DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-1530-N]

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

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

ACTION: Notice.

SUMMARY: This notice updates the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2007. Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act (the Act), as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

EFFECTIVE DATE: This notice is effective on October 1, 2006.

FOR FURTHER INFORMATION CONTACT:

Ellen Gay, (410) 786-4528 (for information related to the case-mix classification methodology).

Jeanette Kranacs, (410) 786-9385 (for information related to

the development of the payment rates).

Bill Ullman, (410) 786-5667 (for information related to level of care determinations, consolidated billing, and general information).

SUPPLEMENTARY INFORMATION:

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

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Abbreviations

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

ADL	Activity of Daily Living
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
BLS	Bureau of Labor Statistics
CAH	Critical Access Hospital
CBSA	Core-Based Statistical Area

CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CPT	(Physicians') Current Procedural Terminology
DRA	Deficit Reduction Act of 2005, Pub.L. 109-171
DRG	Diagnosis Related Group
ECI	Employment Cost Index
FI	Fiscal Intermediary
FQHC	Federally Qualified Health Center
FR	Federal Register
FY	Fiscal Year
GAO	Government Accountability Office
HCPCS	Healthcare Common Procedure Coding System
HIT	Health Information Technology
ICD-9-CM	International Classification of Diseases, Ninth Edition, Clinical Modification
IFC	Interim Final Rule with Comment Period
MDS	Minimum Data Set
MEDPAR	Medicare Provider Analysis and Review File
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub.L. 108-173
MSA	Metropolitan Statistical Area
NAICS	North American Industrial Classification System
OIG	Office of the Inspector General
OMB	Office of Management and Budget

OMRA	Other Medicare Required Assessment
PPI	Producer Price Index
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
SCHIP	State Children's Health Insurance Program
SIC	Standard Industrial Classification System
SNF	Skilled Nursing Facility
STM	Staff Time Measurement
UMRA	Unfunded Mandates Reform Act, Pub.L. 104-4

I. Background

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 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) relating to Medicare payments and consolidated billing for SNFs. Our most recent annual update occurred in a final rule (70 FR 45026, August 4, 2005) that set forth updates to the SNF PPS payment rates for fiscal year (FY) 2006. We subsequently published a correction notice (70 FR 57164, September 30, 2005) 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 Balanced Budget Act of 1997 (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 notice, we are updating the per diem payment rates for SNFs for FY 2007. Major elements of the SNF PPS include:

- Rates. As discussed in section I.F.1 of this notice, 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 furnished to Medicare beneficiaries in a SNF during a Part A covered stay. The rates are adjusted annually using a SNF market basket index, and also are adjusted by the hospital 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 have also been affected at various times by 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, phased 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 fiscal year.

- 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 notice.

- Consolidated Billing. The SNF PPS includes a consolidated billing provision that requires a SNF to submit consolidated Medicare bills to its fiscal intermediary 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 notice.

- 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 notice.

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 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 notice for a discussion of the relationship between the case-mix classification system and SNF level of care determinations).

This notice 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 per

cent 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 notice). 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 notice. 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 PPS for SNFs. 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 critical access hospital (CAH) swing-beds from the SNF PPS. We included further information on this provision in Program Memorandum A-01-09 (Change Request #1509), issued January 16, 2001, which is available online at www.cms.hhs.gov/transmittals/downloads/a0109.pdf.

- Section 311 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.

- Section 312 provided for a temporary 16.66 percent increase 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 General Accounting 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. GAO issued this report (GAO-03-176) in November 2002.

- Section 313 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 notice.)

- Section 314 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 notice. (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 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.

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 PPS for SNFs. Specifically, section 511

amended paragraph (12) of section 1888(e) of the Act to provide for a temporary 128 percent increase in the PPS per diem payment for any SNF resident with Acquired Immune Deficiency Syndrome (AIDS), effective with services furnished on or after October 1, 2004. This special AIDS add-on was to remain in effect until "***such date as the Secretary certifies that there is an appropriate adjustment in the case mix ***." The AIDS add-on is also discussed in Program Transmittal #160 (Change Request #3291), issued on April 30, 2004, which is available online at www.cms.hhs.gov/transmittals/downloads/r160cp.pdf. As discussed in the SNF PPS final rule for FY 2006 (70 FR 45028, August 4, 2005), 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 2004 data, we identified 909 SNF residents with a principal diagnosis code of 042 ("Human Immunodeficiency Virus (HIV) Infection"). The average payment per day for these residents was approximately $385. For FY 2007, an urban facility with a resident with AIDS in the SSA RUG would have a case-mix

adjusted payment of almost $242.90 (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 $553.81.

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). (A more detailed discussion of this provision appears in section IV. of this notice.)

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. The SNF PPS is one that 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 complete discussion of these provisions appears in the May 12, 1998 interim final rule (63 FR 26252).

1. Payment Provisions--Federal Rate

The PPS uses per diem Federal payment rates based on mean SNF costs in a base year updated for inflation to the first effective period of the PPS. We developed the Federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in FY 1995. The data used in developing the Federal rates also incorporated an estimate of the amounts that would be payable under Part B for covered SNF services furnished to individuals 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. Providers that received new provider exemptions from the routine cost limits were excluded from the database used to compute the Federal payment rates, as were costs related to payments for exceptions to the routine cost limits. In accordance with the formula prescribed in the BBA, we set the

Federal rates at a level equal to the weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and weighted mean of all SNF costs (hospital-based and freestanding) combined. We computed and applied separately the payment rates for facilities located in urban and rural areas. In addition, we adjusted the portion of the Federal rate attributable to wage-related costs by a wage index.

