DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 411, 413, 440, 483, 488, and 489

[CMS–1469–F]

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

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

ACTION: Final rule.

SUMMARY: This final rule updates the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2004. Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act (the Act), as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), relating to Medicare payments and consolidated billing for SNFs.

DATES: *Effective Date:* This regulation becomes effective on October 1, 2003.

FOR FURTHER INFORMATION CONTACT: John Davis, (410) 786–0008 (for information related to the Wage Index, and for information related to swing-bed providers).

Ellen Gay, (410) 786–4528 (for information related to the case-mix classification methodology, and for information related to swing-bed providers).

Sheila Lambowitz, (410) 786–7605 (for information related to the SNF Market Basket Index and forecast error).

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

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Regulation Text

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

AHE Average Hourly Earnings
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
CFR Code of Federal Regulations
CMS Centers for Medicare & Medicaid Services
ECEC Employer Cost for Employee Compensation
ECI Employment Cost Index
FI Fiscal Intermediary
FR Federal Register
FY Fiscal Year
GAO General Accounting Office
HCPCS Healthcare Common Procedure Coding System
IFC Interim Final Rule with Comment Period
MDS Minimum Data Set
MedPAC Medicare Payment Advisory Commission
MEDPAR Medicare Provider Analysis and Review File
MSA Metropolitan Statistical Area
NF Nursing Facility
PPI Producer Price Indices
PPS Prospective Payment System
QIO Quality Improvement Organization
RAVEN Resident Assessment Validation Entry
RFA Regulatory Flexibility Act (Pub. L. 96–354)
RIA Regulatory Impact Analysis
RUG Resource Utilization Groups
SCHIP State Children's Health Insurance Program
SNF Skilled Nursing Facility
UMRA Unfunded Mandates Reform Act (Pub. L. 104–4)

I. Background

On May 16, 2003, we published a proposed rule (hereinafter referred to as the ''proposed rule'') in the **Federal Register** (68 FR 26758), setting forth the proposed updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for FY 2004. 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 (Pub. L. 106–113) (the BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) (the BIPA), relating to Medicare payments and consolidated billing for SNFs. In the proposed rule, we invited public comments on a number of proposed revisions and technical corrections to the associated regulations. Following the publication of that proposed rule, we then published a supplemental proposed rule (hereinafter referred to as the ''supplemental proposed rule'') on June 10, 2003 (68 FR 34768), in which we invited public comments on possibly revising the annual update methodology by establishing an adjustment to account for forecast error. In addition, we also invited comments on ways to ensure that additional payments that could result from such an adjustment would be used to promote quality of care in the SNF setting (including direct care services to residents).

A. Current System for Payment of SNF Services Under Part A of the Medicare Program

Section 4432 of the Balanced Budget Act of 1997 (Pub. L. 105–33) (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. We are updating the per diem payment rates for SNFs for FY 2004. Major elements of the SNF PPS include:

• *Rates.* Per diem Federal rates were established for urban and rural areas using allowable costs from FY 1995 cost reports. These rates also included an estimate of the cost of services that, before July 1, 1998, were paid under Part B but furnished to Medicare beneficiaries in a SNF during a Part A covered stay. The rates were adjusted annually using a SNF market basket index. Rates were case-mix adjusted using a classification system (Resource Utilization Groups, version III (RUG–III)) based on beneficiary assessments (using the Minimum Data Set (MDS) 2.0). The rates were also adjusted by the hospital wage index to account for geographic variation in wages. (In section III.C of this final rule, we discuss the wage index adjustment in detail.) A correction notice was published on December 27, 2002 (67 FR 79123) that announced corrections to several of the wage factors. Additionally, as noted in the July 31, 2002 update notice (67 FR 49798), section 101 of the BBRA and certain sections of the BIPA also affect the payment rate.

• *Transition.* The SNF PPS included an initial 3-year, phased transition that blended a facility-specific payment rate with the Federal case-mix adjusted rate. For each cost reporting period after a facility migrated to the new system, the facility-specific portion of the blend decreased and the Federal portion increased in 25 percentage point increments. For most facilities, the facility-specific rate was based on allowable costs from FY 1995; however, since the last year of the transition was FY 2001, all facilities were paid at the full Federal rate by the following fiscal year (FY 2002). Therefore, we are no longer including 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 involving level of care determinations with the outputs of beneficiary assessment and RUG–III classifying activities. We discuss this coordination in greater detail in section III.E of this final rule. Another SNF benefit requirement is that the SNF must be certified by Medicare as meeting the requirements for program participation contained in section 1819 of the Act. This provision of the law defines a SNF as ''* * * an institution (or a distinct part of an institution). * * *'' In section III.K of this final rule, we discuss a clarification that we are making in defining the term ''distinct part'' with respect to SNFs.

• *Consolidated Billing.* The SNF PPS includes a consolidated billing provision that requires a SNF to submit consolidated Medicare bills for almost all of the services that the resident receives 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 from the consolidated billing provision a few services—primarily those of physicians and certain other types of practitioners—which remain separately billable to Part B by the outside entity that furnishes them. We discuss this provision in greater detail in section III.I of this final 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 III.J of this final rule.

• *Technical corrections.* We are also taking this opportunity to make a number of technical corrections in the text of the regulations, as discussed in greater detail in section IV of this final rule.

B. Requirements of the Balanced Budget Act of 1997 (the BBA) for Updating the SNF PPS

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 fiscal year.
2. The case-mix classification system to be applied with respect to these services during the fiscal year.
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 III.E of this final rule).

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

There were several provisions in the BBRA that resulted in adjustments to the SNF PPS. These provisions were described in detail in the final rule that we published in the **Federal Register** on July 31, 2000 (65 FR 46770). In particular, section 101 of the BBRA provided for a temporary 20 percent increase in the per diem adjusted payment rates for 15 specified RUG–III groups (SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, CA1, RHC, RMC, and RMB). Under the statute, this temporary increase remains in effect

until the later of October 1, 2000, or the implementation of case-mix refinements in the PPS. Section 101 also included a 4 percent across-the-board increase in the adjusted Federal per diem payment rates each year for FYs 2001 and 2002, exclusive of the 20 percent increase. Accordingly, this 4 percent temporary increase has now expired.

We included further information on all of the provisions of the BBRA that affect the SNF PPS in Program Memoranda A–99–53 and A–99–61 (December 1999), and Program Memorandum AB–00–18 (March 2000). In addition, 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 in § 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 (the BIPA)

The BIPA included several provisions that resulted in adjustments to the PPS for SNFs. These provisions were described in detail in the final rule that we published in the **Federal Register** on July 31, 2001 (66 FR 39562) as follows:

- 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 (January 16, 2001).
- Section 311 of the BIPA eliminated the one percent reduction in the SNF market basket that the statutory update formula had previously specified for FY 2001, and changed the one percent reduction specified for FYs 2002 and 2003 to a 0.5 percent reduction. This section also required us to conduct a study of alternative case-mix classification systems for the SNF PPS, and to submit a report to the Congress by January 1, 2005.
- Section 312 of the BIPA 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. Accordingly, this temporary increase has now expired.
- 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. This provision also specified that consolidated billing applies only to services furnished to those individuals residing in an institution (or portion of an institution) that is actually certified by Medicare as a SNF.
- Section 314 of the BIPA adjusted the payment rates for all of the rehabilitation RUGs to correct an anomaly under which the existing payment rates for the RHC, RMC, and RMB rehabilitation groups were higher than the rates for some other, more intensive rehabilitation RUGs.
- 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.

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

E. General Overview of the SNF PPS

We implemented the Medicare SNF PPS for cost reporting periods beginning on or after July 1, 1998. Under the PPS, we pay SNFs through prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services. These payment rates cover all the costs of furnishing covered skilled nursing services (routine, ancillary, and capital-related costs) other than costs associated with approved educational activities. Covered SNF services include post-hospital services for which benefits are provided under Part A and all items and services that, before July 1, 1998, had been paid under Part B (other than physician and certain other services specifically excluded under 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 PPS (the 15-month period beginning July 1, 1998) using a SNF market basket, and then standardized for the costs of facility differences in case-mix and for geographic variations in wages. The database used to compute the Federal payment rates excluded 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. 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 44 RUG-III groups. The May 12, 1998 interim final rule (63 FR 26252) included a complete and detailed description of the RUG-III classification system, and a further discussion appears in section III.B of this final rule.

The Federal rates in this final rule reflect an update to the rates that we published in the July 31, 2002 **Federal Register** (67 FR 49798) equal to the full change in the SNF market basket index. According to section 1888(e)(4)(E)(ii)(IV) of the Act, for FY 2004, we have adjusted the current rates by the full SNF market basket index. In addition, the FY 2004 rates will be adjusted by an additional 3.26 percent to reflect the cumulative forecast error since the start of the SNF PPS on July 1, 1998.

2. Payment Provisions—Initial Transition Period

The SNF PPS included an initial, phased transition from a facility-specific rate (which reflected the individual facility's historical cost experience) to the Federal case-mix adjusted rate. The transition extended through the

facility's first three cost reporting periods under the PPS, up to, and potentially including, the one that began in FY 2001. Furthermore, according to section 102 of BBRA, a facility could nonetheless elect to be paid entirely under the Federal rates. Accordingly, starting with cost reporting periods beginning in FY 2002, we base payments entirely on the Federal rates and, as mentioned previously in this final rule, we no longer include adjustment factors related to facility-specific rates for the coming fiscal year.

F. Use of the SNF 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 the covered SNF services. The SNF market basket index is used to update the Federal rates on an annual basis, and is discussed in greater detail in section III.H of this final rule.

II. Provisions of the Proposed Rule and the Supplemental Proposed Rule

The proposed rule that we published in the **Federal Register** on May 16, 2003 (68 FR 26758) included proposed FY 2004 updates to the Federal payment rates used under the SNF PPS. In accordance with section 1888(e)(4)(E)(ii)(IV) of the Act, the updates reflect the full SNF market basket percentage change for the fiscal year. The proposed rule also proposed introducing a one-year lag in the wage index data, similar to the PPS methodologies already being used for home health and inpatient rehabilitation facility services. This one-year lag would avoid the problems associated with multiple mid-year corrections in the hospital wage data. We also proposed clarifying the distinct part criteria to be used, in part, to help identify those SNFs that are hospital-based rather than freestanding. Further, we invited public comments on additional HCPCS codes that could represent the type of ''high-cost, low probability'' services within certain service categories (that is, chemotherapy and its administration, radioisotope services, and customized prosthetic devices) that section 103 of the BBRA has authorized us to exclude from the SNF consolidated billing provision.

In addition to discussing these general issues in the proposed rule, we also proposed making the following specific revisions to the existing text of the regulations:

- In § 409.20, we would make a technical correction to the cross-reference in paragraph (c).
- We would revise § 483.5 to include specific definitions of the terms ''distinct part'' and ''composite distinct part.'' This revision would also involve making conforming changes elsewhere in subpart B of part 483 of the regulations, as well as in parts 413 and 440. In addition, we proposed correcting a typographical error that currently appears in the regulations text at § 483.20(k)(1).

