441.10	189.09
RUL	563.70	394.56	169.14
RVX	472.09	330.43	141.66
RVL	443.18	310.20	132.98
RHX	394.42	276.07	118.35
RHL	385.75	270.00	115.75
RMX	440.02	307.99	132.03
RML	406.77	284.71	122.06
RLX	311.50	218.03	93.47
RUC	547.80	383.43	164.37
RUB	507.33	355.10	152.23
RUA	487.09	340.93	146.16
RVC	428.73	300.09	128.64
RVB	409.94	286.93	123.01
RVA	375.24	262.65	112.59
RHC	365.51	255.84	109.67
RHB	351.06	245.72	105.34
RHA	329.37	230.54	98.83
RMC	334.50	234.13	100.37
RMB	325.83	228.06	97.77
RMA	320.04	224.01	96.03
RLB	288.37	201.84	86.53
RLA	249.34	174.52	74.82
SE3	343.31	240.30	103.01
SE2	294.16	205.89	88.27
SE1	263.80	184.64	79.16
SSC	259.47	181.61	77.86
SSB	246.46	172.51	73.95
SSA	242.12	169.47	72.65
CC2	258.02	180.60	77.42
CC1	237.78	166.43	71.35
CB2	226.22	158.34	67.88
CB1	216.10	151.26	64.84
CA2	214.66	150.25	64.41
CA1	203.09	142.15	60.94
IB2	194.42	136.08	58.34
IB1	191.53	134.06	57.47
IA2	177.07	123.94	53.13
IA1	171.29	119.89	51.40
BB2	192.97	135.07	57.90
BB1	188.64	132.04	56.60
BA2	175.63	122.93	52.70
BA1	164.06	114.83	49.23
PE2	208.87	146.20	62.67
PE1	205.98	144.17	61.81
PD2	198.76	139.12	59.64
PD1	195.87	137.10	58.77
PC2	190.08	133.04	57.04
PC1	188.64	132.04	56.60
PB2	169.85	118.88	50.97
PB1	166.96	116.86	50.10
PA2	165.51	115.85	49.66
PA1	161.17	112.81	48.36

Section 1888(e)(4)(G)(ii) of the Act also requires that we apply this wage index in a manner that does not result in aggregate payments that are greater or less than would otherwise be made in the absence of the wage adjustment. For FY 2009 (Federal rates effective October 1, 2008), we would apply an adjustment to fulfill the budget neutrality requirement. We would meet this requirement by multiplying each of the components of the unadjusted Federal rates by a budget neutrality factor equal to the ratio of the weighted average wage adjustment factor for FY 2008 to the weighted average wage adjustment factor for FY 2009. For this calculation, we use the same 2006 claims utilization data for both the numerator and denominator of this ratio. We define the wage adjustment factor used in this calculation as the labor share of the rate component multiplied by the wage index plus the non-labor share of the rate component. The proposed budget neutrality factor for this year is 1.0009. The wage index applicable to FY 2009 is set forth in Tables 8 and 9, which appear in the Addendum of this proposed rule.

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

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

D. Updates to the Federal Rates

In accordance with section 1888(e)(4)(E) of the Act, as amended by section 311 of the BIPA, the proposed payment rates in this proposed rule reflect an update equal to the full SNF market basket, estimated at 3.1 percentage points. We would continue to disseminate the rates, wage index, and case-mix classification methodology through the **Federal Register** before the August 1 that precedes the start of each succeeding FY.

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

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

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

In this proposed rule, we are continuing the designation of the upper 35 groups for purposes of this administrative presumption, consisting of the following RUG–53 classifications: All groups within the Rehabilitation plus Extensive Services category; All groups within the Ultra High Rehabilitation category; all groups within the Very High Rehabilitation category; all groups within the High Rehabilitation category; all groups within the Medium Rehabilitation category; all groups within the Low Rehabilitation category; all groups within the Extensive Services category; all groups within the Special Care category; and, all groups within the Clinically Complex category.

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

Using the hypothetical SNF XYZ described in Table 10 below, the following shows the adjustments made to the Federal per diem rate to compute the provider's actual per diem PPS payment. SNF XYZ's 12-month cost reporting period begins October 1, 2008. SNF XYZ's total PPS payment would equal $29,719. We derive the Labor and Non-labor columns from Table 6 of this proposed rule.

TABLE 10.—RUG–53 SNF XYZ: LOCATED IN CEDAR RAPIDS, IA (URBAN CBSA 16300)

[Wage Index: 0.8924]

RUG Group	Labor	Wage index	Adj. labor	Non-labor	Adj. rate	Percent adj	Medicare days	payment
RVX	$319.03	0.8924	$284.70	$136.76	$421.46	$421.46	14	$5,900.00
RLX	217.56	0.8924	194.15	93.26	287.41	287.41	30	8,622.00
RHA	222.22	0.8924	198.31	95.27	293.58	293.58	16	4,697.00
CC2	184.22	0.8924	164.40	78.97	243.37	554.88*	10	5,549.00
IA2	124.91	0.8924	111.47	53.55	165.02	165.02	30	4,951.00
Total							100	29,719.00

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

G. Other Issues

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

[If you choose to comment on issues in this section, please include the caption ''STRIVE Project'' at the beginning of your comments.]

As noted previously in section II.B.1 of this proposed rule, section 1888(e)(4)(G)(i) of the Act requires the Secretary to make an adjustment to account for case-mix. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the relative resource use of different patient types, as well as resident assessment and other data that the Secretary considers appropriate. In first implementing the SNF PPS (63 FR 26252, May 12, 1998), we developed the RUG-III case-mix classification system, which tied the amount of payment to resident resource use in combination with resident characteristic information. Staff time measurement (STM) studies conducted in 1990, 1995, and 1997 provided information on resource use (time spent by staff members on residents) and resident characteristics that enabled us not only to establish RUG–III, but also to create case-mix indexes.

Since that time, we have become concerned that incentives of the SNF PPS and the public reporting of nursing home quality measures likely have altered industry practices, and have affected the nursing resources required to treat different types of patients. Changes to technology might also have affected care methods, while more choices in housing alternatives (such as assisted living and community housing) may have altered the population mix served by nursing homes.

To help ensure that the SNF PPS payment rates reflect current practices and resource needs, CMS sponsored a national nursing home time study, STRIVE, which began in the Fall of 2005. Information collected in STRIVE includes the amount of time that staff members spend on residents and information on residents'' physical and clinical status derived from MDS assessment data.

Two hundred and five nursing homes from the following fifteen States and jurisdictions volunteered to participate in STRIVE: The District of Columbia, Nevada, Florida, Illinois, Iowa, Kentucky, Louisiana, Michigan, Montana, New York, Ohio, South Dakota, Texas, Virginia, and Washington. We are currently analyzing staff time and MDS assessment data for approximately 9,700 residents.

Nursing homes with poor survey histories or pending enforcement actions were excluded from the sample. In addition, nursing homes with poor quality measure (QM) scores, low occupancy rates, or large proportions of private pay or pediatric patients were also excluded.