The Federal rate also incorporates adjustments to account for facility case-mix, using a classification system that accounts for the relative resource utilization of different patient types. This classification system, Resource Utilization Groups, version III (RUG-III), 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 complete and 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) appears 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 notice reflect an update to the rates that we published in the August 4, 2005 final rule for FY 2006 (70 FR 45026) and the associated correction notice (70 FR 57164, September 30, 2005), 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 notice.

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. The final rule for FY 2002 (66 FR 39562, July 31, 2001) revised and rebased the market basket to reflect 1997 total cost data.

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

forecast error from the most recently available fiscal year for which there is final data, and applies whenever the difference between the forecasted and actual change in the market basket exceeds a 0.25 percentage point threshold. For FY 2005 (the most recently available fiscal year for which there is final data), the estimated increase in the market basket index was 2.8 percentage points, while the actual increase was 2.9 percentage points, resulting in only a 0.1 percentage point difference. Accordingly, as the difference between the estimated and actual amount of change does not exceed the 0.25 percentage point threshold, the payment rates for FY 2007 do not include a forecast error adjustment. Table 1 below shows the forecasted and actual market basket amounts for FY 2005.

Table 1 - FY 2005 Forecast Error Correction for CMS SNF Market Basket

Index	Forecasted FY 2005 Increase*	Actual FY 2005 Increase**	FY 2005 Forecast Error Correction***
SNF	2.8	2.9	0.1

*Published in Federal Register; based on second quarter 2004 Global Insight Inc. forecast.
**Based on the second quarter 2006 Global Insight forecast.
***The FY 2005 forecast error correction for the PPS Operating portion will be applied to the FY 2007 PPS update recommendations. Any forecast error less than 0.25 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

A. Federal Prospective Payment System

This notice sets forth a schedule of Federal prospective payment rates applicable to Medicare Part A SNF services beginning October 1, 2006. The schedule incorporates per diem Federal rates that provide Part A payment for all costs of services furnished to a beneficiary in a SNF during a Medicare-covered stay.

1. Costs and Services Covered by the Federal Rates

The Federal rates apply to all costs (routine, ancillary, and capital-related) of covered SNF services other than costs associated with approved educational activities as defined in §413.85. Under section 1888(e)(2) of the Act, covered SNF services include post-hospital SNF services for which benefits are provided under Part A (the hospital insurance program), as well as all items and services (other than those services excluded by statute) that, before July 1, 1998, were paid under Part B (the supplementary medical insurance program) but furnished to Medicare beneficiaries in a SNF during a Part A covered stay. (These excluded service categories are discussed in greater detail in section V.B.2. of the May 12, 1998 interim final rule (63 FR 26295-97)).

2. Methodology Used for the Calculation of the Federal Rates

The FY 2007 rates reflect an update using the full amount of the latest market basket index. The FY 2007 market basket increase factor is 3.1 percent. A complete description of the multi-step process initially appeared in the May 12, 1998 interim final rule (63 FR 26252) and was 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 128 percent increase 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 fiscal year beginning October 1 2005, and ending September 30, 2006, and the midpoint of the Federal fiscal year beginning October 1, 2006, and ending September 30, 2007, 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 2007 by a factor equal to the full market basket index percentage increase. 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 2007.

Table 2
FY 2007 Unadjusted Federal Rate Per Diem
Urban

Rate Component	Nursing - Case-Mix	Therapy - Case-Mix	Therapy - Non-Case-mix	Non-Case-Mix
Per Diem Amount	$142.04	$106.99	$14.09	$72.49

Table 3
FY 2007 Unadjusted Federal Rate Per Diem
Rural

Rate Component	Nursing - Case-Mix	Therapy - Case-Mix	Therapy - Non-Case-mix	Non-Case-Mix
Per Diem Amount	$135.70	$123.37	$15.05	$73.83

B. Case-Mix Refinements

Under the BBA, each update of the SNF PPS payment rates must include the case-mix classification methodology applicable for the coming Federal fiscal year. As indicated in section I.F.1. of this notice, the payment rates set forth in this notice reflect the use of the refined 53-group RUG-III case-mix classification system (RUG-53) that we discussed in detail in the proposed and final rules for FY 2006 (70 FR 29070, May 19, 2005, and 70 FR 45026, August 4, 2005). As noted in the FY 2006 final rule, we deferred RUG-53

implementation from the beginning of FY 2006 (October 1, 2005) until January 1, 2006, in order to allow for sufficient time to prepare for and ease the transition to the refinements (70 FR 45034).