In the supplemental proposed rule that we published in the **Federal Register** on June 10, 2003 (68 FR 34768), we invited public comments on the advisability of amending the regulations text at § 413.337(d)(2), to include an adjustment to the annual update of the previous fiscal year's rate that would account for forecast error in the SNF market basket, beginning with FY 2004. In addition, we also invited comments on methods for ensuring that additional payments that could result from that adjustment would be used to promote quality of care in the SNF setting (including direct care services to residents). We also proposed to make a technical correction to the second sentence of the regulations text in § 413.345, in order to correct the spelling of the word ''standardized.''

More detailed information on each of these issues, to the extent that we received public comments on them, appears in the discussion contained in the following section of this preamble.

III. Analysis of and Responses to Public Comments

In response to the publication of the proposed rule on May 16, 2003 (68 FR 26758) and the supplemental proposed rule on June 10, 2003 (68 FR 34768), we received over 400 comments. Many consisted of form letters, in which we received multiple copies of an identically worded letter that had been signed and submitted by different individuals. Further, we received numerous comments from various trade associations and major organizations. Comments originated from nursing homes, hospitals, and other providers, suppliers, and practitioners, nursing home resident advocacy groups, health care consulting firms and private citizens. The following discussion, arranged by subject area, includes a description of the comments that we received, along with our responses.

Comment: A few commenters expressed concern about the abbreviated comment periods available for the proposed rule and the supplemental proposed rule. They asserted that the shorter timeframes were burdensome, and affected their ability to furnish comprehensive responses. They asked us to provide the full 60-day comment period in the future.

Response: While the proposed rule was not actually published until May 16, 2003, we note that this document went on public display at the Office of the Federal Register several days earlier, on May 10, 2003. Accordingly, the contents of the proposed rule were, in fact, publicly available for the full 60-day comment period. Further, we note that in contrast to the proposed rule, the supplemental proposed rule did not attempt to address the SNF PPS in a comprehensive manner, but instead focused exclusively on a single issue—the possibility of introducing an adjustment to account for forecast error. As noted in the preamble to the supplemental proposed rule (68 FR 34772), given the extremely narrow scope of this document, we believe that even a comment period of less than 60 days provided interested parties with sufficient opportunity to comment adequately on it.

A. Update of Federal Payment Rates Under the SNF PPS

This final rule sets forth a schedule of Federal prospective payment rates applicable to Medicare Part A SNF services beginning October 1, 2003. The schedule incorporates per diem Federal rates that provide Part A payment for all costs of services furnished to a beneficiary in a SNF during a Medicare-covered stay.

1. Costs and Services Covered by the Federal Rates

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

2. Methodology Used for the Calculation of the Federal Rates

The FY 2004 rates reflect an update using the full amount of the latest market basket index. The FY 2004 market basket increase factor is 3.0

percent. A complete description of the multi-step process is delineated in the May 12, 1998 interim final rule (63 FR 26252). We note that in accordance with section 101(a) of the BBRA and section 314 of the BIPA, the existing, temporary increase in the per diem adjusted payment rates of 20 percent for certain specified RUGs (and 6.7 percent for certain others) remains in effect until the implementation of case-mix refinements. As we discuss elsewhere in this final rule, while we are proceeding with our ongoing research in this area, we are not implementing case-mix refinements in this final rule.

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, 2002, and ending September 30, 2003, and the midpoint of the Federal fiscal year beginning October 1, 2003, and ending September 30, 2004, to which the payment rates apply. In accordance with section 1888(e)(4)(E)(ii)(IV) of the Act, the payment rates for FY 2004 are updated by a factor equal to the full market basket index percentage increase to determine the payment rates for FY 2004. In addition, the FY 2004 rates will be adjusted by an additional 3.26 percent to reflect the cumulative forecast error since the start of the SNF PPS on July 1, 1998. The rates are further adjusted by a wage index budget neutrality factor, described later in this section. Tables 1 and 2 reflect the updated components of the unadjusted Federal rates for FY 2004.

TABLE 1.—FY 2004 UNADJUSTED FEDERAL RATE PER DIEM URBAN

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$129.96	$97.89	$12.89	$66.32

TABLE 2.—FY 2004 UNADJUSTED FEDERAL RATE PER DIEM RURAL

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$124.16	$112.89	$13.77	$67.55

B. Case-Mix Adjustment

Under the BBA, we must publish the SNF PPS case-mix classification methodology applicable for the next Federal fiscal year before August 1 of each year. As noted in the following discussion, we are proceeding with our ongoing research regarding possible refinements in the existing case-mix classification system, but we are not implementing the refinements in this final rule.

As discussed previously in this final rule, 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. This legislation specified that the 20 percent increase would be effective for SNF services furnished on or after April 1, 2000, and would continue until the later of: (1) October 1, 2000, or (2) implementation of a refined case-mix classification system under section 1888(e)(4)(G)(i) of the Act that would better account for medically complex patients.

In the SNF PPS proposed rule for FY 2001 (65 FR 19190, April 10, 2000), we proposed making an extensive, comprehensive set of refinements to the existing case-mix classification system that collectively would have significantly expanded the existing 44-group structure. However, when our subsequent validation analyses indicated that the refinements would afford only a limited degree of improvement in explaining resource utilization relative to the significant increase in complexity that they would entail, we decided not to implement them at that time (see the FY 2001 final rule published July 31, 2000 (65 FR 46773)). Nevertheless, since the BBRA provision had demonstrated a Congressional interest in improving the ability of the payment system to account for the care furnished to medically complex patients in SNFs, we continued to conduct research in this area.

The Congress subsequently enacted section 311(e) of the BIPA, which directed us to conduct a study of the different systems for categorizing patients in Medicare SNFs in a manner that accounts for the relative resource utilization of different patient types, and to issue a report with any appropriate recommendations to the Congress by January 1, 2005. The extended timeframe for conducting the study, and the broad mandate in the BIPA to consider various classification systems and the full range of patient types, stood in sharp contrast to the BBRA language regarding more incremental refinements to the existing case-mix classification system under section 1888(e)(4)(G)(i) of the Act. This underscored the fact that implementing the latter type of refinements to the existing system in order to better account for medically complex patients need not await the completion of the more comprehensive changes envisioned in the BIPA. Accordingly, we considered the possibility of including these refinements as part of last year's annual update of the SNF payment rates.

However, in the July 31, 2002 update notice (67 FR 49801), we determined that the research was not sufficiently advanced to implement any case-mix refinements at that time, thus leaving the current classification system in place. This also left in place the temporary add-on payments enacted in section 101(a) of the BBRA. Further, while we have continued with our ongoing research regarding possible refinements in the existing case-mix classification system, this research has not yet provided the basis for proceeding with those refinements. Accordingly, we are not implementing case-mix refinements in this final rule.

As a result, the payment rates set forth in this final rule reflect the continued use of the 44-group RUG–III classification system discussed in the May 12, 1998 interim final rule (63 FR 26252). We are also maintaining the add-ons to the Federal rates for the specified RUG–III groups required by section 101(a) of the BBRA and subsequently modified by section 314 of the BIPA. The case-mix adjusted payment rates are listed separately for urban and rural SNFs in Tables 3 and 4, with the corresponding case-mix

values. These tables do not reflect the temporary add-on to the specified RUG–III groups provided in the BBRA, which is applied only after all other adjustments (wage and case-mix) have been made.

Meanwhile, we are continuing to explore both short-term and longer-range revisions to our case-mix classification methodology. In July 2001, we awarded a contract to the Urban Institute for research to aid us in making incremental refinements to the case-mix classification system under section 1888(e)(4)(G)(i) of the Act and to begin the case-mix study mandated by section 311(e) of the BIPA. The results of our current research will be included in the report to the Congress that section 311(e) of the BIPA requires us to submit by January 1, 2005. As we noted in the May 10, 2001 proposed rule (66 FR 23990), this research may also support a longer term goal of developing more integrated approaches for the payment and delivery system for Medicare post acute services in general. This broader, ongoing research project will pursue several avenues in studying various case-mix classification systems. Our preliminary research has focused on incorporating comorbidities and complications into the classification strategy, and we will thoroughly explore and evaluate this approach and other approaches (including procedures that might account more accurately for ancillary services) in our ongoing work.

Comment: Several commenters commended our decision not to implement case-mix refinements in FY 2004. They expressed the belief that incremental refinements may only represent ''patches'' on a system that needs a more comprehensive redesign, and could destabilize an already vulnerable health care industry. Other commenters urged us to move quickly to identify and implement short-term incremental improvements to provide more appropriate reimbursement for patients with heavy non-therapy ancillary needs.

Response: As discussed in the proposed rule, we continue to explore both short-term case-mix refinements and longer-range redesign of the SNF PPS methodology. Our primary goal is to enhance the accuracy of our reimbursement system by more closely matching payment with resource utilization, particularly in the utilization of non-therapy ancillaries. We have made this issue a research priority to ensure continued access to quality care for this very vulnerable heavy care population. However, we are cautious about premature implementation of any policy that has not been thoroughly analyzed to allocate payment dollars more accurately. Therefore, we have decided not to implement case-mix refinements for FY 2004. However, we are proceeding with our research and plan to evaluate the feasibility of implementing refinements again next year.

Comment: Several commenters agreed with the need for short-term action to stabilize the SNF PPS and suggested some alternative methodologies for achieving these goals, including more frequent updating of the SNF market basket and the development of an outlier pool that could address beneficiaries with heavy non-therapy ancillary needs. A few commenters suggested addressing the non-therapy ancillary needs by seeking a legislative change to redirect the 6.7 percent add-on payments for the 14 RUG–III therapy groups to those RUG–III groups used for beneficiaries with complex medical conditions and high utilization of non-therapy ancillary services.

Response: Each of the suggestions discussed above would require statutory authority that does not currently exist. However, we will carefully consider the comments that we received and use these comments to assist us in exploring potential solutions. While we will continue to focus on the needs of those beneficiaries who require an unusually heavy combination of clinical care, rehabilitation services, and ancillary utilization, we will also continue to consider a broad range of potential changes. We expect to discuss our research findings by January 1, 2005, in the report to the Congress that is required under section 311(e) of the BIPA.

Comment: Most of the commenters supported the continuation of our long-term research efforts designed to identify possible alternatives to the existing SNF PPS. Many commenters suggested expanding communications with providers and other interest groups in a manner similar to the approach that we have adopted for Open Door meetings. Most commenters recommended that we also enhance communications by sharing our research findings, and by including a detailed analysis in the 2005 report to the Congress.

Response: We appreciate the interest shown by providers and other stakeholders in our continuing research. We plan to consider all of the comments that we have received regarding potential changes to the classification system, as well as to other components of the SNF PPS, as we continue our analysis and prepare the required report to the Congress. As we pursue our research effort and evaluate our options, we will seek appropriate means to establish ongoing communication with, and input from, all stakeholder groups.

Comment: Most commenters urged us to minimize provider burden by providing adequate lead time for comment and for implementation of any significant changes. One commenter also suggested that we improve our coordination of related projects such as the Minimum Data Set (MDS) 3.0 implementation and the SNF PPS redesign, so that providers can incorporate changes smoothly and provide necessary staff training with minimal disruption to staff and patients.