Nursing homes were randomly recruited within five strata. The five strata follow: Hospital-based facilities; facilities with high concentrations of residents on ventilators; facilities with high concentrations of residents with Human Immunodeficiency Virus (HIV); facilities with high concentrations of residents on Medicare Part A stays; and all other facilities. Facilities with large concentrations of residents on ventilators, residents with HIV, or residents on Part A stays were over-sampled in order to assure sufficient numbers of residents in those populations. Nursing homes were voluntarily recruited in random order until enough facilities in each targeted category agreed to participate.

Participating facilities included both not-for-profit entities and corporations; chains and independent operators; nursing homes with populations small to large in size; and facilities situated in urban and rural locations.

STRIVE began on-site data collection at both SNFs and Medicaid Nursing Facilities (NFs) in the Spring of 2006. STRIVE collected data from both types of facilities because almost half of the States use a version of the RUG-III system for their Medicaid reimbursement systems.

Participating facilities submitted both time and MDS assessment data. Nursing staff recorded their time over 48 hours. Nursing staff included registered nurses, licensed practical nurses, and nursing aides. Therapy staff recorded their time over 7 consecutive days. Therapy staff included physical therapists and aides; occupational therapists and aides; and speech-language pathologists. Each nursing home staff member recorded his or her time at the facility in different categories (for example, resident-specific time (RST), non-resident-specific time (NRST), unpaid time, and non-study time).

As our analysis continues, we expect to introduce changes to the RUG-III grouper methodology and clinical assessment instrument. Further exploration of STRIVE data and possible refinements to the SNF PPS may ultimately culminate in a new RUG model, version IV.

To date, STRIVE has benefited from stakeholder input, starting with the December 2005 Open Door Forum to which the public was invited. The educators, researchers, beneficiary advocates, clinicians, consultants, government experts, and representatives from health care, nursing home, and other related industry associations serving on the STRIVE technical expert panel (TEP) have provided valuable insights on topics such as sample populations. Beginning in 2005 until its most recent February 2008 meeting, the TEP has met twice and held two teleconferences. Additionally, our contractor recently established a smaller Analytic Panel consisting of various stakeholders who meet regularly with our researchers to discuss the analysis of the STRIVE data.

Our preliminary analyses of RUG III-related resource times and payment rates indicated that, as mentioned previously, SNF care patterns have changed significantly over the decade since we last conducted STMs. We note that calculating CMIs based upon STRIVE data for use within a RUG-III model constructed over a decade ago would create methodological challenges and, therefore, could only be considered an interim step, as we would have to reexamine the CMIs after changes to the structural model are finalized. We will continue to analyze STRIVE data and intend to create an updated RUG classification structure that would more accurately reflect current care practices and resource use. Our contractors also plan to receive input from the TEP and the Analytic Panel to guide the STRIVE analysis. We may also use the results of the contractors' analyses to make changes to the RUG classification structure. It is our intention to introduce new case-mix weights in FY 2010 that reflect the results of the STRIVE analysis and any changes to the RUG classification structure.

More information on STRIVE appears at the following Web site: *https://www.qtso.com/strive.html.* Items posted there include: Assessment forms distributed by STRIVE; ''train the trainer'' materials used to teach the data monitors who, in turn, instructed nursing home staff members on how to record their time; materials from State teleconferences; and slides presented at STRIVE TEPs. We plan to post preliminary results of the STRIVE analyses, when available, on the following Web site: *http://www.cms.hhs.gov/SNFPPS/10_TimeStudy.asp.*

2. Minimum Data Set (MDS) 3.0

[If you choose to comment on issues in this section, please include the caption ''MDS 3.0'' at the beginning of your comments.]

Sections 1819(f)(6)(A)–(B) and 1919(f)(6)(A)–(B) of the Social Security

Act, as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), require the Secretary of the Department of Health and Human Services (the Secretary) to specify a minimum data set of core elements for use in conducting comprehensive assessments. As stated in § 483.20, Medicare- and Medicaid-participating nursing homes must conduct ''a comprehensive, accurate, standardized, reproducible assessment'' of each nursing home resident's functional capacity.

CMS is developing a new version of the MDS, MDS 3.0, to reflect more accurately each resident's clinical, cognitive, and functional status as well as the care that nursing homes provide residents. The regulations at § 483.20(b)(1)(i) through (xviii) list the clinical domains that must be included in the Resident Assessment Instrument (RAI). These domains have been incorporated into the MDS 2.0 and would also be included in MDS 3.0. We anticipate that in FY 2010, MDS 3.0 would become the current version of the MDS. MDS 3.0, like MDS 2.0, would focus on the clinical assessment of each nursing home resident to screen for common, often unrecognized or unevaluated, conditions and syndromes. We made clinical revisions to the instrument based on input from subject-area experts, feedback from MDS users, resident advocates and families, and new knowledge and evidence about resident assessment. With the implementation of MDS 3.0, we aim to increase the clinical relevance, accuracy, and efficiency of assessments; require assessors to record direct resident responses on some items; include assessment items used in other care settings; and move items toward future electronic health record formats. On January 24, 2008, CMS hosted a special Open Door Forum to provide details about MDS 3.0.

We now plan to evaluate the impact of the MDS 3.0 changes on the RUG–III resident classification system used in the Medicare payment structure. We intend to develop ways to adapt the RUG system to the MDS 3.0 assessment instrument as part of the STRIVE study. We would then finalize changes to the MDS 3.0 and any necessary adaptations to the RUG classification system. Our intent would be to implement the updated system nationally in FY 2010.

We are very much aware that the transition to a new MDS instrument in conjunction with the possible release of a new RUG grouper requires careful planning and extensive provider training. CMS staff are already working on training plans that would include a new MDS 3.0 manual, documentation explaining the updated RUG grouper methodology, data specifications for providers and vendors, training videos, a help desk call and e-mail center, and a train-the-trainer conference tentatively scheduled for Spring 2009. However, we realize that the most effective training would require coordination between CMS and its key stakeholders, including provider and professional associations, Fiscal Intermediaries and Part A and Part B Medicare Administrative Contractors (MACs), and State agencies. We want to encourage stakeholders to work with CMS staff to provide additional training opportunities on the local level to ensure a smooth transition. We plan to publish a transition plan in 2008 that should highlight opportunities for joint action. In 2009, we intend to make draft MDS 3.0 specifications available to providers and vendors. We also tentatively plan to include in the update to the FY 2010 SNF PPS rates (which we intend to introduce in Spring 2009 and finalize by the end of July, 2009) definitive information on the final MDS 3.0 and RUG grouper specifications. Additional information is available online at *http://www.cms.hhs.gov* via the following links:

- MDS 3.0 information: *http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp.*
- January 15, 2008 version of the MDS 3.0 instrument: *http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30DraftVersion.pdf.*
- MDS 3.0 timeline: *http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30Timeline.pdf.*

3. Integrated Post Acute Care Payment

[If you choose to comment on issues in this section, please include the caption ''Integrated Post Acute Care Payment'' at the beginning of your comments.]

Under current law, Medicare covers post-acute care (PAC) services in various care settings, including SNFs, home health agencies (HHAs), long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs). Each of the PAC sites has a separate payment system that relies on different patient assessment instruments, although there is no mandated assessment instrument for LTCHs. The current model is based on provider-oriented ''silos'' with significant payment differentials existing between provider types that treat similar patients and provide similar services.