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	1.9	2.25	269.88	240.73		72.49	583.10
RUL	1.4	2.25	198.86	240.73		72.49	512.08
RVX	1.54	1.41	218.74	150.86		72.49	442.09
RVL	1.33	1.41	188.91	150.86		72.49	412.26
RHX	1.42	0.94	201.70	100.57		72.49	374.76
RHL	1.37	0.94	194.59	100.57		72.49	367.65
RMX	1.93	0.77	274.14	82.38		72.49	429.01
RML	1.68	0.77	238.63	82.38		72.49	393.50
RLX	1.31	0.43	186.07	46.01		72.49	304.57
RUC	1.28	2.25	181.81	240.73		72.49	495.03
RUB	0.99	2.25	140.62	240.73		72.49	453.84
RUA	0.84	2.25	119.31	240.73		72.49	432.53

RVC	1.23	1.41	174.71	150.86		72.49	398.06
RVB	1.09	1.41	154.82	150.86		72.49	378.17
RVA	0.82	1.41	116.47	150.86		72.49	339.82
RHC	1.22	0.94	173.29	100.57		72.49	346.35
RHB	1.11	0.94	157.66	100.57		72.49	330.72
RHA	0.94	0.94	133.52	100.57		72.49	306.58
RMC	1.15	0.77	163.35	82.38		72.49	318.22
RMB	1.09	0.77	154.82	82.38		72.49	309.69
RMA	1.04	0.77	147.72	82.38		72.49	302.59
RLB	1.14	0.43	161.93	46.01		72.49	280.43
RLA	0.85	0.43	120.73	46.01		72.49	239.23
SE3	1.86		264.19		14.09	72.49	350.77
SE2	1.49		211.64		14.09	72.49	298.22
SE1	1.26		178.97		14.09	72.49	265.55
SSC	1.23		174.71		14.09	72.49	261.29
SSB	1.13		160.51		14.09	72.49	247.09
SSA	1.1		156.24		14.09	72.49	242.82
CC2	1.22		173.29		14.09	72.49	259.87
CC1	1.06		150.56		14.09	72.49	237.14
CB2	0.98		139.20		14.09	72.49	225.78
CB1	0.91		129.26		14.09	72.49	215.84
CA2	0.9		127.84		14.09	72.49	214.42
CA1	0.8		113.63		14.09	72.49	200.21
IB2	0.74		105.11		14.09	72.49	191.69
IB1	0.72		102.27		14.09	72.49	188.85
IA2	0.61		86.64		14.09	72.49	173.22
IA1	0.56		79.54		14.09	72.49	166.12
BB2	0.73		103.69		14.09	72.49	190.27
BB1	0.69		98.01		14.09	72.49	184.59
BA2	0.6		85.22		14.09	72.49	171.80
BA1	0.52		73.86		14.09	72.49	160.44
PE2	0.85		120.73		14.09	72.49	207.31
PE1	0.82		116.47		14.09	72.49	203.05
PD2	0.78		110.79		14.09	72.49	197.37
PD1	0.76		107.95		14.09	72.49	194.53
PC2	0.71		100.85		14.09	72.49	187.43
PC1	0.69		98.01		14.09	72.49	184.59
PB2	0.55		78.12		14.09	72.49	164.70
PB1	0.54		76.70		14.09	72.49	163.28
PA2	0.53		75.28		14.09	72.49	161.86
PA1	0.5		71.02		14.09	72.49	157.60

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

RURAL

RUG III Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RUX	1.9	2.25	257.83	277.58		73.83	609.24
RUL	1.4	2.25	189.98	277.58		73.83	541.39
RVX	1.54	1.41	208.98	173.95		73.83	456.76
RVL	1.33	1.41	180.48	173.95		73.83	428.26
RHX	1.42	0.94	192.69	115.97		73.83	382.49
RHL	1.37	0.94	185.91	115.97		73.83	375.71
RMX	1.93	0.77	261.90	94.99		73.83	430.72
RML	1.68	0.77	227.98	94.99		73.83	396.80
RLX	1.31	0.43	177.77	53.05		73.83	304.65
RUC	1.28	2.25	173.70	277.58		73.83	525.11
RUB	0.99	2.25	134.34	277.58		73.83	485.75
RUA	0.84	2.25	113.99	277.58		73.83	465.40
RVC	1.23	1.41	166.91	173.95		73.83	414.69
RVB	1.09	1.41	147.91	173.95		73.83	395.69
RVA	0.82	1.41	111.27	173.95		73.83	359.05
RHC	1.22	0.94	165.55	115.97		73.83	355.35
RHB	1.11	0.94	150.63	115.97		73.83	340.43
RHA	0.94	0.94	127.56	115.97		73.83	317.36
RMC	1.15	0.77	156.06	94.99		73.83	324.88
RMB	1.09	0.77	147.91	94.99		73.83	316.73
RMA	1.04	0.77	141.13	94.99		73.83	309.95
RLB	1.14	0.43	154.70	53.05		73.83	281.58
RLA	0.85	0.43	115.35	53.05		73.83	242.23
SE3	1.86		252.40		15.05	73.83	341.28
SE2	1.49		202.19		15.05	73.83	291.07
SE1	1.26		170.98		15.05	73.83	259.86
SSC	1.23		166.91		15.05	73.83	255.79
SSB	1.13		153.34		15.05	73.83	242.22
SSA	1.10		149.27		15.05	73.83	238.15
CC2	1.22		165.55		15.05	73.83	254.43
CC1	1.06		143.84		15.05	73.83	232.72
CB2	0.98		132.99		15.05	73.83	221.87
CB1	0.91		123.49		15.05	73.83	212.37
CA2	0.90		122.13		15.05	73.83	211.01
CA1	0.80		108.56		15.05	73.83	197.44
IB2	0.74		100.42		15.05	73.83	189.30
IB1	0.72		97.70		15.05	73.83	186.58
IA2	0.61		82.78		15.05	73.83	171.66
IA1	0.56		75.99		15.05	73.83	164.87
BB2	0.73		99.06		15.05	73.83	187.94
BB1	0.69		93.63		15.05	73.83	182.51
BA2	0.60		81.42		15.05	73.83	170.30
BA1	0.52		70.56		15.05	73.83	159.44