Response: We recognize the inherent difficulties in coordinating potential changes to the MDS with potential changes to the SNF PPS. In fact, our staff in the payment, quality monitoring, and survey and certification areas have addressed this issue by establishing an in-house work group to share information and coordinate activities. By working together, we believe that we enhance our effectiveness and can introduce changes with minimal disruption and burden to providers. In addition, the introduction of the MDS 3.0 and any case-mix refinement changes to the SNF PPS would be accomplished through established administrative processes that will solicit stakeholder input. Finally, we fully agree that providers and other stakeholders will need adequate lead time to implement significant policy and operational changes.

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Table 3
CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES
URBAN

RUG-III Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RUC	1.30	2.25	168.95	220.25		66.32	455.52
RUB	0.95	2.25	123.46	220.25		66.32	410.03
RUA	0.78	2.25	101.37	220.25		66.32	387.94
RVC	1.13	1.41	146.85	138.02		66.32	351.19
RVB	1.04	1.41	135.16	138.02		66.32	339.50
RVA	0.81	1.41	105.27	138.02		66.32	309.61
RHC	1.26	0.94	163.75	92.02		66.32	322.09
RHB	1.06	0.94	137.76	92.02		66.32	296.10
RHA	0.87	0.94	113.07	92.02		66.32	271.41
RMC	1.35	0.77	175.45	75.38		66.32	317.15
RMB	1.09	0.77	141.66	75.38		66.32	283.36
RMA	0.96	0.77	124.76	75.38		66.32	266.46
RLB	1.11	0.43	144.26	42.09		66.32	252.67
RLA	0.80	0.43	103.97	42.09		66.32	212.38
SE3	1.70		220.93		12.89	66.32	300.14
SE2	1.39		180.64		12.89	66.32	259.85
SE1	1.17		152.05		12.89	66.32	231.26
SSC	1.13		146.85		12.89	66.32	226.06
SSB	1.05		136.46		12.89	66.32	215.67
SSA	1.01		131.26		12.89	66.32	210.47
CC2	1.12		145.56		12.89	66.32	224.77
CC1	0.99		128.66		12.89	66.32	207.87
CB2	0.91		118.26		12.89	66.32	197.47
CB1	0.84		109.17		12.89	66.32	188.38
CA2	0.83		107.87		12.89	66.32	187.08
CA1	0.75		97.47		12.89	66.32	176.68
IB2	0.69		89.67		12.89	66.32	168.88
IB1	0.67		87.07		12.89	66.32	166.28
IA2	0.57		74.08		12.89	66.32	153.29
IA1	0.53		68.88		12.89	66.32	148.09
BB2	0.68		88.37		12.89	66.32	167.58

BB1	0.65		84.47		12.89	66.32	163.68
BA2	0.56		72.78		12.89	66.32	151.99
BA1	0.48		62.38		12.89	66.32	141.59
PE2	0.79		102.67		12.89	66.32	181.88
PE1	0.77		100.07		12.89	66.32	179.28
PD2	0.72		93.57		12.89	66.32	172.78
PD1	0.70		90.97		12.89	66.32	170.18
PC2	0.65		84.47		12.89	66.32	163.68
PC1	0.64		83.17		12.89	66.32	162.38
PB2	0.51		66.28		12.89	66.32	145.49
PB1	0.50		64.98		12.89	66.32	144.19
PA2	0.49		63.68		12.89	66.32	142.89
PA1	0.46		59.78		12.89	66.32	138.99

Table 4
CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES
RURAL

RUG-III Category	Nursing Index	Therapy Index	Nursing Comp-onent	Therapy Compo-nent	Non-case Mix Therapy Comp	Non-case Mix Compo-nent	Total Rate
RUC	1.30	2.25	161.41	254.00		67.55	482.96
RUB	0.95	2.25	117.95	254.00		67.55	439.50
RUA	0.78	2.25	96.84	254.00		67.55	418.39
RVC	1.13	1.41	140.30	159.17		67.55	367.02
RVB	1.04	1.41	129.13	159.17		67.55	355.85
RVA	0.81	1.41	100.57	159.17		67.55	327.29
RHC	1.26	0.94	156.44	106.12		67.55	330.11
RHB	1.06	0.94	131.61	106.12		67.55	305.28
RHA	0.87	0.94	108.02	106.12		67.55	281.69
RMC	1.35	0.77	167.62	86.93		67.55	322.10
RMB	1.09	0.77	135.33	86.93		67.55	289.81
RMA	0.96	0.77	119.19	86.93		67.55	273.67
RLB	1.11	0.43	137.82	48.54		67.55	253.91
RLA	0.80	0.43	99.33	48.54		67.55	215.42
SE3	1.70		211.07		13.77	67.55	292.39
SE2	1.39		172.58		13.77	67.55	253.90
SE1	1.17		145.27		13.77	67.55	226.59
SSC	1.13		140.30		13.77	67.55	221.62
SSB	1.05		130.37		13.77	67.55	211.69
SSA	1.01		125.40		13.77	67.55	206.72
CC2	1.12		139.06		13.77	67.55	220.38
CC1	0.99		122.92		13.77	67.55	204.24
CB2	0.91		112.99		13.77	67.55	194.31
CB1	0.84		104.29		13.77	67.55	185.61
CA2	0.83		103.05		13.77	67.55	184.37
CA1	0.75		93.12		13.77	67.55	174.44
IB2	0.69		85.67		13.77	67.55	166.99
IB1	0.67		83.19		13.77	67.55	164.51
IA2	0.57		70.77		13.77	67.55	152.09
IA1	0.53		65.80		13.77	67.55	147.12
BB2	0.68		84.43		13.77	67.55	165.75
BB1	0.65		80.70		13.77	67.55	162.02

BA2	0.56		69.53		13.77	67.55	150.85
BA1	0.48		59.60		13.77	67.55	140.92
PE2	0.79		98.09		13.77	67.55	179.41
PE1	0.77		95.60		13.77	67.55	176.92
PD2	0.72		89.40		13.77	67.55	170.72
PD1	0.70		86.91		13.77	67.55	168.23
PC2	0.65		80.70		13.77	67.55	162.02
PC1	0.64		79.46		13.77	67.55	160.78
PB2	0.51		63.32		13.77	67.55	144.64
PB1	0.50		62.08		13.77	67.55	143.40
PA2	0.49		60.84		13.77	67.55	142.16
PA1	0.46		57.11		13.77	67.55	138.43

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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 2004.

Section 315 of the BIPA authorizes us to establish a reclassification system for SNFs, similar to the hospital methodology. This geographic reclassification system cannot be implemented until we have collected the data necessary to establish an area wage index for SNFs based on SNF wage data. We presented a comprehensive discussion of this wage data in the May 10, 2001 proposed rule (66 FR 23984) and the July 31, 2001 final rule (66 FR 39562).

1. Selecting the Most Appropriate Wage Index

In the May 10, 2001 proposed rule, we published a wage index prototype based on SNF data, along with the wage index based on the hospital wage data that were used in the preceding year's final rule (July 31, 2000, 65 FR 46770). In addition, we included a discussion of the wage index computations for the SNF prototype. We also indicated our concern about the reliability of the existing data used in establishing a SNF wage index, in view of the significant variations in the SNF-specific wage data and the large number of SNFs that are unable to provide adequate wage and hourly data. Accordingly, we expressed the belief that a wage index based on hospital wage data remains the best and most appropriate to use in adjusting payments to SNFs, since both hospitals and SNFs compete in the same labor markets.

In the July 31, 2001 final rule (66 FR 39579), we indicated that we had decided not to adopt the SNF-specific wage index prototype from the proposed rule, citing concerns such as the significant amount of volatility in the data. In addition, while we acknowledged that auditing all SNFs would provide more accurate and reliable data, we observed that this would place a burden on providers in terms of recordkeeping and completion of the cost report worksheet. We also noted that adopting such an approach would require a significant commitment of resources by us and by our contractors.

As we noted in the May 16, 2003 proposed rule (68 FR 26767), while we continue to believe that the development of a SNF-specific wage index potentially could improve the accuracy of SNF payments, we do not regard an undertaking of this magnitude as being feasible within the current level of programmatic resources. However, we remain willing to consider the adoption of a SNF-specific wage index should sufficient staffing and budgetary resources to support it become available in the future.

In the May 16, 2003 rule, we proposed continuing to use the final FY 2003 hospital wage index to adjust SNF PPS payments beginning October 1, 2003. Then, for future rate years, we proposed continuing to use the most recently published wage index values (that is, the final FY 2003 wage index data) final wage index values rather than following our current practice of using the most recent available data. The impact of this change would have been to establish a one-year lag between the wage index values used in the hospital PPS (that is, FY 2004 wage index) and the data used in the SNF PPS. As explained in our responses to the comments shown later in this section, we have decided not to implement this one-year lag. Therefore, the wage index values in Tables 7 and 8 reflect the most recent available data; that is, the same FY 2004 wage data that will be used for the FY 2004 inpatient hospital PPS rates.

Comment: A substantial number of commenters expressed concern about the appropriateness of using the most recently published wage index values to adjust the payments for SNFs, when more recent data are available. Many asked that we use the more recent data, even if they are more vulnerable to errors requiring mid-year correction. They pointed out that the most recently published wage index values are already several years old, since the data have to be reviewed and audited before use in a wage index. These commenters argued that imposing an additional 1-year lag on wage data ignores the current trends in the labor markets, fails to recognize fully those areas where severe nursing shortages necessitate paying a higher rate to attract nurses, and results in a less accurate reimbursement rate. In addition, a few commenters were concerned about the burden on hospital-based providers that would have to maintain two wage index systems, one for the hospital and another for the SNF.

Response: Based on our review of the comments, we have determined to continue using the most current available wage index data in determining the SNF payment rates, and we are not adopting the position taken in the May 16, 2003 proposed rule.

Comment: A few commenters, while opposing the use of the most recently published wage index values, urged us to make a retroactive wage index adjustment to account for errors in a prior year's reporting of hospital wage

data that lowered payments to SNFs located in the Baltimore MSA.

Response: The SNF PPS does not include a methodology for retroactive adjustments to the wage index. The payment rates and wage indices are applied prospectively. Similarly, any corrections to the wage indices are also applied prospectively. We rely on the best available data reported by hospitals and audited by our fiscal intermediaries. Clearly, retroactive application of these wage index changes would jeopardize the prospective nature of the system and introduce an even higher level of instability.

The commenters cited § 412.63(x)(2) of the regulations to support their request for this retroactive adjustment. However, this section applies solely to mid-year corrections of the wage index for inpatient hospitals and applies only in cases where the FI or CMS made an error in tabulating the hospital data. In this case, the error was made by the providers and not by either the FI or by CMS. Moreover, the errors in the as-reported data were subject to public review and comment before adoption under the SNF PPS. In fact, this public process has facilitated correction of the data going forward. Unfortunately, the errors in this case were not identified until the data were audited. By that time, it was too late to make a mid-year rate correction. While we regret the impact on Maryland providers, we note that this situation is inherent in a system that uses more recent data. Under a policy of using the most recently published wage index values, the correction to the Baltimore MSA could have been incorporated in the published wage index and resulted in revised reimbursement to providers in the Baltimore MSA.