In the SNF PPS update notice for FY 2007 (71 FR 43172 through 43173, July 31, 2006), we described our plans to explore refinements to the existing PAC payment methodologies to create a more seamless system for payment and delivery of PAC under Medicare. The new model will focus on beneficiary needs rather than provider type and will be characterized by more consistent payments for the same type of care across different sites of service, quality-driven pay-for-performance incentives, and collection of uniform clinical assessment information to support quality and discharge planning functions.

We also noted in the FY 2007 SNF PPS update notice (71 FR 43172) that section 5008 of the Deficit Reduction Act (DRA) of 2005 mandates a PAC payment reform demonstration for purposes of understanding costs and outcomes across different PAC sites. To meet this mandate, CMS implemented the PAC Payment Reform Demonstration (PAC–PRD) to examine differences in costs and outcomes for PAC patients of similar case-mix who use different types of PAC providers and to develop a standardized patient assessment tool for use at hospital discharge and at PAC admission and discharge. This tool, the Continuity Assessment Record and Evaluation (CARE) tool, will measure the health and functional status of Medicare acute discharges. During the demonstration, CARE will be used at hospital discharge and upon admission and discharge from PAC settings. The CARE instrument consists of a core set of assessment items that are common to all patients and care settings and are organized under several major domains: Medical, Functional, Cognitive, Social, and Continuity of Care, in addition to supplemental items for specific conditions and care settings. Additional information on the PAC–PRD is available at: *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=dual,%20keyword&filterValue=post%20acute%20care&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1201325&intNumPerPage=10.*

We are interested in receiving public comments on the CARE instrument, and specifically invite comments on how CARE might advance the use of Health Information Technology (HIT) in automating the process for collecting and submitting quality data. The CARE tool is available at *http://www.cms.hhs.gov/paperworkreductionactof1995/pral/list.asp.* Viewers should scroll down to the entry for CMS–10243, ''Data

Collection for Administering the Medicare Continuity Assessment Record and Evaluation (CARE) Instrument.'' Viewers can then click on the link to CMS–10243, click on the link to ''Downloads,'' and open Appendix A (''CARE Tool Item Matrix,'' a .pdf file) and Appendix B (''CARE Tool Master Document,'' in Microsoft Word).

In addition, we wish to take this opportunity to discuss recent developments in the related area of value-based purchasing (VBP). VBP ties payment to performance through the use of incentives based on measures of quality and cost of care. The implementation of VBP is rapidly transforming CMS from being a passive payer of claims to an active purchaser of higher quality, more efficient health care for Medicare beneficiaries. Our VBP initiatives include hospital pay for reporting (the Reporting Hospital Quality Data for the Annual Payment Update Program), physician pay for reporting (the Physician Quality Reporting Initiative), home health pay for reporting, the Hospital VBP Plan Report to Congress, and various VBP demonstration programs across payment settings, including the Premier Hospital Quality Incentive Demonstration and the Physician Group Practice Demonstration.

The preventable hospital-acquired conditions (HAC) payment provision for IPPS hospitals is another of CMS'' value-based purchasing initiatives. The principal behind the HAC payment provision (Medicare not paying more for healthcare-associated conditions) could be applied to the Medicare payment systems for other settings of care. Section 1886(d)(4)(D) of the Act required the Secretary to select for the HAC IPPS payment provision conditions that: (a) are high cost, high volume, or both; (b) are assigned to a higher-paying Medicare severity diagnosis-related group (MS–DRG) when present as a secondary diagnosis; and (c) could reasonably have been prevented through the application of evidence-based guidelines. Beginning October 1, 2008, Medicare can no longer assign an inpatient hospital discharge to a higher-paying MS–DRG if a selected HAC condition was not present on admission. That is, the case will be paid as though the secondary diagnosis were not present. (Medicare will continue to assign a discharge to a higher-paying MS–DRG in those instances where the selected condition was, in fact, present on admission).

The broad principle articulated in the HAC payment provision for IPPS hospitals—of Medicare not paying for these types of preventable conditions—could potentially be applied to other Medicare payment systems for similar conditions that occur in settings other than IPPS hospitals. Other possible settings of care might include hospital outpatient departments, SNFs, HHAs, end-stage renal disease facilities, and physician practices. The implementation would be different for each setting, as each payment system is different and the reasonable preventability through the application of evidence-based guidelines could vary for candidate conditions over the different settings. However, alignment of incentives across settings of care is an important goal for all of CMS'' VBP initiatives, including the HAC provision.

A related application of the broad principle behind the HAC payment provision for IPPS hospitals could be considered through Medicare secondary payer policy by requiring the provider that failed to prevent the occurrence of a preventable condition in one setting to pay for all or part of the necessary follow-up care in a second setting. This would help shield the Medicare program from inappropriately paying for the downstream effects of a preventable condition acquired in the first setting but treated in the second setting.

We note that we are not proposing new Medicare policy in this discussion of the possible application of HACs payment policy for IPPS hospitals to other settings, as some of these approaches may require new statutory authority. Rather, we are seeking public comment on the application of the preventable HACs payment provision for IPPS hospitals to other Medicare payment systems and settings. We look forward to working with stakeholders in the fight against these preventable conditions.

H. Miscellaneous Technical Corrections and Clarifications

We are also taking the opportunity to set forth certain technical corrections and clarifications in this proposed rule, as discussed below.

1. Bad Debt Payments

We are proposing to make a technical revision in the SNF PPS regulations at § 413.335(b) to reflect Medicare bad debt payments to SNFs. Under section 1861(v)(1) of the Act and § 413.89 of the regulations, Medicare may pay some or all of the uncollectible deductible and coinsurance amounts to those entities paid under a reasonable cost payment methodology that are eligible to receive payment for ''bad debt'' as defined in § 413.89(b)(1). Under the original reasonable cost SNF payment methodology that preceded the introduction of the SNF PPS, SNFs did, in fact, receive bad debt payments for uncollectible SNF coinsurance amounts (the SNF benefit has no deductible). As we noted in the preamble to the July 30, 1999 SNF PPS final rule (64 FR 41656), while the SNF PPS has maintained this longstanding practice of recognizing SNF bad debt payments ever since its inception, these payments are not included within the SNF PPS per diem itself, but rather, are claimed on the SNF's Medicare cost report. However, in drafting the regulations text in § 413.335(b) on the scope of the SNF PPS per diem payment, we inadvertently omitted a reference to this practice.

Accordingly, in this proposed rule, we now propose to rectify that inadvertent omission by adding a new clause to § 413.335(b), to clarify that in addition to the Federal per diem payment amounts, SNFs receive payment for bad debts of Medicare beneficiaries, as specified in the provisions of the regulations at § 413.89. We note that those provisions include the 30 percent reduction in applicable SNF bad debt payments made in accordance with section 5004 of the DRA, as specified in § 413.89(h)(2). Further, we note that the President's budget currently includes a provision that would eliminate Medicare bad debt payments altogether, and that the provisions outlined in this proposed rule would need to reflect any legislation that the Congress may enact to adopt that proposal. Finally, we note that our proposed revision is similar to language that already appears in the regulations text for the inpatient psychiatric facility PPS, at § 412.422(b)(2).

2. Additional Clarifications

We are also proposing to make clarifications in two other areas: When a SNF may bill at the default payment rate, and the role of rehabilitation services evaluations in SNFs.