PE2	0.85		115.35		15.05	73.83	204.23
PE1	0.82		111.27		15.05	73.83	200.15
PD2	0.78		105.85		15.05	73.83	194.73
PD1	0.76		103.13		15.05	73.83	192.01
PC2	0.71		96.35		15.05	73.83	185.23
PC1	0.69		93.63		15.05	73.83	182.51
PB2	0.55		74.64		15.05	73.83	163.52
PB1	0.54		73.28		15.05	73.83	162.16
PA2	0.53		71.92		15.05	73.83	160.80
PA1	0.50		67.85		15.05	73.83	156.73

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 are continuing that practice for FY 2007.

We apply the wage index adjustment to the labor-related portion of the Federal rate, which is 75.839 percent of the total rate. This percentage reflects the labor-related relative importance for FY 2007. The labor-related relative importance for FY 2006 was 75.922, 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 2007. 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 2007 than the base year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2007 in four steps. First, we compute the FY 2007 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 2007 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2007 relative importance for each cost category by multiplying this ratio by the base year (FY 1997) weight. Finally, we sum the FY 2007 relative importance for each of the labor-related cost categories (wages and salaries, employee benefits, nonmedical professional fees, labor-intensive services, and a portion of capital-related expenses) to produce the FY 2007 labor-related relative importance. Tables 6 and 7 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	583.10	442.22	140.88

RUL	512.08	388.36	123.72
RVX	442.09	335.28	106.81
RVL	412.26	312.65	99.61
RHX	374.76	284.21	90.55
RHL	367.65	278.82	88.83
RMX	429.01	325.36	103.65
RML	393.50	298.43	95.07
RLX	304.57	230.98	73.59
RUC	495.03	375.43	119.60
RUB	453.84	344.19	109.65
RUA	432.53	328.03	104.50
RVC	398.06	301.88	96.18
RVB	378.17	286.80	91.37
RVA	339.82	257.72	82.10
RHC	346.35	262.67	83.68
RHB	330.72	250.81	79.91
RHA	306.58	232.51	74.07
RMC	318.22	241.33	76.89
RMB	309.69	234.87	74.82
RMA	302.59	229.48	73.11
RLB	280.43	212.68	67.75
RLA	239.23	181.43	57.80
SE3	350.77	266.02	84.75
SE2	298.22	226.17	72.05
SE1	265.55	201.39	64.16
SSC	261.29	198.16	63.13
SSB	247.09	187.39	59.70
SSA	242.82	184.15	58.67
CC2	259.87	197.08	62.79
CC1	237.14	179.84	57.30
CB2	225.78	171.23	54.55
CB1	215.84	163.69	52.15
CA2	214.42	162.61	51.81
CA1	200.21	151.84	48.37
IB2	191.69	145.38	46.31
IB1	188.85	143.22	45.63
IA2	173.22	131.37	41.85
IA1	166.12	125.98	40.14
BB2	190.27	144.30	45.97
BB1	184.59	139.99	44.60
BA2	171.80	130.29	41.51
BA1	160.44	121.68	38.76
PE2	207.31	157.22	50.09
PE1	203.05	153.99	49.06
PD2	197.37	149.68	47.69
PD1	194.53	147.53	47.00
PC2	187.43	142.15	45.28

PC1	184.59	139.99	44.60
PB2	164.70	124.91	39.79
PB1	163.28	123.83	39.45
PA2	161.86	122.75	39.11
PA1	157.60	119.52	38.08

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	609.24	462.04	147.20
RUL	541.39	410.58	130.81
RVX	456.76	346.40	110.36
RVL	428.26	324.79	103.47
RHX	382.49	290.08	92.41
RHL	375.71	284.93	90.78
RMX	430.72	326.65	104.07
RML	396.80	300.93	95.87
RLX	304.65	231.04	73.61
RUC	525.11	398.24	126.87
RUB	485.75	368.39	117.36
RUA	465.40	352.95	112.45
RVC	414.69	314.50	100.19
RVB	395.69	300.09	95.60
RVA	359.05	272.30	86.75
RHC	355.35	269.49	85.86
RHB	340.43	258.18	82.25
RHA	317.36	240.68	76.68
RMC	324.88	246.39	78.49
RMB	316.73	240.20	76.53
RMA	309.95	235.06	74.89
RLB	281.58	213.55	68.03
RLA	242.23	183.70	58.53
SE3	341.28	258.82	82.46
SE2	291.07	220.74	70.33
SE1	259.86	197.08	62.78
SSC	255.79	193.99	61.80
SSB	242.22	183.70	58.52
SSA	238.15	180.61	57.54
CC2	254.43	192.96	61.47
CC1	232.72	176.49	56.23
CB2	221.87	168.26	53.61
CB1	212.37	161.06	51.31