Comment: Several commenters expressed concern that we may have discarded the SNF-specific wage index without further work or development to ensure its accuracy. Another pointed out that we already have the legal authority to develop and collect data necessary to establish an SNF wage index through the Social Security Act Amendments of 1994 (Pub. L. 103–432). These commenters urged us to work with the industry to educate SNF providers, improve the cost reporting tools we use to collect the data, and immediately seek funding for the full-scale auditing of SNF data that would be needed to create and validate an SNF-specific wage index. A few commenters suggested that we should commit the resources required to implement an SNF-specific wage index not later than FY 2006. One commenter expressed concern that the SNF community does not participate in the hospital wage data collection process. However, a few commenters cautioned us against a precipitous conversion until we are sure that the SNF-specific wage index has been tested to ensure a high level of stability and accuracy.

Response: As we discussed in the May 10, 2001 proposed rule (66 FR 24010 through 24011), there is a great deal of volatility in the SNF-specific wage index prototype—not only between it and the hospital wage data, but also between the 2 years of data that we used in developing the SNF-specific wage index prototype. As many commenters suggested, the data could be improved if we were to establish better controls, edits, and screens of the data, and insist that more of the provider's data be audited to ensure its accuracy. We are committed to a process to ensure the accuracy of the data and have already implemented several edits and screens to improve the quality of data reported. We have made several corrections and changes to the cost reports/edits/screens as a result of consultation with industry representatives. However, these changes were made prospectively, and the full year's data needed to evaluate these efforts are not yet available. Moreover, while we are proceeding with our analysis, we still have concerns about the accuracy of the data being reported. Hospitals have been reporting wage and hourly data for years, yet the FIs and providers must still spend a considerable amount of time resolving problems and changes to the data to derive the published hospital wage index. The problem experienced by Maryland providers in FY 2001 illustrates the difficulty of timely verification of wage data, which often results in changes being made to the wage index even after the update regulations are published.

We agree that auditing all SNFs would provide more accurate and reliable data; however, this approach involves a significant commitment of our resources and our contractors and may place a significant recordkeeping and reporting burden on providers. Developing a desk review and audit program similar to what is required in the hospital setting would, at a minimum, require significant resources. The FIs that are involved in preparing the hospital wage data currently spend considerable resources to ensure the accuracy of the wage data submitted by approximately 6,000 hospitals. As we noted in the July 31, 2001 final rule (66 FR 39579), this process involves editing, reviewing, auditing, and performing desk reviews of the data. Requiring FIs to do the same for the approximately 14,000 SNFs would nearly triple the contractors' workload and budgets in this area. While we have noted the industry concerns and funding needs, there are no funds currently available to develop this system to the point where we could rely on the data that any such system would produce. We are committed to continuing our investigation of an SNF-specific wage index that would enhance our current payment methodology.

However, we do not expect to propose a SNF-specific wage index until we can demonstrate that it would significantly improve our ability to determine payments for facilities, and justify the resources required to collect the data, as well as the increased burden on providers. We also want to point out that the development of the hospital wage data can also be scrutinized and evaluated by the SNF industry when commenting on the hospital proposed rule that is published each spring. Therefore, because of the problems associated with the current SNF-specific data, and our inability to demonstrate that an SNF-specific wage index would be more reflective of the wages and salaries paid in a specific area, we continue to believe that hospital wage data are the most appropriate data for adjusting payments made to SNFs.

Comment: A small number of commenters suggested that if SNFs are going to use the hospital wage index, several components of the hospital PPS should be immediately applied to SNFs. For example, one commenter suggested that we ensure that no MSA wage index value is lower than the State-wide rural wage index. Other commenters recommended an immediate change in SNF PPS methodology to allow provider reclassification.

Response: As discussed above, the calculation of the wage indices must be made in a budget neutral manner. If we adopted this hospital PPS provision and established a wage index floor, there would be no change in the aggregate reimbursement for SNFs. While we are not convinced a state-wide floor would provide a more accurate wage index, we encourage input from the industry on why this could provide a more accurate wage index, noting that the redistribution of funds would reduce payments to some providers while it increased payments to others.

Under section 315 of the BIPA, the Congress authorized the use of a reclassification methodology in the SNF PPS that would allow providers to seek geographic reclassification. However, the statute specifically noted that such reclassification could not be

implemented until we have collected the data necessary to establish an SNF-specific wage index. Accordingly, under the current legislative authority, we are prohibited from implementing an SNF reclassification system until reliable data in this area become available.

We would also like to point out on June 6, 2003, the Office of Management and Budget (OMB) issued OMB Bulletin No. 03–04, announcing revised definitions of Metropolitan Statistical Areas, and new definitions of Micropolitan Statistical Areas and Combined Statistical Areas. A copy of the bulletin may be attained at the following Internet address: *http://www.whitehouse.gov/omb/bulletins/b03–04.html*.

These new definitions will not be applied to the FY 2004 wage index. However, we will be studying the new definitions and their impact and, if warranted, may adopt them in the future, using appropriate administrative processes. To the extent these definitions are used, the concerns expressed by many for the use of a geographical reclassification system may be mitigated.

2. Determining the Labor-Related Portion of the SNF PPS Rate

The wage index adjustment is applied to the labor-related portion of the Federal rate, which in FY 2004 is 76.372 percent of the total rate. This percentage reflects the labor-related relative importance for FY 2004. The labor-related relative importance is calculated from the SNF market basket, and approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2004. 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 2004 than the base year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2004 in four steps. First, we compute the FY 2004 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 2004 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2004 relative importance for each cost category by multiplying this ratio by the base year (FY 1997) weight. Finally, we sum the FY 2004 relative importance for each of the labor-related cost categories (wages and salaries, employee benefits, nonmedical professional fees, labor-intensive services, and capital-related expenses) to produce the FY 2004 labor-related relative importance. Tables 5 and 6 show the Federal rates by labor-related and non-labor-related components.

3. Calculating the Budget Neutrality Factor

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 lesser than would otherwise be made in the absence of the wage adjustment. In this sixth PPS year (Federal rates effective October 1, 2003), we are applying the wage index applicable to SNF payments using the most recent hospital wage data applicable to FY 2004 payments (as discussed in the following comments), and applying an adjustment to fulfill the budget neutrality requirement. This requirement is met by multiplying each of the components of the unadjusted Federal rates by a factor equal to the ratio of the volume weighted mean wage adjustment factor (using the wage index from the previous year) to the volume weighted mean wage adjustment factor, using the wage index for the fiscal year beginning October 1, 2003. The same volume weights are used in both the numerator and denominator and will be derived from 1997 Medicare Provider Analysis and Review File (MEDPAR) data. The wage adjustment factor used in this calculation is defined as the labor share of the rate component multiplied by the wage index plus the non-labor share. The budget neutrality factor for this year is 1.005. In order to give the public a sense of the magnitude of this adjustment, last year's factor was 0.9997.

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Table 5
Case-Mix Adjusted Federal Rates for Urban SNFs
By Labor and Non-Labor Component

RUG III Category	Total Rate	Labor Portion	Non-Labor Portion
RUC	455.52	347.89	107.63
RUB	410.03	313.15	96.88
RUA	387.94	296.28	91.66
RVC	351.19	268.21	82.98
RVB	339.50	259.28	80.22
RVA	309.61	236.46	73.15
RHC	322.09	245.99	76.10
RHB	296.10	226.14	69.96
RHA	271.41	207.28	64.13
RMC	317.15	242.21	74.94
RMB	283.36	216.41	66.95
RMA	266.46	203.50	62.96
RLB	252.67	192.97	59.70
RLA	212.38	162.20	50.18
SE3	300.14	229.22	70.92
SE2	259.85	198.45	61.40
SE1	231.26	176.62	54.64
SSC	226.06	172.65	53.41
SSB	215.67	164.71	50.96
SSA	210.47	160.74	49.73
CC2	224.77	171.66	53.11
CC1	207.87	158.75	49.12
CB2	197.47	150.81	46.66
CB1	188.38	143.87	44.51
CA2	187.08	142.88	44.20
CA1	176.68	134.93	41.75
IB2	168.88	128.98	39.90
IB1	166.28	126.99	39.29
IA2	153.29	117.07	36.22
IA1	148.09	113.10	34.99
BB2	167.58	127.98	39.60
BB1	163.68	125.01	38.67
BA2	151.99	116.08	35.91
BA1	141.59	108.14	33.45
PE2	181.88	138.91	42.97
PE1	179.28	136.92	42.36
PD2	172.78	131.96	40.82
PD1	170.18	129.97	40.21
PC2	163.68	125.01	38.67
PC1	162.38	124.01	38.37
PB2	145.49	111.11	34.38
PB1	144.19	110.12	34.07
PA2	142.89	109.13	33.76
PA1	138.99	106.15	32.84

Table 6
Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component

RUG III Category	Total Rate	Labor Portion	Non-Labor Portion
RUC	482.96	368.85	114.11
RUB	439.50	335.65	103.85
RUA	418.39	319.53	98.86
RVC	367.02	280.30	86.72
RVB	355.85	271.77	84.08
RVA	327.29	249.96	77.33
RHC	330.11	252.11	78.00
RHB	305.28	233.15	72.13
RHA	281.69	215.13	66.56
RMC	322.10	245.99	76.11
RMB	289.81	221.33	68.48
RMA	273.67	209.01	64.66
RLB	253.91	193.92	59.99
RLA	215.42	164.52	50.90
SE3	292.39	223.30	69.09
SE2	253.90	193.91	59.99
SE1	226.59	173.05	53.54
SSC	221.62	169.26	52.36
SSB	211.69	161.67	50.02
SSA	206.72	157.88	48.84
CC2	220.38	168.31	52.07
CC1	204.24	155.98	48.26
CB2	194.31	148.40	45.91
CB1	185.61	141.75	43.86
CA2	184.37	140.81	43.56
CA1	174.44	133.22	41.22
IB2	166.99	127.53	39.46
IB1	164.51	125.64	38.87
IA2	152.09	116.15	35.94
IA1	147.12	112.36	34.76
BB2	165.75	126.59	39.16
BB1	162.02	123.74	38.28
BA2	150.85	115.21	35.64
BA1	140.92	107.62	33.30
PE2	179.41	137.02	42.39
PE1	176.92	135.12	41.80
PD2	170.72	130.38	40.34
PD1	168.23	128.48	39.75
PC2	162.02	123.74	38.28
PC1	160.78	122.79	37.99
PB2	144.64	110.46	34.18
PB1	143.40	109.52	33.88
PA2	142.16	108.57	33.59
PA1	138.43	105.72	32.71