A recent analysis of claims data has confirmed confusion among providers as to when it is permissible to submit a claim using the Health Insurance Prospective Payment System (HIPPS) rate code of AAA00, which is the default code. Under the SNF PPS, SNFs are required to submit resident assessment data according to an assessment schedule. When the resident assessment is prepared timely, the provider should bill the RUG payment group that is assigned to the assessment. When the SNF fails to comply with the assessment schedule, it must file a late assessment in order to be paid. In this

situation, CMS pays a ''default rate''—a reduced payment made in lieu of the full SNF PPS rate that would have been paid had the resident been assessed in a timely manner. Noncompliance with the schedule is determined by the assessment reference date (ARD) on the resident assessment.

Program instructions also allow for payment at the default rate in the following limited circumstances where the SNF has failed to assess the beneficiary: When the stay is less than 8 days within a spell of illness; the SNF is notified on an untimely basis or is unaware of a Medicare Secondary Payer denial; the SNF is notified on an untimely basis of the revocation of a payment ban; the beneficiary requests a demand bill; or, the SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage plan. Further information regarding these limited circumstances can be found in the Provider Reimbursement Manual, Part I (CMS Pub. 15–1), Chapter 28.

In circumstances other than those described above, no payment is available to the SNF where the SNF fails to assess the resident. However, even when no payment will be made, we wish to clarify that the SNF must nonetheless submit a claim using the HIPPS default rate code and an occurrence code 77 indicating provider liability in order to ensure that the beneficiary's spell of illness (benefit period) is updated.

We have also recently received questions concerning Change Request (CR) 5532 (Transmittal no. 73, dated June 29, 2007), regarding coverage of rehabilitation services in a SNF (see CMS Pub. 100–2, Chapter 8, § 30.4.1.1). As a result, we wish to clarify the requirement that an initial evaluation must be completed and the plan of treatment developed before recording the number of minutes of rehabilitation services provided or estimated for each discipline on the Resident Assessment Instrument (RAI).

For Medicare to cover rehabilitation services in a SNF, the services must be directly and specifically related to an active written treatment plan that is developed before the start of rehabilitation services. The plan must be based upon an initial evaluation performed by a qualified therapist (after SNF admission and before the start of rehabilitation services in the SNF) and must be approved by the physician after any needed consultation with the qualified therapist. This means that the evaluation must have been performed for each discipline and the plan of treatment developed in order to include minutes for each discipline under Section P (''Special Treatments and Procedures'') of the Resident Assessment Instrument, and also to project minutes under Section T (''Therapy Supplement for Medicare PPS'') of the Resident Assessment Instrument. Section T of the MDS is completed for Medicare 5-day assessments and in certain cases, when a beneficiary is readmitted to the SNF, whereas Section P is completed for each Medicare-required assessment. In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon readmission to the SNF, prior to the start of rehabilitation services in the SNF.

III. The Skilled Nursing Facility Market Basket Index

[If you choose to comment on issues in this section, please include the caption ''Market Basket Index'' at the beginning of your comments.]

Section 1888(e)(5)(A) of the Act requires us to establish a SNF market basket index (input price index), that reflects changes over time in the prices of an appropriate mix of goods and services included in the SNF PPS. This proposed rule incorporates the latest available projections of the SNF market basket index. We will incorporate updated projections based on the latest available projections when we publish the SNF final rule. Accordingly, we have developed a SNF market basket index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses.

Each year, we calculate a revised labor-related share based on the relative importance of labor-related cost categories in the input price index. Table 11 below summarizes the proposed updated labor-related share for FY 2009.

TABLE 11.—LABOR-RELATED RELATIVE IMPORTANCE, FY 2008 AND FY 2009

	Relative importance, labor-related, FY 2008 07:2 forecast	Relative importance, labor-related, FY 2009 08:1 forecast
Wages and salaries	51.218	51.139
Employee benefits	11.720	11.595
Nonmedical professional fees	1.333	1.331
Labor-intensive services	3.456	3.454
Capital-related (.391)	2.522	2.475
Total	70.249	69.994

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

A. Use of the Skilled Nursing Facility Market Basket Percentage

Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage as the percentage change in the SNF market basket index from the average of the previous FY to the average of the current FY. For the Federal rates established in this proposed rule, we use the percentage increase in the SNF market basket index to compute the update factor for FY 2009. We use the Global Insight, Inc. (formerly DRI–WEFA), first quarter 2008 forecasted percentage increase in the FY 2004-based SNF market basket index for routine, ancillary, and capital-related expenses, described in the previous section, to compute the update factor in this proposed rule. Finally, as discussed in section I.A. of this proposed rule, we no longer compute update factors to adjust a facility-specific portion of the SNF PPS rates because the initial three-phase transition period from facility-specific to full Federal rates that started with cost reporting periods beginning in July 1998 has expired.

B. Market Basket Forecast Error Adjustment

As discussed in the June 10, 2003, supplemental proposed rule (68 FR 34768) and finalized in the August 4,

2003, final rule (68 FR 46067), the regulations at § 413.337(d)(2) provide for an adjustment to account for market basket forecast error. The initial adjustment applied to the update of the FY 2003 rate for FY 2004, and took into account the cumulative forecast error for the period from FY 2000 through FY 2002. Subsequent adjustments in succeeding FYs take into account the forecast error from the most recently available FY for which there is final data, and apply whenever the difference between the forecasted and actual change in the market basket exceeds a specified threshold. We originally used a 0.25 percentage point threshold for this purpose; however, for the reasons specified in the FY 2008 SNF PPS final rule (72 FR 43425, August 3, 2007), we adopted a 0.5 percentage point threshold effective with FY 2008. As discussed previously in section I.F.2. of this proposed rule, as the difference between the estimated and actual amounts of increase in the market basket index for FY 2007 (the most recently available FY for which there is final data) does not exceed the 0.5 percentage point threshold, the proposed payment rates for FY 2009 do not include a forecast error adjustment.

C. Federal Rate Update Factor

Section 1888(e)(4)(E)(ii)(IV) of the Act requires that the update factor used to establish the FY 2009 Federal rates be at a level equal to the full market basket percentage change. Accordingly, to establish the update factor, we determined the total growth from the average market basket level for the period of October 1, 2007 through September 30, 2008 to the average market basket level for the period of October 1, 2008 through September 30, 2009. Using this process, the proposed market basket update factor for FY 2009 SNF Federal rates is 3.1 percent. We used this revised proposed update factor to compute the Federal portion of the SNF PPS rate shown in Tables 2 and 3.

IV. Consolidated Billing

[If you choose to comment on issues in this section, please include the caption ''Consolidated Billing'' at the beginning of your comments.]

Section 4432(b) of the BBA established a consolidated billing requirement that places the Medicare billing responsibility for virtually all of the services that the SNF's residents receive on the SNF, except for a small number of services that the statute specifically identifies as being excluded from this provision. As noted previously in section I. of this proposed rule, subsequent legislation enacted a number of modifications in the consolidated billing provision.