CA2	211.01	160.03	50.98
CA1	197.44	149.74	47.70
IB2	189.30	143.56	45.74
IB1	186.58	141.50	45.08
IA2	171.66	130.19	41.47
IA1	164.87	125.04	39.83
BB2	187.94	142.53	45.41
BB1	182.51	138.41	44.10
BA2	170.30	129.15	41.15
BA1	159.44	120.92	38.52
PE2	204.23	154.89	49.34
PE1	200.15	151.79	48.36
PD2	194.73	147.68	47.05
PD1	192.01	145.62	46.39
PC2	185.23	140.48	44.75
PC1	182.51	138.41	44.10
PB2	163.52	124.01	39.51
PB1	162.16	122.98	39.18
PA2	160.80	121.95	38.85
PA1	156.73	118.86	37.87

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 2007 (Federal rates effective October 1, 2006), we are applying the most recent wage index using the hospital wage data, and applying an adjustment to fulfill the budget neutrality requirement. We meet this requirement by multiplying each of the components of the unadjusted Federal rates by a factor equal to the ratio of the volume weighted mean wage adjustment factor (using the wage index from the previous year) to the volume weighted mean wage adjustment factor, using the wage index for the FY beginning

October 1, 2006. We use the same volume weights in both the numerator and denominator, and derive them from the 1997 Medicare Provider Analysis and Review File (MEDPAR) data. 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. The budget neutrality factor for this year is 1.0013.

The wage index applicable to FY 2007 appears in Table 8 and Table 9 in the Addendum of this notice. 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.

In the SNF PPS final rule for FY 2006 (70 FR 45026), we adopted the changes discussed in the Office of Management and Budget (OMB) Bulletin No. 03-04 (June 6, 2003), which announced revised definitions for Metropolitan Statistical Areas (MSAs), and the creation of Micropolitan Statistical Areas and Combined Statistical Areas. 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), in FY 2007 we will be using the full CBSA-based wage index values as presented in Tables 8 and 9.

Finally, we continue to use the same methodology discussed in the SNF PPS proposed rule for FY 2006 (70 FR 29095, May 19, 2005) and finalized in the SNF PPS final rule for FY 2006 (70 FR 45041, August 4, 2005) to address those geographic areas where there were no hospitals and, thus, no hospital wage index data on which to base the calculation of the FY 2007 SNF PPS wage index. For FY 2007, those areas consist of rural Massachusetts, rural Puerto Rico and urban CBSA (25980) Hinesville-Fort Stewart, GA.

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 payment rates listed here reflect an update equal to the full SNF market basket, which equals 3.1 percentage points. We will 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 fiscal year.

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 53-group RUG-III case-mix classification system (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 notice, 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 XYZ SNF described in Table 10, 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, 2006. SNF XYZ's total PPS payment would equal $28,709. The Labor and Non-labor columns are derived from Table 6.

Table 10
RUG-53

SNF XYZ: Located in Cedar Rapids, IA (Urban CBSA 16300)
Wage Index: 0.8888

RUG Group	Labor	Wage index	Adj. Labor	Non-Labor	Adj. Rate	Percent Adj	Medicare Days	Payment
RVX	$335.28	0.8888	$298.00	$106.81	$404.81	$404.81	14	$5,667.00
RLX	$230.98	0.8888	$205.30	$73.59	$278.89	$278.89	30	$8,367.00
RHA	$232.51	0.8888	$206.65	$74.07	$280.72	$280.72	16	$4,492.00
CC2	$197.08	0.8888	$175.16	$62.79	$237.95	$542.54	10	$5,425.00
IA2	$131.37	0.8888	$116.76	$41.85	$158.61	$158.61	30	$4,758.00
							100	$28,709.00

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

III. The Skilled Nursing Facility Market Basket Index

Section 1888(e)(5)(A) of the Act requires us to establish a SNF market basket index (input price index) that reflects changes over time in the prices of an appropriate mix of goods and services included in the SNF PPS. This notice incorporates the latest available projections of the SNF market basket index. 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.

In constructing the SNF market basket, we used the methodology set forth in the SNF PPS final rule for FY 2002 (66 FR 39584, July 31, 2001), when we last revised and rebased the SNF market basket. In that final rule, we included a complete discussion on the rebasing of the SNF market basket to FY 1997. There are 21 separate cost categories and

respective price proxies. These cost categories appeared in Tables 10.A, 10.B, and Appendix A, along with other relevant information, in the FY 2002 final rule. As discussed in that final rule, the SNF market basket primarily uses the Bureau of Labor Statistics' (BLS) data as price proxies, which are grouped in one of the three BLS categories: Producer Price Indexes (PPI), Consumer Price Indexes (CPI), and Employment Cost Indexes (ECI).

Beginning in April 2006, with the publication of March 2006 data, the BLS' ECI is using a different classification system, the North American Industrial Classification System (NAICS), instead of the Standard Industrial Classification System (SIC), which no longer exists. We have consistently used the ECI as the data source for wages and salaries and other price proxies in the SNF market basket and are not making any changes to the usage at this time. However, we welcome input on our continued use of the BLS ECI data in light of the BLS change to the NAICS-based ECI. Interested parties who would like to provide input on this issue are invited to do so by contacting Jeanette Kranacs or Bill Ullman (please refer to the section entitled **FOR FURTHER INFORMATION CONTACT** at the beginning of this document).

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 summarizes the updated labor-related share for FY 2007.