BILLING CODE 4120–01–C

TABLE 7.—WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties or county equivalents)	Wage index
0040 Abilene, TX	0.7596
Taylor, TX	
0060 Aguadilla, PR	0.4289
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9208
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0819
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY	0.8455
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9263
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.7987
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	0.9682
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.8771
Blair, PA	
0320 Amarillo, TX	0.8950
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2167
Anchorage, AK	
0440 Ann Arbor, MI	1.1029
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8058
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.8999
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4138
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9680
Buncombe, NC	
Madison, NC	
0500 Athens, GA	0.9778
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA	1.0089
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
De Kalb, GA	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic City-Cape May, NJ	1.0751
Atlantic City, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8460
Lee, AL	
0600 Augusta-Aiken, GA-SC	0.9587
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX	0.9570
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA	0.9770
Kern, CA	
0720 Baltimore, MD	0.9879
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Annes, MD	
0733 Bangor, ME	0.9864
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.2904
Barnstable, MA	
0760 Baton Rouge, LA	0.8372
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8390
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1710
Whatcom, WA	
0870 Benton Harbor, MI	0.8835
Berrien, MI	
0875 Bergen-Passaic, NJ	1.1644
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.8925
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8993
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY	0.8394
Broome, NY	
Tioga, NY	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
1000 Birmingham, AL	0.9175
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7933
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8627
Monroe, IN	
1040 Bloomington-Normal, IL	0.8796
McLean, IL	
1080 Boise City, ID	0.9172
Ada, ID	
Canyon, ID	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1188
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	1.0008
Boulder, CO	
1145 Brazoria, TX	0.8105
Brazoria, TX	
1150 Bremerton, WA	1.0537
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	1.0261
Cameron, TX	
1260 Bryan-College Station, TX	0.8983
Brazos, TX	
1280 Buffalo-Niagara Falls, NY	0.9565
Erie, NY	
Niagara, NY	
1303 Burlington, VT	0.9665
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4141
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.9034
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9058
Natrona, WY	
1360 Cedar Rapids, IA	0.8838
Linn, IA	
1400 Champaign-Urbana, IL	0.9867
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9294
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.8845

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Kanawha, WV	
Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC-SC	0.9721
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	0.9985
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.9049
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY	0.8760
Laramie, WY	
1600 Chicago, IL	1.0848
Cook, IL	
De Kalb, IL	
Du Page, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	1.0152
Butte, CA	
1640 Cincinnati, OH-KY-IN	0.9375
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN-KY	0.8211
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH	0.9632
Ashtabula, OH	
Geauga, OH	
Cuyahoga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9793
El Paso, CO	
1740 Columbia, MO	0.8660
Boone, MO	
1760 Columbia, SC	0.8866
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL	0.8659
Russell, AL	
Chattanoochee, GA	
Harris, GA	
Muscogee, GA	
1840 Columbus, OH	0.9609
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8486
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1470
Benton, OR	
1900 Cumberland, MD-WV	0.8166
Allegany, MD	
Mineral, WV	
1920 Dallas, TX	0.9934
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.8998
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8949
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9479
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9042
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8793
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL	0.8128
Macon, IL	
2080 Denver, CO	1.0793
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.9069
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI	1.0060
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7710
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9765
Kent, DE	
2200 Dubuque, IA	0.8850
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0130
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0890
Dutchess, NY	
2290 Eau Claire, WI	0.9027
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9159
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9744
Elkhart, IN	
2335 Elmira, NY	0.8343
Chemung, NY	
2340 Enid, OK	0.8524
Garfield, OK	
2360 Erie, PA	0.8566
Erie, PA	
2400 Eugene-Springfield, OR	1.1410
Lane, OR	
2440 Evansville-Henderson, IN-KY	0.8395
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9758
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8950
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8362
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.1287
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.0814
Genesee, MI	
2650 Florence, AL	0.7716
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8673
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0067
Larimer, CO	
2680 Ft. Lauderdale, FL	1.0122
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9776
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	0.9968
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.8390
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.8930
Okaloosa, FL	
2760 Fort Wayne, IN	0.9546
Adams, IN	
Allen, IN	
De Kalb, IN	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Fort Worth-Arlington, TX	0.9321
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0053
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8173
Etowah, AL	
2900 Gainesville, FL	0.9653
Alachua, FL	
2920 Galveston-Texas City, TX	0.9242
Galveston, TX	
2960 Gary, IN	0.9372
Lake, IN	
Porter, IN	
2975 Glens Falls, NY	0.8441
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8587
Wayne, NC	
2985 Grand Forks, ND-MN	0.8601
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9594
Mesa, CO.	
3000 Grand Rapids-Muskegon-Holland, MI	0.9430
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.8773
Cascade, MT	
3060 Greeley, CO	0.9334
Weld, CO	
3080 Green Bay, WI	0.9422
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC	0.9129
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9061
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9297
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9135
Washington, MD	
3200 Hamilton-Middletown, OH	0.9176
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9127
Cumberland, PA	
Dauphin, PA	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Lebanon, PA	
Perry, PA	
3283 Hartford, CT	1.1508
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 Hattiesburg, MS	0.7278
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9205
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1053
Honolulu, HI	
3350 Houma, LA	0.7717
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX	0.9794
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9556
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.9208
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN	0.9875
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9510
Johnson, IA	
3520 Jackson, MI	0.8950
Jackson, MI	
3560 Jackson, MS	0.8324
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.8948
Chester, TN	
Madison, TN	
3600 Jacksonville, FL	0.9490
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC	0.8510
Onslow, NC	
3610 Jamestown, NY	0.7730
Chautaqua, NY	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
3620 Janesville-Beloit, WI	0.9244
Rock, WI	
3640 Jersey City, NJ	1.1070
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8220
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8125
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7762
Craighead, AR	
3710 Joplin, MO	0.8646
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battle Creek, MI	1.0458
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	1.0377
Kankakee, IL	
3760 Kansas City, KS-MO	0.9675
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9721
Kenosha, WI	
3810 Killeen-Temple, TX	0.9122
Coryell, TX	
3840 Knoxville, TN	0.8784
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.9008
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.9210
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8156
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.8549
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7809
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.8775
Polk, FL	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
4000 Lancaster, PA	0.9244
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9675
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8059
Webb, TX	
4100 Las Cruces, NM	0.8653
Dona Ana, NM	
4120 Las Vegas, NV-AZ	1.1481
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.8642
Douglas, KS	
4200 Lawton, OK	0.8234
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9345
Androscoggin, ME	
4280 Lexington, KY	0.8650
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9483
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	0.9992
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8887
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.9076
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA	1.1748
Los Angeles, CA	
4520 Louisville, KY-IN	0.9205
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8238
Lubbock, TX	
4640 Lynchburg, VA	0.9097
Amherst, VA	
Bedford City, VA	
Bedford, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.8916
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0222
Dane, WI	
4800 Mansfield, OH	0.8210
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4776
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8347
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0729
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.9736
Brevard, Fl	
4920 Memphis, TN-AR-MS	0.8973
Crittenden, AR	
De Soto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	0.9651
Merced, CA	
5000 Miami, FL	0.9854
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ	1.1320
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 Milwaukee-Waukesha, WI	0.9947
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St Paul, MN-WI	1.0957
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Sherburne, MN	
Washington, MN	
Wright, MN	
Pierce, WI	
St. Croix, WI	
5140 Missoula, MT	0.8683
Missoula, MT	
5160 Mobile, AL	0.7962
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.1230
Stanislaus, CA	
5190 Monmouth-Ocean, NJ	1.0912
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.7890
Ouachita, LA	
5240 Montgomery, AL	0.7875
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.8739
Delaware, IN	
5330 Myrtle Beach, SC	0.9075
Horry, SC	
5345 Naples, FL	0.9750
Collier, FL	
5360 Nashville, TN	0.9815
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY	1.2933
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2335
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT	1.1584
New London, CT	
5560 New Orleans, LA	0.9137
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John The Baptist, LA	
St. Tammany, LA	
5600 New York, NY	1.3913
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ	1.1471
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1462
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA-NC	0.8584
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City, VA	
Williamsburg City, VA	
York, VA	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
5775 Oakland, CA	1.4860
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9689
Marion, FL	
5800 Odessa-Midland, TX	0.9290
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK	0.8948
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.0919
Thurston, WA	
5920 Omaha, NE-IA	0.9705
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA	1.1326
Orange, CA	
5960 Orlando, FL	0.9615
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8340
Daviess, KY	
6015 Panama City, FL	0.8169
Bay, FL	
6020 Parkersburg-Marietta, WV-OH	0.8007
Washington, OH	
Wood, WV	
6080 Pensacola, FL	0.8672
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8699
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA-NJ	1.0839
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ	1.0088
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7833
Jefferson, AR	
6280 Pittsburgh, PA	0.8865
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA	1.0234
Berkshire, MA	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
6340 Pocatello, ID	0.9006
Bannock, ID	
6360 Ponce, PR	0.4689
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9909
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR-WA	1.1167
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Pawtucket, RI	1.0932
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	0.9936
Utah, UT	
6560 Pueblo, CO	0.8743
Pueblo, CO	
6580 Punta Gorda, FL	0.9472
Charlotte, FL	
6600 Racine, WI	0.8778
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC	0.9919
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8771
Pennington, SD	
6680 Reading, PA	0.9096
Berks, PA	
6690 Redding, CA	1.1306
Shasta, CA	
6720 Reno, NV	1.0639
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.0566
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9311
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Richmond City, VA	
6780 Riverside-San Bernardino, CA	1.1296
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8664
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.1691
Olmsted, MN	
6840 Rochester, NY	0.9392
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9627
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9039
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA	1.1797
El Dorado, CA	
Placer, CA	
Sacramento, CA	
A6960 Saginaw-Bay City-Midland, MI	0.9992
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9468
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO	0.9718
Andrews, MO	
Buchanan, MO	
7040 St. Louis, MO-IL	0.8996
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
Sullivan City, MO	
7080 Salem, OR	1.0440
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4281
Monterey, CA	
7160 Salt Lake City-Ogden, UT	0.9873
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8500
Tom Green, TX	
7240 San Antonio, TX	0.8834
Bexar, TX	
Comal, TX	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA	1.1102
San Diego, CA	
7360 San Francisco, CA	1.4455
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA	1.4567
Santa Clara, CA	
7440 San Juan-Bayamon, PR	0.4880
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Ceiba, PR	
Comerio, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Morovis, PR	
Naguabo, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.1383
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0399
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.2890
Santa Cruz, CA	
7490 Santa Fe, NM	1.0610
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.2825
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9924
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9433
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton—Wilkes-Barre—Hazleton, PA	0.8378
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA	1.1516
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA	0.7719
Mercer, PA	
7620 Sheboygan, WI	0.8589
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9661
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.9047
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.8956
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9271
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9782
St. Joseph, IN	
7840 Spokane, WA	1.0857
Spokane, WA	
7880 Springfield, IL	0.8908
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8423
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.0419
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.8705
Centre, PA	
8080 Steubenville-Weirton, OH-WV	0.8364
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0362
San Joaquin, CA	
8140 Sumter, SC	0.8210
Sumter, SC	
8160 Syracuse, NY	0.9374
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1071
Pierce, WA	
8240 Tallahassee, FL	0.8485
Gadsden, FL	
Leon, FL	
8280 Tampa-St. Petersburg-Clearwater, FL	0.9066
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN	0.8292
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana, AR-Texarkana, TX	0.8117
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9343
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9071
Shawnee, KS	
8480 Trenton, NJ	1.0474
Mercer, NJ	
8520 Tucson, AZ	0.8945
Pima, AZ	
8560 Tulsa, OK	0.9148
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8179
Tuscaloosa, AL	
8640 Tyler, TX	0.9366
Smith, TX	
8680 Utica-Rome, NY	0.8369
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3323
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.1019
Ventura, CA	
8750 Victoria, TX	0.8151
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0363
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA	0.9755
Tulare, CA	
8800 Waco, TX	0.8360
McLennan, TX	
8840 Washington, DC-MD-VA-WV	1.0860
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpepper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 Waterloo-Cedar Falls, IA	0.8332
Black Hawk, IA	
8940 Wausau, WI	0.9653
Marathon, WI	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index
8960 West Palm Beach-Boca Raton, FL	0.9759
Palm Beach, FL	
9000 Wheeling, OH-WV	0.7464
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9200
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.8307
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8125
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.0838
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9524
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0330
Yakima, WA	
9270 Yolo, CA	0.9167
Yolo, CA	
9280 York, PA	0.9082
York, PA	
9320 Youngstown-Warren, OH	0.9176
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0155
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.8859
Yuma, AZ	