Specifically, section 103 of the BBRA amended this provision by further excluding a number of individual ''high-cost, low-probability'' services, identified by the Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy and its administration, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA amendment in greater detail in the proposed and final rules for FY 2001 (65 FR 19231 through 19232, April 10, 2000, and 65 FR 46790 through 46795, July 31, 2000), as well as in Program Memorandum AB–00–18 (Change Request #1070), issued March 2000, which is available online at *http://www.cms.hhs.gov/transmittals/downloads/ab001860.pdf.*

Section 313 of the BIPA further amended this provision by repealing its Part B aspect; that is, its applicability to services furnished to a resident during a SNF stay that Medicare does not cover. (However, physical, occupational, and speech-language therapy remain subject to consolidated billing, regardless of whether the resident who receives these services is in a covered Part A stay.) We discuss this BIPA amendment in greater detail in the proposed and final rules for FY 2002 (66 FR 24020 through 24021, May 10, 2001, and 66 FR 39587 through 39588, July 31, 2001).

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

To date, the Congress has enacted no further legislation affecting the consolidated billing provision. However, as noted above and explained in the proposed rule for FY 2001 (65 FR 19232, April 10, 2000), the amendments enacted in section 103 of the BBRA not only identified for exclusion from this provision a number of particular service codes within four specified categories (that is, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices), but also gave the Secretary ''* * * the authority to designate additional, individual services for exclusion within each of the specified service categories.'' In the proposed rule for FY 2001, we also noted that the BBRA Conference report (H.R. Rep. No.

106–479 at 854 (1999) (Conf. Rep.)) characterizes the individual services that this legislation targets for exclusion as, ''* * * high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment [SNFs] receive under the prospective payment system * * *''. According to the conferees, section 103(a), ''is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs * * *''. By contrast, we noted that the Congress declined to designate for exclusion any of the remaining services within those four categories (thus leaving all of those services subject to SNF consolidated billing), because they are relatively inexpensive and are furnished routinely in SNFs.

As we further explained in the final rule for FY 2001 (65 FR 46790, July 31, 2000), and as our longstanding policy, any additional service codes that we might designate for exclusion under our discretionary authority must meet the same criteria that the Congress used in identifying the original codes excluded from consolidated billing under section 103(a) of the BBRA: they must fall within one of the four service categories specified in the BBRA, and they also must meet the same standards of high cost and low probability in the SNF setting. Accordingly, we characterized this statutory authority to identify additional service codes for exclusion ''* * * as essentially affording the flexibility to revise the list of excluded codes in response to changes of major significance that may occur over time (for example, the development of new medical technologies or other advances in the state of medical practice)'' (65 FR 46791). In this proposed rule, we specifically invite public comments identifying codes in any of these four service categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) representing recent medical advances that might meet our criteria for exclusion from SNF consolidated billing.

We note that the original BBRA legislation (as well as the implementing regulations) identified a set of excluded services by means of specifying HCPCS codes that were in effect as of a particular date (in that case, as of July 1, 1999). Identifying the excluded services in this manner made it possible for us to utilize program issuances as the vehicle for accomplishing routine updates of the excluded codes, in order

to reflect any minor revisions that might subsequently occur in the coding system itself (for example, the assignment of a different code number to the same service). Accordingly, in the event that we identify through the current rulemaking cycle any new services that would actually represent a substantive change in the scope of the exclusions from SNF consolidated billing, we would identify these additional excluded services by means of the HCPCS codes that are in effect as of a specific date (in this case, as of October 1, 2008). By making any new exclusions in this manner, we could similarly accomplish routine future updates of these additional codes through the issuance of program instructions.

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

[If you choose to comment on issues in this section, please include the caption ''Swing-Bed Hospitals'' at the beginning of your comments.]

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

Accordingly, all non-CAH swing-bed rural hospitals have come under the SNF PPS as of June 30, 2003. Therefore, all rates and wage indexes outlined in earlier sections of this proposed rule for the SNF PPS also apply to all non-CAH swing-bed rural hospitals. A complete discussion of assessment schedules, the MDS and the transmission software (RAVEN–SB for Swing Beds) appears in the final rule for FY 2002 (66 FR 39562, July 31, 2001). The latest changes in the MDS for swing-bed rural hospitals appear on our SNF PPS Web site, *www.cms.hhs.gov/snfpps*.

VI. Provisions of the Proposed Rule

[If you choose to comment on issues in this section, please include the caption ''Provisions of the Proposed Rule'' at the beginning of your comments.]

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

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

VII. Collection of Information Requirements

[If you choose to comment on issues in this section, please include the caption ''Collection of Information'' at the beginning of your comments.]

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

VIII. Regulatory Impact Analysis

[If you choose to comment on issues in this section, please include the caption ''Impact Analysis'' at the beginning of your comments.]

A. Overall Impact

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

Executive Order 12866, as amended, directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This proposed rule is a major rule, as defined in Title 5, United States Code, section 804(2), because we estimate the FY 2009 impact reflects a $710 million increase from the update to the payment rates and a $770 million reduction from the recalibration of the case-mix adjustment, thereby yielding a net decrease of $60 million on payments to SNFs.

The proposed update set forth in this proposed rule would apply to payments in FY 2009. Accordingly, the analysis that follows only describes the impact of this single year. In accordance with the requirements of the Act, we will publish a notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Most SNFs and most other providers and suppliers are small entities, either by their nonprofit status or by having revenues of $11.5 million or less in any 1 year. For purposes of the RFA, approximately 53 percent of SNFs are considered small businesses according to the Small Business Administration's latest size standards, with total revenues of $11.5 million or less in any 1 year (for further information, see 65 FR 69432, November 17, 2000). Individuals and States are not included in the definition of a small entity. In addition, approximately 29 percent of SNFs are nonprofit organizations.

This proposed rule would update the SNF PPS rates published in the final rule for FY 2008 (72 FR 43412, August 3, 2007) and the associated correction notices (72 FR 55085, September 28, 2007, and 72 FR 67652, November 30, 2007), thereby decreasing net payments by an estimated $60 million. As indicated in Table 12, the effect on facilities will be a net negative impact of 0.3 percent. The total impact reflects a $770 million reduction from the recalibration of the case-mix adjustment, offset by a $710 million increase from the update to the payment rates. We note that some individual providers may experience a net increase in payments while most others experience a decrease. This is due to the distributional impact of the FY 2009 wage indexes and the degree of Medicare utilization. While this proposed rule is considered major, its relative impact on SNFs overall is extremely small; that is, less than 3 percent of total SNF revenues from all payor sources. Therefore, the Secretary has determined that this proposed rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to

the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. The proposed rule will affect small rural hospitals that (a) furnish SNF services under a swing-bed agreement or (b) have a hospital-based SNF. We anticipate that the impact on small rural hospitals will be similar to the impact on SNF providers overall.

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

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

B. Anticipated Effects

This proposed rule sets forth proposed updates of the SNF PPS rates contained in the final rule for FY 2008 (72 FR 43412, August 3, 2007) and the associated correction notices (72 FR 55085, September 28, 2007, and 72 FR 67652, November 30, 2007). Based on the above, we estimate the FY 2009 impact would be a net decrease of $60 million on payments to SNFs (this reflects a $770 million reduction from the recalibration of the case-mix adjustment, offset by a $710 million increase from the update to the payment rates. The impact analysis of this proposed rule represents the projected effects of the changes in the SNF PPS from FY 2008 to FY 2009. We estimate the effects by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to these changes, and we do not make adjustments for future changes in such variables as days or case-mix.