Table 11 - Labor-related Relative Importance, FY 2006 and FY 2007

	Relative importance, labor-related, FY 2006 (97 index) 05:2 forecast	Relative importance, labor-related, FY 2007 (97 index) 06:2 forecast
Wages and salaries	54.391	54.231
Employee benefits	11.648	11.903
Nonmedical professional fees	2.739	2.721
Labor-intensive services	4.128	4.035
Capital-related (.391)	3.016	2.949
Total	75.922	75.839

Source: Global Insights, Inc., formerly DRI-WEFA, 2nd Quarter, 2006.

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, as described in the previous section, from the average of the prior fiscal year to the average of the current fiscal year. For the Federal rates established in this notice, we use the percentage increase in the SNF market basket index to compute the update factor for FY 2007. We use the Global Insight, Inc. (formerly DRI-WEFA), 2nd quarter 2006 forecasted percentage increase in the FY 1997-based SNF market basket index for routine, ancillary, and capital-related expenses, described in the previous section, to compute the update factor in this notice. Finally, as discussed in

section I.A. of this notice, we no longer compute update factors to adjust a facility-specific portion of the SNF PPS rates, because the initial 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 42 CFR 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 fiscal year for which there is final data, and apply whenever the difference between the forecasted and actual change in the market basket exceeds a 0.25 percentage point threshold. As discussed previously in section I.F.2. of this notice, as the difference between the estimated and actual amounts of increase in the market basket index for FY 2005 (the most recently available fiscal year for which there is final data) do not exceed the 0.25 percentage point threshold, the payment rates for FY 2007 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 2007 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, 2005 through September 30, 2006 to the average market basket level for the period of October 1, 2006 through September 30, 2007. Using this process, the market basket update factor for FY 2007 SNF Federal rates is 3.1 percent. We used this revised update factor to compute the Federal portion of the SNF PPS rate shown in Tables 2 and 3.

IV. Consolidated Billing

Section 4432(b) of the BBA established a consolidated billing requirement that places with the SNF the Medicare billing responsibility for virtually all of the services that the SNF's residents receive, except for a small number of services that the statute specifically identifies as being excluded from this provision. As noted previously in section I. of this notice, 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 19231-19232, April 10, 2000, and 65 FR 46790-46795, July 31, 2000), as well as in Program Memorandum AB-00-18 (Change Request #1070), issued March 2000, which is available online at www.cms.hhs.gov/transmittals/downloads/ab001860.pdf. Section 313 of the BIPA further amended this provision by repealing its Part B aspect; that is, its applicability to services furnished to a resident during a SNF stay that Medicare does not cover. (However, physical, occupational, and speech-language therapy remain subject to consolidated billing, regardless of whether the resident who receives these services is in a covered Part A stay.) We discuss this BIPA amendment in greater detail in the proposed and final rules for FY 2002 (66 FR 24020-24021, May 10, 2001, and 66 FR 39587-39588, 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 www.cms.hhs.gov/transmittals/downloads/r390cp.pdf. To date, the Congress has enacted no further legislation affecting the consolidated billing provision.

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

In accordance with section 1888(e)(7) of the Act as amended by section 203 of the BIPA, Part A pays CAHs on a reasonable cost basis for SNF services furnished under a swing-bed agreement, as previously indicated in sections I.A. and I.D. of this notice. 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 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 notice for the SNF PPS also apply to all swing-bed rural hospitals.

A complete discussion of assessment schedules, the MDS and the transmission software (Raven-SB for Swing Beds) appears in the final rule for FY 2002 (66 FR 39562, July 31, 2001). The latest changes in the MDS for swing-bed rural hospitals appear on our SNF PPS website, www.cms.hhs.gov/snfpps.

VI. Other Issues

Both Medicare's payment structures and the actual delivery of post acute care have evolved significantly over the past decade. Before the BBA, SNFs and other post-acute settings such as inpatient rehabilitation facilities (IRFs) were paid on the basis of cost. Since that time, we have implemented various legislative mandates that established prospective payment systems in these settings. The PPS methodologies used in these settings rely on patient-level clinical information to provide pricing, support the provision of high quality services, and encourage the efficient delivery of care.

CMS is exploring refinements to the existing provider-oriented "silos" to create a more seamless system for payment and delivery of post-acute care (PAC) under Medicare. This new model could feature more consistent payments for the same type of care across different sites of service, Value Based Purchasing incentives, and collection of uniform clinical assessment information to support quality and discharge

planning functions.

Section 5008 of the Deficit Reduction Act of 2005 (DRA) provides a pathway to achieve the goals of the new model by providing for a demonstration on uniform assessment and data collection across different sites of service. This 3-year demonstration project is to be established by January 1, 2008. We are in the early stages of developing a standard, comprehensive assessment instrument to be completed at hospital discharge and ultimately integrated with PAC assessments. The demonstration will enable us to test the usefulness of this instrument, and analyze cost and outcomes across different PAC sites. The lessons learned from this demonstration will inform efforts to improve the post-acute payment systems. We intend for the instrument to cover the population admitted to all institutional PAC settings (SNFs, IRFs, and long-term care hospitals) as well as residential-based PAC (home health agencies, outpatient programs).

We have evaluated the existing assessment instruments that managed care and other insurers use. These instruments will form the basis of our efforts to create a discharge assessment tool that can serve to: facilitate post-hospital placement decision making; enhance the safety and quality of care during patient transfers through transmission of core information to a receiving provider; and provide baseline

information for longitudinal follow-up of health and function.