TABLE 8.—WAGE INDEX FOR RURAL AREAS

Rural area	Wage index
Alabama	0.7461
Alaska	1.1838
Arizona	0.9233
Arkansas	0.7703
California	0.9987
Colorado	0.9291
Connecticut	1.2134
Delaware	0.9518
Florida	0.8834
Georgia	0.8560
Guam	0.9611
Hawaii	0.9918
Idaho	0.8937
Illinois	0.8221
Indiana	0.8788
Iowa	0.8382
Kansas	0.8002
Kentucky	0.7941
Louisiana	0.7428
Maine	0.8776
Maryland	0.9088
Massachusetts	1.0390
Michigan	0.8848
Minnesota	0.9293
Mississippi	0.7747
Missouri	0.7860
Montana	0.8765
Nebraska	0.8787
Nevada	0.9767
New Hampshire	0.9989
New Jersey [1]	.....
New Mexico	0.8236
New York	0.8491
North Carolina	0.8424
North Dakota	0.7746
Ohio	0.8784
Oklahoma	0.7506
Oregon	0.9953
Pennsylvania	0.8344
Puerto Rico	0.4002
Rhode Island [1]	.....
South Carolina	0.8464
South Dakota	0.8162
Tennessee	0.7854
Texas	0.7748
Utah	0.8937
Vermont	0.9269
Virginia	0.8464
Virgin Islands	0.7166
Washington	1.0346
West Virginia	0.7986
Wisconsin	0.9266
Wyoming	0.9073

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

D. Publication of Updates to the Federal Rates

In accordance with section 1888(e)(4)(E) of the Act, the final payment rates listed here reflect an update equal to the full SNF market basket, which equals 3.0 percent. In addition, the FY 2004 rates will be adjusted by an additional 3.26 percent to reflect the cumulative forecast error since the start of the SNF PPS on July 1, 1998. We will continue to publish the rates, wage index, and case-mix classification methodology in the **Federal Register** before August 1 preceding the start of each succeeding fiscal year. Along with a number of other revisions discussed elsewhere in this preamble, this final rule provides the annual updates to the Federal rates as mandated by the Act.

E. Relationship of RUG–III Classification System to Existing SNF 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 current 44-group RUG–III classification system. Our presumption is that any beneficiary who is correctly assigned to one of the upper 26 RUG–III groups in the initial 5-day, Medicare-required assessment is automatically classified as meeting the SNF level of care definition up to the assessment reference date (ARD) for that assessment.

Any 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 26 groups during the immediate post-hospital period require a covered level of care, which would be significantly less likely for those beneficiaries assigned to one of the lower 18 groups.

In this final rule, we are continuing the existing designation of the upper 26 RUG–III groups for purposes of this administrative presumption. Accordingly, we are designating the following RUG–III classifications:

- All groups within the Ultra High Rehabilitation category;
- All groups within the Very High Rehabilitation category;
- All groups within the High Rehabilitation category;
- All groups within the Medium Rehabilitation category;
- All groups within the Low Rehabilitation category;
- All groups within the Extensive Services category;
- All groups within the Special Care category; and
- All groups within the Clinically Complex category.

Comment: One commenter supported the continuation of our presumption policy based on accurate classification into one of the upper 26 RUG–III groups.

Response: We agree that this policy should be retained.

F. Expiration of Initial Three-Year Transition Period

As noted previously in sections I.A and I.E.2 of this final rule, the initial three-year transition period from facility-specific to Federal rates under the SNF PPS has expired. Therefore, payment now equals 100 percent of the adjusted Federal per diem rate.

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

Using the XYZ SNF described in Table 9, the following shows the adjustments made to the Federal per

diem rate to compute the provider's actual per diem PPS payment. XYZ's 12-month cost reporting period begins October 1, 2004. XYZ's total PPS payment would equal $20,379. The Labor and Non-labor columns are derived from Table 5. In addition, the adjustments for certain specified RUG–III groups enacted in section 101(a) of the BBRA (as amended by section 314 of the BIPA) remain in effect, and are reflected in Table 9.

TABLE 9.—SNF XYZ: LOCATED IN STATE COLLEGE, PA

[Wage Index: 0.8705]

RUG group	Labor	Wage index	Adj. labor	Non-labor	Adj. rate	Percent adjustment	Medicare days	Payment
RVC	$268.21	0.8705	$233.48	$82.98	$316.46	$337.66*	14	$4,727
RHA	207.28	0.8705	180.44	64.13	244.57	260.96*	16	4,175
SSC	172.65	0.8705	150.29	53.41	203.70	244.44**	30	7,333
IA2	117.07	0.8705	101.91	36.22	138.13	138.13	30	4,144
Total	.....	.....	.....	.....	.....	.....	90	20,379

* Reflects a 6.7 percent adjustment from section 314 of the BIPA.
** Reflects a 20 percent adjustment from section 101(a) of the BBRA.

H. SNF Market Basket Index

1. Background

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 final rule 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 the July 31, 2001 **Federal Register** (66 FR 39562), 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 were illustrated in Table 10.A, Table 10.B, and Appendix A, along with other relevant information, in the July 31, 2001 **Federal Register**.

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 10 summarizes the updated labor-related share for FY 2004.

TABLE 10.—FY 2004 LABOR-RELATED SHARE

Cost category	FY 2003 Relative importance	FY 2004 Relative importance
Wages and Salaries	54.796	55.115
Employee Benefits	11.232	11.304
Nonmedical Professional Fees	2.652	2.651
Labor-Intensive Services	4.124	4.130
Capital-Related	3.324	3.172
Total	76.128	76.372

Source: (Table 10) Global Insights, Inc., DRI–WEFA, 4th Quarter, 2002.

2. Use of the SNF 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 index level of the prior fiscal year to the average index level of the current fiscal year. For the Federal rates established in this final rule, this percentage increase in the SNF market basket index is used to compute the update factor occurring between FY 2003 and FY 2004. We used the Global Insights, Inc. (formerly DRI–WEFA), 4th quarter 2002 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.

3. Market Basket Forecast Error Adjustment

In the supplemental proposed rule, we discussed the possibility of developing a market basket forecast adjustment to the rates. We solicited comments on—

- The appropriateness of making a cumulative market basket forecast adjustment reflecting underforecasts since the start of the SNF PPS;
- The continued use of this forecast error adjustment in future rate years;
- The appropriateness of applying a threshold to these annual rate adjustments; and
- Ways that we could use our authority to encourage industry innovation and monitor efforts to further promote quality improvement efforts among SNFs (see section III.L).

4. Federal Rate Update Factor

Section 1888(e)(4)(E)(ii)(IV) of the Act requires that the update factor used to establish the FY 2004 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, 2002 through September 30, 2003 to the average market basket level for the period of October 1, 2003 through September 30, 2004. Using this process, the market basket update factor for FY 2004 SNF Federal rates is 3.0 percent. In addition, as noted in the comments and responses shown below, the rates were adjusted by 3.26 percent to reflect the difference between the market basket forecast and the actual market basket increase from the start of the SNF PPS in July 1998.

We used this revised update factor to compute the Federal portion of the SNF PPS rate shown in Tables 1 and 2.

Comment: The majority of commenters strongly supported the proposed rule's provision for a full market basket adjustment for FY 2004. However, a few commenters cited a MedPAC analysis indicating that an across-the-board update may not be appropriate. These commenters recommended either a zero update or an update targeted to specific types of providers, such as hospital-based SNFs.

Response: We are required by statute to implement a full market basket adjustment for FY 2004. In the proposed rule, we published a preliminary market basket factor of 2.9 percent, based on the Global Insights Inc., DRI-WEFA, 4th Quarter, 2002 update. For this final rule, we are using an updated market basket forecast amount of 3.0 percent, based on the Global Insights Inc., DRI-WEFA, 2nd Quarter, 2003 update, which is the most recent data available.

Comment: The vast majority of commenters supported our proposal in the supplemental proposed rule to incorporate a market basket forecast error adjustment into the SNF PPS rate-setting system. These commenters urged us to implement the 3.26 percent cumulative market basket adjustment for the FY 2004 rates. They indicated that the cumulative adjustment is a necessary stabilizing factor, and reflects actual market conditions. A few commenters questioned the necessity of this cumulative adjustment, and suggested that the money could be used more effectively if targeted to specific programs. However, all commenters agreed that, if we proceeded with the cumulative market basket forecast error adjustment, we should apply the forecast error adjustment in subsequent rate years, even in situations where an overstatement of the forecasted market basket adjustment could result in a later downward adjustment.

Response: We carefully considered the implications of adopting this market basket forecast error adjustment. We concluded that, in making the 3.26 percent adjustment, we are not providing a source of new industry funding. Instead, we are correcting an underforecast of pricing levels that resulted in lower payments than we would otherwise have made if actual, instead of forecast, data were used. To a great extent, this underforecast reflects the faster-than-expected growth in wages and benefits for nursing home workers since the start of the SNF PPS, as a result of continued rapid growth in the health sector and the shortage of nurses. As a result of these market conditions, SNFs have already incurred expenses at a higher-than-forecasted level. Our overarching Medicare integrity goal is to pay the appropriate amount, to the correct provider, for the proper service, at the right time. Adjusting for this difference between the forecasted and actual market basket values is consistent with that goal. Therefore, we will implement the 3.26 percent cumulative adjustment for FY 2004. For future years, as actual market basket data become available, we will apply the forecast error adjustment to subsequent rate years. As explained in our supplemental proposed rule, this annual adjustment will be applied on a two-year lag basis (that is, the time period for obtaining final market basket data), and will reflect both upward and downward adjustments, as appropriate.

Comment: Several commenters expressed concern about the proposed use of a 0.25 percentage point threshold for application of the annual forecast adjustments. Some commenters maintained that every forecast error, however small, should be corrected, and that the use of a threshold would build over time, resulting in increasing inaccuracies in the rates. Other commenters said that the adjustment should be meaningful, and that the 0.25 percent threshold was consistent with similar CMS rate-setting provisions. A few commenters suggested increasing the threshold.