We note that certain events may combine to limit the scope or accuracy of our impact analysis, because an analysis is future-oriented and, thus, very susceptible to forecasting errors due to other changes in the forecasted impact time period. Some examples of possible events are newly-legislated general Medicare program funding changes by the Congress, or changes specifically related to SNFs. In addition, changes to the Medicare program may continue to be made as a result of previously-enacted legislation, or new statutory provisions. Although these changes may not be specific to the SNF PPS, the nature of the Medicare program is that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon SNFs.

In accordance with section 1888(e)(4)(E) of the Act, we update the payment rates for FY 2008 by a factor equal to the full market basket index percentage increase plus the FY 2007 forecast error adjustment to determine the payment rates for FY 2009. The special AIDS add-on established by section 511 of the MMA remains in effect until ''* * *such date as the Secretary certifies that there is an appropriate adjustment in the case mix. * * *'' We have not provided a separate impact analysis for the MMA provision. Our latest estimates indicate that there are less than 2,700 beneficiaries who qualify for the AIDS add-on payment. The impact to Medicare is included in the ''total'' column of Table 12. In proposing to update the rates for FY 2009, standard annual revisions and clarifications mentioned elsewhere in this proposed rule (for example, the update to the wage and market basket indexes used for adjusting the Federal rates). These revisions would increase payments to SNFs by approximately $710 million.

The net decrease in payments associated with this proposed rule is estimated to be $60 million for FY 2009. The decrease of $770 million due to the recalibration of the case-mix adjustment, together with the market basket increase of $710 million, results in a net decrease of $60 million.

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

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

The first row of figures in the first column describes the estimated effects of the various changes on all facilities. The next six rows show the effects on facilities split by hospital-based, freestanding, urban, and rural categories. The urban and rural designations are based on the location of the facility under the CBSA designation. The next twenty-two rows show the effects on urban versus rural status by census region.

The second column in the table shows the number of facilities in the impact database.

The third column of the table shows the effect of the annual update to the wage index. This represents the effect of using the most recent wage data available. The total impact of this change is zero percent; however, there are distributional effects of the change.

The fourth column shows the effect of recalibrating the two adjustments (parity and NTA) to the CMIs. As explained previously in section II.B.2 of this proposed rule, we are proposing this recalibration so that the CMIs more accurately reflect parity in expenditures under the refined, 53-group RUG system introduced in 2006 relative to payments made under the original, 44-group RUG system, and in order to keep the NTA component at the appropriate level specified in the FY 2006 SNF PPS final rule. The total impact of this change is a decrease of 3.3 percent. We note that some individual providers may experience larger decreases in payments than others due to case-mix utilization.

The fifth column shows the effect of all of the changes on the FY 2009 payments. The market basket increase of 3.1 percentage points is constant for all providers and, though not shown individually, is included in the total column. It is projected that aggregate payments will decrease by 0.3 percent, assuming facilities do not change their care delivery and billing practices in response.

As can be seen from this table, the combined effects of all of the changes vary by specific types of providers and by location. For example, though most facilities experience payment decreases, some providers (for example, those in the urban Pacific region) show an increase of 1.0 percent. Payment increases for facilities in the urban and rural Pacific areas of the country are the highest for any of the provider categories.

Table 12
Projected Impact to the SNF PPS for FY 2009

	Number of facilities	Update wage data	Revised CMIs	Total FY 2009 change
Total	**15,346**	0.0%	-3.3%	-0.3%
Urban	10,485	0.0%	-3.3%	-0.3%
Rural	4,861	0.0%	-3.1%	-0.2%
Hospital based urban	1,520	-0.1%	-3.4%	-0.5%
Freestanding urban	8,965	0.0%	-3.3%	-0.3%
Hospital based rural	1,140	0.0%	-3.3%	-0.3%
Freestanding rural	3,721	0.0%	-3.1%	-0.1%
Urban by region				
New England	838	0.2%	-3.4%	-0.2%
Middle Atlantic	1,486	-0.4%	-3.5%	-0.9%
South Atlantic	1,733	-0.3%	-3.2%	-0.5%
East North Central	2,009	-0.5%	-3.2%	-0.7%
East South Central	529	0.0%	-3.3%	-0.3%
West North Central	826	0.6%	-3.3%	0.3%
West South Central	1,165	0.2%	-3.2%	0.0%
Mountain	471	0.0%	-3.2%	-0.2%
Pacific	1,420	1.3%	-3.3%	1.0%
Outlying	8	0.3%	-3.6%	-0.3%
Rural by region				
New England	149	-1.5%	-3.1%	-1.6%
Middle Atlantic	257	-0.1%	-3.3%	-0.4%
South Atlantic	601	0.0%	-3.1%	-0.2%
East North Central	934	-0.6%	-3.1%	-0.7%
East South Central	551	0.2%	-3.1%	0.1%
West North Central	1,144	0.5%	-3.3%	0.2%
West South Central	819	0.5%	-3.1%	0.4%
Mountain	256	-0.2%	-3.2%	-0.3%
Pacific	148	1.1%	-3.2%	0.9%
Outlying	2	0.1%	-3.9%	-0.8%
Ownership				
Government	663	-0.1%	-3.5%	-0.6%
Proprietary	11,265	0.0%	-3.2%	-0.2%
Voluntary	3,418	-0.1%	-3.4%	-0.5%

C. Alternatives Considered

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

The proposed rule would recalibrate the case-mix adjustment to the case-mix indexes based on actual CY 2006 data instead of continuing to use FY 2001 data, in order to make the change from the 44-group RUG model to the refined 53-group model in a budget-neutral manner, as described in section II.B.2. In the FY 2006 SNF PPS final rule (70 FR 45031, August 4, 2005), we committed to monitoring the accuracy and effectiveness of the case-mix indexes used in the 53-group model. We believe that using actual data instead of superseded historical data better meets our objective of paying SNFs more accurately.

We considered various options for implementing the revised case-mix adjustment. For example, we considered implementing partial adjustments to the case-mix indexes over multiple years until parity was achieved. However, we believe that these options would further delay moving to the most appropriate payment amounts. Moreover, in anticipation of the possible changes resulting from STRIVE in the RUG–III structural model and the CMIs used in payment, we believe it is important for the recalibration to be entirely completed beforehand, in order to ensure stability in the base as we move forward with these other changes.

We also considered introducing new case-mix weights derived from the STRIVE time study data. However, our initial analyses show that it would be more efficient and less burdensome to providers to introduce any new case-mix weights as part of an overall restructuring of the RUG–III model that is currently scheduled for October 2009.

D. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf)*, in Table 13 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. This table provides our best estimate of the change in Medicare payments under the SNF PPS as a result of the policies in this proposed rule based on the data for 15,346 SNFs in our database. All expenditures are classified as transfers to Medicare providers (that is, SNFs).

TABLE 13.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2008 SNF PPS FISCAL YEAR TO THE 2009 SNF PPS FISCAL YEAR

[In Millions]

Category	Transfers
Annualized Monetized Transfers.	$60 million*
From Whom To Whom?.	SNF Medicare Providers to Federal Government

*The net decrease of $60 million in transfer payments is a result of the decrease of $770 million due to the proposed recalibration of the case-mix adjustment, together with the proposed market basket increase of $710 million.