In addition, we are developing the Nursing Home Value Based Purchasing Demonstration as part of a broad effort at CMS to eliminate wasteful Medicare spending and improve quality of care through Value Based Purchasing initiatives. We plan to invite State agencies to participate in a demonstration project where nursing homes would be eligible for additional payment based upon review of certain quality measures.

In the April 25, 2006 Inpatient Prospective Payment Systems (IPPS) proposed rule (71 FR 23996), we discussed in detail the Health Care Information Transparency Initiative and our efforts to promote effective use of health information technology (HIT) as a means of improving health care quality and efficiency. Specifically, we discussed several potential options under the transparency initiative for making pricing and quality information more readily available to the public (71 FR 24120 through 24121), with the expectation that this will assist the patient--as the ultimate consumer of health care--in making cost-effective purchasing decisions. We solicited comments on ways the Department can encourage transparency in health care quality and pricing, whether through its leadership on voluntary initiatives or through regulatory requirements. We also sought comments on the

Department's statutory authority to impose such requirements. In addition, we discussed the potential for HIT to facilitate improvements in the quality and efficiency of health care services (71 FR 24100 through 24101). We solicited comments on our statutory authority to encourage the adoption and use of HIT. The President's 2007 Budget for Health and Human Services states that "the Administration supports the adoption of health information technology (HIT) as a normal cost of doing business to ensure patients receive high quality care." We also sought comments on the appropriate role of HIT in potential value-based purchasing programs, beyond the intrinsic incentives of a PPS to provide efficient care, encourage the avoidance of unnecessary costs, and increase quality of care. In addition, we sought comments on promotion of the use of effective HIT through Medicare conditions of participation.

Further, the Nursing Home Quality Initiative was launched in 2002 with the cooperation of the major nursing home professional associations and the CMS Quality Improvement Organization (QIO) program. While this initiative has already achieved significant progress nationally in reducing the use of physical restraints and in reducing the number of residents in moderate or severe pain, more can be done.

Accordingly, we plan to initiate a new Nursing Home

Quality Campaign this fall, which will be conducted over the next two years (through 2008). The purpose of this new Quality Campaign will be to build upon the past successes of the Nursing Home Quality Initiative, and spread the knowledge of quality improvement in the nursing home setting more widely across the country. The ultimate objective of this new Nursing Home Quality Campaign is to make a real difference in the quality of life and efficiency of care delivery in nursing homes, by accelerating progress in identifying and treating pain and pressure ulcers, by virtually eliminating the use of physical restraints, and by transforming the nursing home work environment to attract and retain nursing and other staff. More information about the campaign, and free evidence-based improvement materials, can be found at: www.medqic.org.

At this time, we do not offer specific proposals related to the preceding discussion. However, we believe that it is useful to encourage discussion of a broad range of ideas in order to assess the relative advantages and disadvantages of the various policies affecting PAC sites. We note that we are in the process of seeking input on these initiatives in various proposed Medicare payment rules being issued this year. In particular, we intend to consider both the health care information transparency initiative and the use of HIT as we refine and update all Medicare payment systems.

VII. Collection of Information Requirements

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

VIII. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA, Pub. L. 96-354, September 16, 1980), section 1102(b) of the Social Security Act (the Act), the Unfunded Mandates Reform Act of 1995 (UMRA, Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) 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 notice is a major rule, as defined in Title 5, United States Code, section 804(2), because we estimate the impact of the standard update will be to increase payments to SNFs by approximately $560 million.

The update set forth in this notice applies to payments in FY 2007. Accordingly, the analysis that follows describes the impact of this one year only. In accordance with the requirements of the Act, we will publish a notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. 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 notice updates the SNF PPS rates published in the final rule for FY 2006 (70 FR 45026, August 4, 2005) and the associated correction notice (70 FR 57164, September 30, 2005), thereby increasing aggregate payments by an estimated $560 million. As indicated in Table 12, the effect on facilities will be an aggregate positive impact of 3.1 percent. We note that some individual providers may experience larger increases in payments than others due to the distributional impact of the FY 2007 wage indexes and the degree of Medicare utilization. While this notice is considered major, its overall impact is extremely small; that is, less than 3 percent of total SNF revenues from all payor sources. As the overall impact is positive on the industry as a whole, and on small entities specifically, it is not necessary to consider regulatory alternatives.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. Because the increase in SNF payment rates set forth in this notice also applies to rural

hospital swing-bed services, we believe that this notice will have a positive fiscal impact on swing-bed rural hospitals.

Section 202 of the UMRA also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million or more. This notice will 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 notice will have no substantial effect on State and local governments.

B. Anticipated Effects

This notice sets forth updates of the SNF PPS rates contained in the final rule for FY 2006 (70 FR 45026, August 4, 2005) and the associated correction notice (70 FR 57164, September 30, 2005). Based on the above, we estimate the FY 2007 impact will be a net increase of $560 million in payments to SNF providers. The impact analysis of this notice represents the projected effects of the changes in the SNF PPS from FY 2006 to FY 2007. 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 such an analysis is future-oriented and, thus, very susceptible to forecasting errors due to other changes in the forecasted impact time period. Some examples of such possible events are newly-legislated general Medicare program funding changes by the Congress, or changes specifically related to SNFs. In addition, changes to the Medicare program may continue to be made as a result of the BBA, the BBRA, the BIPA, the MMA, or new statutory provisions. Although these changes may not be specific to the SNF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon SNFs.