Response: In the supplemental proposed rule, we discussed establishing an adjustment for forecast error that would take account annually a forecast error that was at least 0.25 percentage points above or below the actual market basket performance. For the capital PPS update and in the hospital PPS update framework, a forecast error adjustment is reflected only when the forecast and actual market basket percent changes differ by more than 0.25 percentage points. To apply this methodology to the SNF PPS would follow an established practice. In addition, our experience with those PPS frameworks suggests that the forecast errors are relatively small, and generally clustered around zero, so we do not anticipate an accumulation that would significantly affect the rates over time. We are more concerned that the forecast error in any given year is large enough that the SNF PPS base payment rate does not adequately reflect the historical price changes faced by SNFs. Therefore, we will use the 0.25 percentage point threshold to determine whether a forecast error adjustment is appropriate.

Comment: A few commenters expressed concern about the market basket and its methodology and urged us to institute a thorough review of all of the weight and price proxy components in the market basket, particularly wages, capital, and malpractice insurance. These commenters proposed a collaborative effort between the Federal government and private industry to review the market basket methodology.

Response: We agree that it is important to review the market basket weights and price proxies regularly to ensure that they adequately reflect the requirements of section 1888(e)(5) of the Act. It has always been our policy to regularly revise and update the market basket when appropriate, and we did so most recently in 2001, when we rebased the market basket to reflect 1997 cost data. In addition, we have discussed issues related to the market basket with interested parties since the implementation of the SNF PPS, and continue to do so in order to have a technically and conceptually sound market basket that satisfies the legislative requirement explained in section 1888(e)(5) of the Act.

In the July 31, 2001 final rule introducing the 1997-based market basket, we fully explained our criteria for choosing price proxies for market basket cost categories. We use four criteria for this process: timeliness (published and available on a regular basis, preferably at least quarterly, with little lag), reliability (consistent historical time-series as well as being technically and methodologically sound), representativeness (reflecting or proxying actual provider experience), and relevance (holding non-price factors constant, such as skill mix and quality shifts). The current price proxy for wages and salaries, the Employment Cost Index (ECI) for nursing home workers, meets all four of these criteria. We believe that the ECI better meets our criteria than the two other government statistics for nursing home wages, the Average Hourly Earnings (AHE) for nonsupervisory workers in nursing homes and the Employer Cost for Employee Compensation (ECEC) for workers in nursing homes. Although the ECI represents total nursing home wages and salaries, SNFs comprise over 75 percent both of employment and payroll totals for the nursing home industry and, with this representation, SNF wages and salaries are the drivers for changes in the ECI for nursing home wages and salaries. Thus, given available data, we continue to believe that the ECI for nursing home workers is the most appropriate price proxy for growth in wages in SNFs, and we will continue to use it in the SNF market basket. It should be noted that the use

of this wage proxy should not be confused with the forecast error correction, which is only the difference between the actual and forecasted percent change in the ''same'' market basket.

These commenters disagreed with the use of the average yield for AAA bonds as the price proxy for interest costs of for-profit nursing homes, rather than the average yield for BAA or lower rated bonds. In the SNF market basket, the change in the average yield for AAA bonds is used in calculating the SNF market basket price change of the debt held by for-profit SNFs. The amount of the bonds issued, the average term of these bonds, and the mix of bond ratings issued should all be held constant in a fixed-weight Laspeyres price index, such as the SNF market basket. The price change of interest costs associated with corporate bonds should reflect the change in interest rates (yield) for the mix of differently rated corporate bonds held in the base period. Our price proxy should represent the change in the interest rates associated with this fixed mix.

We have conducted sensitivity analyses of the market basket using the change in the yield for different bond ratings, and the change in the long-run yields of AAA, AA, A, and BAA bonds were all very similar. The use of any of these bond yields would produce essentially similar results. For simplicity, both in the maintenance of the index and in the availability of forecasted data, we have chosen to use Moody's AAA corporate bonds. Had we used BAA corporate bonds, the resulting SNF market basket increases would have been identical.

We believe that the current method for reflecting corporate bond prices in the SNF market basket is appropriate because it keeps the mix of corporate bonds issued constant at the base period proportions and captures the associated price change in this mix without having to reflect the rating on each separately issued bond, since they move similarly over time. While we understand the commenter's concern, our research and analysis indicate that our method of accounting for change in bond prices for for-profit SNFs in the market basket is appropriate.

These commenters noted that the current price proxies for interest costs do not reflect the short-term nature of the debt funding currently available to the industry or the fluctuations in rate changes in the leasing marketplace. These are important issues and we will continue to conduct the necessary research on these topics to ensure that they are adequately considered in the market basket. Since we currently use a similar debt life for SNFs and hospitals when vintage weighting the capital components of the market basket, a movement towards shorter average debt terms for SNFs should be considered. (Vintage weighting is the process of weighting together the price changes of current and prior capital purchases (or debt held) based on the average historical acquisition pattern over the useful life of the asset or debt instrument.) We will review available data sources on this information and make a change if appropriate. While we currently believe that leasing costs are appropriately accounted for in the market basket, we will also review this issue more fully to ensure that this is both theoretically and empirically the case.

When we rebased the SNF market basket in 2001, we reviewed Medicare cost report data on professional liability insurance, and found that the vast majority of SNFs did not enter their data into this section of the cost reports (only about 20 SNFs provided that information in 1997). We also looked at Department of Commerce Input-Output data for 1997, and found that insurance was less than 0.2 percent of total SNF expenses. Because the SNF market basket is currently based on the cost structure facing SNFs in 1997, it appears that professional liability costs are a very small portion of total costs and, thus, would likely not have a significant impact on the market basket percentage change. However, we also understand the emerging importance of this issue to SNFs and will continue to review the Medicare cost report data, as well as any other data sources that commenters can recommend to us that would meet our criteria, with the hope that we may possibly incorporate this information into the market basket structure when appropriate.

Comment: A commenter stated that we should reconsider the necessity of a two-year forecast error correction lag if, over time, data become available on a more timely basis.

Response: It is our policy when determining the forecast error correction to use the most recent data available. Currently, this would mean a two-year lag on the correction is necessary, since historical data for the current fiscal year are not available until after the following year's update is determined. Should the data become available on a quicker basis, we would investigate the continued need for a two-year lag. However, a change in availability of data is unlikely, since these data (primarily from Federal government databases) are published on pre-determined schedules. Producer Price Indices (PPI), for instance, are not final until five months after the reference month, and Employment Cost Indices (ECI) only become available in the quarter following the reference quarter. Based on these schedules, for example, a determination of the actual market basket change for FY 2004 would not be available until March 2005. Therefore, it would be impossible to incorporate this information any earlier than the FY 2006 update, creating an unavoidable two-year lag.

I. Consolidated Billing

As established by section 4432(b) of the BBA, the consolidated billing requirement 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. Section 103 of the BBRA amended this provision by further excluding a number of high-cost, low probability services (identified by Healthcare Common Procedure Coding System (HCPCS) codes) within several broader categories that otherwise remained subject to the provision. 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.) In addition, section 313 of the BIPA specified that consolidated billing applies only to services furnished to those individuals residing in an institution (or portion of an institution) that is actually certified by Medicare as a SNF.

To date, the Congress has enacted no further legislation affecting the consolidated billing provision. However, as we noted in the April 10, 2000 proposed rule (65 FR 19232), section 1888(e)(2)(A)(iii) of the Act, as added by 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 gives the Secretary the authority to designate additional, individual services for exclusion within each of the specified service categories.'' In the FY 2001 proposed rule, we also noted that the BBRA Conference Report (H.R. Conf.

Rep. No. 106–479 at 854) 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 July 31, 2000 final rule (65 FR 46790), 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 view of the amount of time that has elapsed since we made that statement, we invited public comments in the May 16, 2003 proposed rule (68 FR 26776) on codes in any of these four service categories which represent recent medical advances that might meet the BBRA criteria for exclusion from SNF consolidated billing.

Comment: Although the proposed rule specifically invited comments on possible exclusions within the specific service categories identified in the BBRA legislation, a number of commenters took this opportunity to reiterate concerns about other aspects of consolidated billing. For example, we received a number of comments concerning the possible exclusion of additional categories of services from SNF consolidated billing, beyond those specified in the BBRA. The commenters identified services such as modified barium swallows, stress tests, hyperbaric oxygen treatments, doppler studies, and nuclear medicine scans as appropriate candidates for exclusion. In addition, a number of commenters recommended a further set of services for exclusion. These additional services are durable medical equipment (including, but not limited to, ventilators, speech devices, specialty beds, wheelchairs, wound care devices and diabetic shoes), antibiotics, TPN, and diagnostic tests.

Response: As enacted by section 4432(b) of the BBA, the original set of consolidated billing exclusions at section 1888(e)(2)(A)(ii) of the Act broadly excluded entire categories of services from consolidated billing (primarily, those of physicians and certain other types of medical practitioners). By contrast, the set of statutory exclusions at section 1888(e)(2)(A)(iii) of the Act, as subsequently enacted by section 103 of the BBRA, was more specifically targeted within a number of broader service categories. In the proposed rule, we noted that the original BBRA legislation (as well as the implementing regulations) provides the Secretary the authority to designate additional, individual services for exclusion within each of the BBRA-specified service categories. However, the statute does not provide the Secretary the authority to create additional categories of excluded services beyond those specified in the law. Therefore, based on the statute, we cannot exclude services and items from consolidated billing unless they fall into the categories of services provided in the statute and addressed in the BBRA.

Comment: Several commenters recommended that we exclude a variety of additional chemotherapy agents and radioisotopes used for cancer treatment. One commenter specifically recommended that we exclude Zevalin which is used in the treatment of non-Hodgkins lymphoma.

Response: The BBRA specified that certain chemotherapy drugs and radioisotope services (sections 1888(e)(2)(A)(iii)(II) and (IV) of the Act) be excluded from the SNF PPS payments. Specific chemotherapy drugs and radioisotope services were then identified by HCPCS code in the statute. The BBRA authorized us to update the list of excluded services to reflect advances in technology and medical practice.

We note that most of the chemotherapy drugs and radioisotope services mentioned by commenters were considered for exclusion under the BBRA, but were not adopted by the Congress in the BBRA list of excluded items and services.

However, we did identify a new radiopharmaceutical (that is, radiotherapeutic substance linked to a radioisotope administered to deliver therapeutic radioactivity), Zevalin, which combines elements of both the chemotherapy and radioisotope categories excluded under the BBRA. This radiopharmaceutical links monoclonal antibodies with a radioisotope. In the case of Zevalin, the monoclonal antibody it uses is a chemotherapy drug that is already excluded from the SNF PPS payments. In addition, the Food and Drug Administration (FDA) has recently approved Bexxar, a radiopharmaceutical equivalent to Zevalin. We believe that these two radiopharmaceutical agents meet the criteria that were used to create the original lists of items to be excluded, because they are high-cost services that are unlikely to be used in the SNF setting, and that could not have been reflected in the base year costs for the SNF PPS (since neither of these products were available at that time).

Accordingly, we will add Zevalin (HCPCS codes A9522 and A9523) and Bexxar (HCPCS code not yet available) to the list of items excluded from consolidated billing. These exclusions will appear in the Consolidated Billing Annual Update Program Memorandum that we will issue at the end of CY 2003, and will be effective as of January 1, 2004.