E. Conclusion

Overall estimated payments for SNFs in FY 2009 are projected to decrease by 0.3 percent compared with those in FY 2008. We estimate that SNFs in urban areas would experience a 0.3 percent decrease in estimated payments compared with FY 2008. We estimate that SNFs in rural areas would experience a 0.2 percent decrease in estimated payments compared with FY 2008. Providers in the urban Pacific region and the rural Pacific region show increases in payments of 1.0 and 0.9 percent, respectively.

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

List of Subjects in 42 CFR Part 413

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

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

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

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

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

Subpart J—Prospective Payment for Skilled Nursing Facilities

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

§ 413.333 Definitions.

* * * * *

Rural area means, for services provided on or after July 1, 1998, but before October 1, 2005, an area as defined in § 412.62(f)(1)(iii) of this chapter. For services provided on or after October 1, 2005, *rural area* means an area as defined in § 412.64(b)(1)(ii)(C) of this chapter.

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

§ 413.335 [Amended]

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

§ 413.335 Basis of payment.

* * * * *

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

(2) In addition to the Federal per diem payment amounts, SNFs receive payment for bad debts of Medicare

beneficiaries, as specified in § 413.89 of this part.

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

Dated: March 14, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: April 24, 2008.

Michael O. Leavitt,

Secretary.

BILLING CODE 4120–01–P

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

Addendum - FY 2009 CBSA Wage Index Tables

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

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

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8102
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.3401
10420	Akron, OH Portage County, OH Summit County, OH	0.8858
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.8708
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8713
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9293
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8128
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9513
11020	Altoona, PA Blair County, PA	0.8527
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8933
11180	Ames, IA Story County, IA	0.9493
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.1939
11300	Anderson, IN Madison County, IN	0.8765
11340	Anderson, SC Anderson County, SC	0.9576
11460	Ann Arbor, MI Washtenaw County, MI	1.0451
11500	Anniston-Oxford, AL Calhoun County, AL	0.7931
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9446
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9148

12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9582
12060	Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA	0.9744
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1909
12220	Auburn-Opelika, AL Lee County, AL	0.7549
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9619
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9542
12540	Bakersfield, CA Kern County, CA	1.1213
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0056
12620	Bangor, ME Penobscot County, ME	1.0180
12700	Barnstable Town, MA Barnstable County, MA	1.2624
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.8153
12980	Battle Creek, MI Calhoun County, MI	1.0127
13020	Bay City, MI Bay County, MI	0.9254
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8484
13380	Bellingham, WA Whatcom County, WA	1.1600
13460	Bend, OR Deschutes County, OR	1.1384

13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0555
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8811
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8580
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.8798
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7153
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8160
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8985
14060	Bloomington-Normal, IL McLean County, IL	0.9329
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9237
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.1905
14500	Boulder, CO Boulder County, CO	1.0309
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8394
14600	Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	0.9907
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0777
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2976
15180	Brownsville-Harlingen, TX Cameron County, TX	0.8922
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9807
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9543
15500	Burlington, NC Alamance County, NC	0.8742
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9260
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1041
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0442
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8846
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9402
16180	Carson City, NV Carson City, NV	1.0135
16220	Casper, WY Natrona County, WY	0.9585
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8924

16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9400
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8280
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9240
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9599
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9822
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.8884
16940	Cheyenne, WY Laramie County, WY	0.9282
16974	Chicago-Naperville-Joliet, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.0426
17020	Chico, CA Butte County, CA	1.0904
17140	Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH	0.9686
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8303
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.8015
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9239
17660	Coeur d'Alene, ID Kootenai County, ID	0.9328
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9352
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9997
17860	Columbia, MO Boone County, MO Howard County, MO	0.8545

17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8939
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8745
18020	Columbus, IN Bartholomew County, IN	0.9738
18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	0.9907
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8604
18700	Corvallis, OR Benton County, OR	1.1311
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.7821
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	0.9952
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8647
19180	Danville, IL Vermilion County, IL	0.9380
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8400
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8441
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9209
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7808
19500	Decatur, IL Macon County, IL	0.8106
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8892
19740	Denver-Aurora, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.0825
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9541
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9959

20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7565
20100	Dover, DE Kent County, DE	1.0332
20220	Dubuque, IA Dubuque County, IA	0.8385
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0370
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9738
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9654
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1291
20940	El Centro, CA Imperial County, CA	0.8752
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8531
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9566
21300	Elmira, NY Chemung County, NY	0.8252
21340	El Paso, TX El Paso County, TX	0.8700
21500	Erie, PA Erie County, PA	0.8678
21660	Eugene-Springfield, OR Lane County, OR	1.1055
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8695
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1305
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.4063
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8171
22140	Farmington, NM San Juan County, NM	0.8056
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9346
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8976
22380	Flagstaff, AZ Coconino County, AZ	1.1751
22420	Flint, MI Genesee County, MI	1.1432
22500	Florence, SC Darlington County, SC Florence County, SC	0.8178
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.7854
22540	Fond du Lac, WI Fond du Lac County, WI	0.9299
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9873
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	0.9953

22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7702
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.8775
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9182
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9715
23420	Fresno, CA Fresno County, CA	1.1018
23460	Gadsden, AL Etowah County, AL	0.7988
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9314
23580	Gainesville, GA Hall County, GA	0.9092
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9279
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8478
24140	Goldsboro, NC Wayne County, NC	0.9149
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7570
24300	Grand Junction, CO Mesa County, CO	0.9818
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9190
24500	Great Falls, MT Cascade County, MT	0.8790
24540	Greeley, CO Weld County, CO	0.9690
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9739
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9017
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9454
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9813
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3251
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.9035
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9002
25260	Hanford-Corcoran, CA Kings County, CA	1.0877
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9158
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.8900

25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1076
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7341
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.8982
25980	Hinesville-Fort Stewart, GA1 Liberty County, GA Long County, GA	0.9123
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9014
26180	Honolulu, HI Honolulu County, HI	1.1834
26300	Hot Springs, AR Garland County, AR	0.9118
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7763
26420	Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	0.9844
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9260
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9088
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9086
26900	Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	0.9928
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9490
27060	Ithaca, NY Tompkins County, NY	0.9620
27100	Jackson, MI Jackson County, MI	0.9315
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8073
27180	Jackson, TN Chester County, TN Madison County, TN	0.8529
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9008
27340	Jacksonville, NC Onslow County, NC	0.8182
27500	Janesville, WI Rock County, WI	0.9667
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8781

27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7968
27780	Johnstown, PA Cambria County, PA	0.7919
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7922
27900	Joplin, MO Jasper County, MO Newton County, MO	0.9412
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0808
28100	Kankakee-Bradley, IL Kankakee County, IL	1.2092
28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	0.9610
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	0.9917
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.8770
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.7748
28740	Kingston, NY Ulster County, NY	0.9381
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.7886
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9355
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9764
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9136
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8368
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7561
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0376
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	0.9784
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8535
29540	Lancaster, PA Lancaster County, PA	0.9330
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	0.9937
29700	Laredo, TX Webb County, TX	0.8371
29740	Las Cruces, NM Dona Ana County, NM	0.8934
29820	Las Vegas-Paradise, NV Clark County, NV	1.1984