In accordance with section 1888(e)(4)(E) of the Act, we update the payment rates for FY 2007 by a factor equal to the full market basket index percentage increase to determine the payment rates for FY 2007. 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 2,000 beneficiaries who qualify for the AIDS add-on payment. The impact to Medicare is included in the "total" column of Table 12. In updating the rates for FY 2007, we made a number of standard annual revisions and clarifications mentioned elsewhere in this notice (for example, the update to the wage and market basket indexes used for adjusting the Federal rates). These revisions will increase payments to SNFs by approximately $560 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 impact of updating the wage data for the rural Outlying region increased by 3.2 percent (reflecting the wage index increase for only one provider).

The fourth column of the table shows the effect of moving from the FY 2006 transition-based wage index to using the new OMB geographic designations based on CBSAs. During the FY 2006 transition to CBSAs, SNFs received a transition-based wage index value consisting 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. For FY 2007, SNFs will receive the FY 2007 CBSA-based wage index values.

The fifth column shows the effect of all of the changes on the FY 2007 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 increase by 3.1

percent in total, assuming facilities do not change their care delivery and billing practices in response.

As can be seen from this table, the combined effects of all of the changes vary by specific types of providers and by location. For example, though facilities in the rural Mountain region experience only a slight payment increase of 1.2, some providers (such as those in the urban Mountain region) show a greater increase of 4.2 percent. Payment increases for facilities in the urban Mountain area of the country are the highest for any provider category.

Table 12
Projected Impact to the SNF PPS for FY 2007

	Number of facilities	Update wage data	Transition to full CBSA	Total FY 2007 change
Total	15,645	0.0%	0.0%	3.1%
Urban	10,629	0.0%	0.1%	3.2%
Rural	5,016	0.1%	-0.5%	2.7%
Hospital based urban	1,432	0.1%	0.0%	3.2%
Freestanding urban	9,197	0.0%	0.1%	3.2%
Hospital based rural	1,252	0.1%	-0.4%	2.8%
Freestanding rural	3,764	0.1%	-0.5%	2.7%
Urban by region				
New England	902	-0.3%	-0.3%	2.5%
Middle Atlantic	1,504	0.1%	0.1%	3.3%
South Atlantic	1,741	-0.4%	0.1%	2.8%
East North Central	2,010	0.3%	0.1%	3.5%
East South Central	529	-0.3%	0.3%	3.1%
West North Central	854	0.1%	0.2%	3.4%
West South Central	1,144	-0.4%	0.2%	2.9%
Mountain	462	0.8%	0.3%	4.2%
Pacific	1,477	0.3%	0.0%	3.4%
Outlying	6	0.4%	0.0%	3.5%
Rural by region				
New England	136	-1.0%	0.0%	2.1%
Middle Atlantic	256	0.7%	-0.6%	3.2%
South Atlantic	617	-0.1%	-0.8%	2.2%
East North Central	943	-0.1%	-0.5%	2.5%

East South Central	572	0.3%	-0.3%	3.1%
West North Central	1,214	0.5%	-0.1%	3.5%
West South Central	813	0.1%	-0.4%	2.8%
Mountain	296	-0.3%	-1.5%	1.2%
Pacific	167	0.2%	0.0%	3.3%
Outlying	2	3.2%	-2.9%	3.3%
Ownership				
Government	718	0.0%	0.1%	3.2%
Proprietary	11,324	0.0%	0.0%	3.1%
Voluntary	3,603	0.1%	-0.1%	3.1%

C. 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 final rule. This table provides our best estimate of the change in Medicare payments under the SNF PPS as a result of the policies in this update notice based on the data for 15,645 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 2006 SNF PPS Rate Year to the 2007 SNF PPS Rate Year (in Millions)

Category	Transfers
Annualized Monetized Transfers	$560 million
From Whom To Whom?	Federal Government to SNF Medicare Providers

D. 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, such as case-mix classification methodology, the MDS assessment schedule, a market basket index, a wage index, and the urban and rural distinction used in the development or adjustment of the Federal rates. Further, section 1888(e)(4)(H) of the Act specifically requires us to disseminate the payment rates for each new fiscal year through the **Federal Register**, and to do so before the August 1 that precedes the start of the new fiscal year. Accordingly, we are not pursuing alternatives with respect to the payment methodology.

E. Conclusion

This notice does not initiate any policy changes with regard to the SNF PPS; rather, it simply provides an update to the rates for FY 2007. Therefore, for the reasons set forth in the preceding discussion, we are not preparing analyses for either the RFA or section 1102(b) of the Act, because we have determined that this notice will not have a significant economic impact on a substantial number of small entities or a

significant impact on the operations of a substantial number of small rural hospitals.

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

IX. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a notice such as this take effect. We can waive this procedure, however, if we find good cause that notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporate a statement of the finding and the reasons for it into the notice issued.

We believe it is unnecessary to undertake notice and comment rulemaking in this instance, as the statute requires annual updates to the SNF PPS rates, the methodologies used to update the rates have been previously subject to public comment, and this notice initiates no policy changes with regard to the SNF PPS but simply reflects the application of previously established methodologies. Therefore, we find good cause to waive notice and comment procedures.

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

Dated: _____

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Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services

Dated: _____

_____

Michael O. Leavitt,

Secretary

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