29940	Lawrence, KS Douglas County, KS	0.8348
30020	Lawton, OK Comanche County, OK	0.8216
30140	Lebanon, PA Lebanon County, PA	0.8960
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9471
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9189
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9115
30620	Lima, OH Allen County, OH	0.9433
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9765
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.8633
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8771
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8376
31020	Longview, WA Cowlitz County, WA	1.1215
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2184
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.9255
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8736
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8722
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9576
31460	Madera, CA Madera County, CA	0.7944
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.0974
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0366
31900	Mansfield, OH1 Richland County, OH	0.9336
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3942
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9047

32780	Medford, OR Jackson County, OR	1.0251
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9238
32900	Merced, CA Merced County, CA	1.2251
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	0.9836
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9150
33260	Midland, TX Midland County, TX	0.9833
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0086
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1158
33540	Missoula, MT Missoula County, MT	0.8979
33660	Mobile, AL Mobile County, AL	0.7864
33700	Modesto, CA Stanislaus County, CA	1.2137
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7905
33780	Monroe, MI Monroe County, MI	0.8837
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8148
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8533
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7258
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0299
34620	Muncie, IN Delaware County, IN	0.8494
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0060
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.8649
34900	Napa, CA Napa County, CA	1.4530
34940	Naples-Marco Island, FL Collier County, FL	0.9679

34980	Nashville-Davidson--Murfreesboro--Franklin, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN	0.9510
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2457
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1737
35300	New Haven-Milford, CT New Haven County, CT	1.1749
35380	New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	0.9270
35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.2891
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9072
35980	Norwich-New London, CT New London County, CT	1.1356
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.5851
36100	Ocala, FL Marion County, FL	0.8517
36140	Ocean City, NJ Cape May County, NJ	1.1503
36220	Odessa, TX Ector County, TX	0.9480
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9159
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.8730
36500	Olympia, WA Thurston County, WA	1.1544
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	0.9460
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9122
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9480

36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8690
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.1886
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9338
37380	Palm Coast, FL Flagler County, FL	0.8968
37460	Panama City-Lynn Haven, FL Bay County, FL	0.8366
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7872
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8107
37764	Peabody, MA Essex County, MA	1.0754
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8247
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.8933
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.1002
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0394
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.7931
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8626
38340	Pittsfield, MA Berkshire County, MA	1.0452
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9349
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4292
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	0.9948
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.1445
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	0.9874
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.0909
39140	Prescott, AZ Yavapai County, AZ	1.0227
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.0573

39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9133
39380	Pueblo, CO Pueblo County, CO	0.8718
39460	Punta Gorda, FL Charlotte County, FL	0.8982
39540	Racine, WI Racine County, WI	0.8858
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9829
39660	Rapid City, SD Meade County, SD Pennington County, SD	0.9604
39740	Reading, PA Berks County, PA	0.9248
39820	Redding, CA Shasta County, CA	1.3619
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0313
40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	0.9369
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1418
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.8666
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1221
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8820
40420	Rockford, IL Boone County, IL Winnebago County, IL	0.9841
40484	Rockingham County, NH Rockingham County, NH Strafford County, NH	0.9933
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9036
40660	Rome, GA Floyd County, GA	0.9140
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.3403
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.8708
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.0983
41100	St. George, UT Washington County, UT	0.9027

41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0372
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9010
41420	Salem, OR Marion County, OR Polk County, OR	1.0801
41500	Salinas, CA Monterey County, CA	1.4976
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9252
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9164
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8498
41700	San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.8861
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1509
41780	Sandusky, OH Erie County, OH	0.8876
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.5428
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.4759
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.6167

41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	0.4396
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.2462
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.1983
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.1927
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.6416
42140	Santa Fe, NM Santa Fe County, NM	1.0616
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.5471
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9157
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8317
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1763
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9223
43100	Sheboygan, WI Sheboygan County, WI	0.8926
43300	Sherman-Denison, TX Grayson County, TX	0.9030
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8447
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.8920
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9360
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9601

43900	Spartanburg, SC Spartanburg County, SC	0.9031
44060	Spokane, WA Spokane County, WA	1.0566
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9108
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0227
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8354
44220	Springfield, OH Clark County, OH	0.8765
44300	State College, PA Centre County, PA	0.8942
44700	Stockton, CA San Joaquin County, CA	1.1983
44940	Sumter, SC Sumter County, SC	0.8262
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9792
45104	Tacoma, WA Pierce County, WA	1.1249
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8970
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.8848
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9089
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8149
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9411
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8761
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0611
46060	Tucson, AZ Pima County, AZ	0.9235
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8464
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8435
46340	Tyler, TX Smith County, TX	0.8810
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8409
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8032

46700	Vallejo-Fairfield, CA Solano County, CA	1.4368
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8129
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0373
47260	Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA	0.8882
47300	Visalia-Porterville, CA Tulare County, CA	1.0151
47380	Waco, TX McLennan County, TX	0.8601
47580	Warner Robins, GA Houston County, GA	0.8982
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9907
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.0813
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8495
48140	Wausau, WI Marathon County, WI	0.9622
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.8040
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	0.9550
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9770
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6960
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9075

48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.8838
48700	Williamsport, PA Lycoming County, PA	0.8101
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0703
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9095
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	0.9807
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9022
49340	Worcester, MA Worcester County, MA	1.0842
49420	Yakima, WA Yakima County, WA	0.9955
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3434
49620	York-Hanover, PA York County, PA	0.9576
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8921
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.0987
49740	Yuma, AZ Yuma County, AZ	0.9287

[1] At this time, there are no hospitals located in this urban area on which to base a wage index.

Table 9 FY 2008 WAGE INDEX BASED ON CBSA LABOR MARKET AREAS FOR RURAL AREAS

State Code	Nonurban Area	Wage Index
1	Alabama	0.7592
2	Alaska	1.1906
3	Arizona	0.8459
4	Arkansas	0.7478
5	California	1.2244
6	Colorado	0.9556
7	Connecticut	1.1147
8	Delaware	0.9969
10	Florida	0.8510
11	Georgia	0.7614
12	Hawaii	1.1003
13	Idaho	0.7655
14	Illinois	0.8391
15	Indiana	0.8466

16	Iowa	0.8810
17	Kansas	0.8057
18	Kentucky	0.7797
19	Louisiana	0.7451
20	Maine	0.8650
21	Maryland	0.8889
22	Massachusetts1	1.1599
23	Michigan	0.8880
24	Minnesota	0.9065
25	Mississippi	0.7588
26	Missouri	0.7984
27	Montana	0.8664
28	Nebraska	0.8736
29	Nevada	0.9366
30	New Hampshire	1.0224
31	New Jersey1	-----
32	New Mexico	0.8818
33	New York	0.8198
34	North Carolina	0.8582
35	North Dakota	0.7209
36	Ohio	0.8579
37	Oklahoma	0.7783
38	Oregon	1.0225
39	Pennsylvania	0.8371
40	Puerto Rico1	0.4047
41	Rhode Island1	-----
42	South Carolina	0.8544
43	South Dakota	0.8608
44	Tennessee	0.7794
45	Texas	0.7899
46	Utah	0.8272
47	Vermont	1.0086
48	Virgin Islands	0.6930
49	Virginia	0.7865
50	Washington	1.0188
51	West Virginia	0.7508

52	Wisconsin	0.9469
53	Wyoming	0.9321
65	Guam	0.9611

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

[FR Doc. 08–1214 Filed 5–1–08; 8:45 am]

BILLING CODE 4120–01–C