In excluding the additional services from consolidated billing and the SNF PPS (and, thus, qualifying them for separate payment under Part B), section 103 of the BBRA also mandated a corresponding proportional reduction in Part A SNF payments, beginning with FY 2001. Specifically, section 1888(e)(4)(G)(iii) of the Act provides that the Secretary ''* * * shall provide for an appropriate proportional reduction in payments'' so that the *aggregate* reduction in Part A payments is equal to the *aggregate* increase in Part B payments attributable to the exclusions provided under section 1888(e)(2)(A)(iii) of the Act. This requirement applies not only to the original legislation, but to the BBRA-authorized update process. Thus, the actual result of this provision's mandatory Part A payment reduction is to take the expense of the excluded items (which could be financially devastating to an individual SNF that actually incurs it, if borne solely by that particular facility) and effectively redistribute it over the entire universe of providers. As we noted in the July 31, 2000 final rule (65 FR 46792), in much the same way that an insurance pool reduces the degree of financial risk to an

individual member of the pool in the event of a catastrophic loss, effectively spreading the expense of the excluded items over such a large provider population helps minimize the potential financial liability that any individual provider might otherwise incur.

The consolidated billing exclusions addressed under the BBRA were items and services that had been in use for many years. We had data for the SNF PPS base year that were used to determine utilization of these services and make the appropriate adjustment. In our July 31, 2001 final rule, we implemented a $.05 reduction in the SNF PPS rate to reflect this proportional adjustment.

The situation is slightly different when applied to these new consolidated billing exclusions. Since these two radiopharmaceuticals were not in existence during the SNF PPS base year, we cannot rely on historical utilization data to develop an appropriate reduction. In addition, as a new class of treatment, there may not be a relationship between the use of these radiopharmaceuticals and the use of other chemotherapy agents or radioisotopes used during the SNF PPS base year.

In light of these considerations, we have developed the following approach. We estimate the combined utilization of these two radiopharmaceuticals to be approximately 25 doses per year, which most closely equates to a $.01 reduction to the unadjusted urban and rural SNF PPS per diem rates to reflect the FY 2004 revision of the consolidated billing exclusions. (For comparison purposes, as stated above, the offset used to adjust for the complete list of BBRA exclusions was a negative $.05 adjustment.) Once we have collected actual utilization data on the use of these new radiopharmaceuticals (as well as on changes in utilization in other chemotherapy and radioisotope agents), we will reassess whether the $.01 offset most accurately represents an ''appropriate proportional reduction'' in Part A SNF payments under section 1888(e)(4)(G)(iii) of the Act, and will make any appropriate adjustments in the amount of that offset. This aggregate adjustment could involve either an increase or decrease in the interim $.01 offset amount applied for FY 2004, in order to ensure that the final adjustment most accurately reflects the ''appropriate proportional reduction'' required under section 1888(e)(4)(G)(iii) of the Act.

Comment: Some commenters cited the existing list of exclusions (in § 411.15(p)(3)(iii)) for certain high-intensity outpatient hospital services, and expressed the view that these exclusions should not be limited to only those services that actually require the intensity of a hospital setting, but rather, should also encompass services furnished in other, nonhospital settings as well. As an example, they cited services such as magnetic resonance imaging (MRIs) furnished in freestanding imaging centers and radiation therapy furnished in freestanding oncology centers, both of which may be cheaper and more accessible in certain particular localities than those furnished by hospitals.

Response: As we noted in the May 12, 1998 interim final rule (63 FR 26298), and again in the July 31, 2000 final rule (65 FR 46790 through 46791), the exclusion of certain outpatient hospital services (in § 411.15(p)(3)(iii)) is targeted specifically at those services ''* * * that, under commonly accepted standards of medical practice, lie *exclusively* within the purview of hospitals * * *'' (emphasis added); that is, services which generally require the intensity of the hospital setting in order to be furnished safely and effectively. Basically, we determined that this high level of outpatient hospital care is beyond the scope of SNF comprehensive care plans and should be excluded from consolidated billing. The intensive outpatient hospital services identified under this exclusion were not subject to consolidated billing. However, this exclusion does not encompass services furnished in any other health care setting. Thus, to the extent that advances in medical practice over time may make it feasible to perform such a service more widely in a less intensive, nonhospital setting, this would not argue in favor of unbundling the nonhospital performance of the service under these regulations, but rather, of considering whether to rebundle the service entirely back to the SNF. In addition, we note that unlike the outpatient hospital exclusions in § 411.15(p)(3)(iii), the statutory exclusions enacted by the BBRA for certain chemotherapy and other services apply regardless of the setting (hospital versus freestanding) in which the services are furnished. Adding services such as MRIs and radiation therapy to the existing statutory list of exclusions would require legislation by the Congress to amend the law itself.

Comment: One commenter requested the exclusion of specific speech-language pathology evaluations and treatments.

Response: As we noted in the FY 2002 proposed rule (66 FR 24020), we regard the provision of therapy services as an inherent and integral function of an SNF, and we believe that the statutory provisions on consolidated billing clearly reflect this position. Section 1888(e)(2)(A)(ii) of the Act provides that physical, occupational, and speech-language therapy services are subject to consolidated billing, even when performed by a type of practitioner (for example, a physician) whose services would otherwise be excluded. In addition, section 1862(a)(18) of the Act specifies that consolidated billing applies to these services when furnished to *any* resident of an SNF, even if Part A does not cover the resident's stay. Accordingly, all physical, occupational, and speech-language therapy services furnished to SNF residents are subject to consolidated billing, and any changes to this aspect of the provision would require legislation by the Congress to amend the law.

Comment: Several commenters also proposed expanding the list of excluded services by redefining categories of service that are currently excluded from consolidated billing. For example, while the BBRA excludes specific chemotherapy services by HCPCS codes, these commenters recommended not only adding to the list of excluded chemotherapy pharmaceuticals, but expanding the exclusion to encompass all related services associated with a chemotherapy treatment, such as supplies and other pharmaceuticals used to treat side effects. In addition, several commenters recommended exclusion of oral chemotherapy agents that are not separately billable to Medicare Part B for any beneficiary, and are currently covered only as part of the overall package of services furnished under the Part A inpatient hospital or SNF benefits.

Response: In the proposed rule, we noted that the BBRA's list of services excluded by HCPCS code is a targeted list, narrowly carving out only certain individual ''high-cost, low probability'' services *within* a number of broader service categories—such as chemotherapy services—that otherwise remained subject to consolidated billing. As we noted in the proposed rule (68 FR 26776), the BBRA provides the Secretary the authority to designate additional, individual services for exclusion within each of the service categories that it specifies. However, the statute does not provide authority to exclude other services that, while related, fall outside of the specified service categories themselves. For example, although anti-nausea drugs are commonly used *in conjunction with* chemotherapy, they are not in themselves chemotherapeutic agents and, consequently, do not fall within

one of the excluded categories designated in the BBRA. Further, we believe that the Congress was clear in its intent regarding the particular items and services to be excluded from consolidated billing, by use of the HCPCS codes specified in the Act. Regarding the suggestion to exclude from consolidated billing those oral chemotherapy agents that are not separately billable to Part B (and are currently covered only under the Part A inpatient hospital and SNF benefits), we note that expanding the existing drug coverage available under Part B to include those drugs is not within our authority. Implementing this change would require legislation by the Congress to amend the law.

We note that some chemotherapy pharmaceuticals that commenters proposed for exclusion have already been included in the list of HCPCS codes excluded from the consolidated billing provisions. The most recent annual update regarding HCPCS exclusions from consolidating billing can be found in Program Memorandum A–02–118 (Change Request (CR) #2459), published November 8, 2002.

Comment: Two commenters requested an expansion of the dialysis exclusion to encompass dialysis services furnished directly by the SNF. In addition, several commenters noted that erythropoietin (EPO) currently is excluded from consolidated billing only when furnished in conjunction with the Part B dialysis benefit, and they recommended expanding this exclusion to encompass its use in connection with other, non-dialysis forms of treatment (such as chemotherapy).

Response: Under section 1888(e)(2)(A)(ii) of the Act, the exclusion of dialysis services from consolidated billing applies only to those services that meet the requirements for coverage under the separate Part B dialysis benefit at section 1861(s)(2)(F) of the Act. The Part B benefit allows for home dialysis and dialysis performed on the premises of a certified dialysis facility. By contrast, if the SNF itself elects to furnish dialysis services to a resident during a covered Part A stay (either directly with its own resources, or under an ''arrangement'' with a certified dialysis facility in which the SNF itself does the billing), the services are no longer considered Part B dialysis services, but rather, are Part A SNF services. Accordingly, they would no longer qualify for the statutory exclusion of Part B dialysis services from consolidated billing, and would instead be bundled into the comprehensive PPS per diem payment that the SNF receives for the package of services that it furnishes during the resident's covered Part A stay. Any change in the scope of the dialysis exclusion from consolidated billing would require legislation by the Congress to amend the law. We note that we are proactively monitoring the impact of the SNF PPS to ensure that beneficiary access is not compromised. To that end, we have requested that the Office of the Inspector General (OIG) specifically examine the effect of the PPS on SNF residents' access to dialysis treatment. We will continue to gather extensive information from around the country with respect to SNF PPS implementation and will look to a variety of sources for objective information and evidence of the impact of this policy on access to quality care.

Similarly, under section 1888(e)(2)(A)(ii) of the Act, the exclusion of EPO from consolidated billing applies only to those services that meet the requirements for coverage under the separate Part B EPO benefit at section 1861(s)(2)(O) of the Act. Section 1861(s)(2)(O) of the Act permits coverage of EPO and items related to its administration for those dialysis patients who can self-administer the drug, subject to methods and standards established by the Secretary for its safe and effective use (as described in § 405.2163(g) and (h)). Since EPO that is used for non-dialysis patients does not fall within the scope of section 1861(s)(2)(O) of the Act, that usage does not fall within the scope of the EPO exclusion from consolidated billing.

Comment: One commenter requested that we ''develop a system to eliminate the billing of SNFs for extraneous physician visits.''

Response: Under section 1888(e)(2)(A)(ii) of the Act and § 411.15(p)(2)(i) of the regulations, physician services that meet the criteria for payment on a fee schedule basis are excluded from consolidated billing and, accordingly, can already be billed directly to the Part B carrier by physicians themselves.

Comment: A few commenters recommended expanding the consolidated billing exclusions to provide short-term relief pending the implementation of SNF PPS refinements. They urged this course of action as a way of ensuring continued access to SNF care for beneficiaries with heavy non-therapy ancillary needs.

Response: We agree that the SNF PPS needs to identify more accurately those beneficiaries with high pharmaceutical and other non-therapy ancillary needs, and we are actively conducting research designed to address these issues. However, we do not have the authority, nor do we believe it is appropriate, to expand the consolidated billing exclusions as a substitute for actual refinements. As we noted in the July 31, 2001 final rule (66 FR 39588) in response to similar comments,

> * * * we do not share the view of those commenters who suggested that the creation of additional exclusions from consolidated billing could serve, in effect, as an interim substitute for implementing case-mix refinements. We believe that payment adjustments relating to case-mix would best be accomplished directly through refinements in the case-mix classification system. Further, we note that the Congress has already provided an interim adjustment until the refinements can be implemented, in the form of the temporary rate increases for certain specified RUG–III groups [enacted by section 101(a) of the BBRA, as amended by section 314 of the BIPA].

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

In the July 31, 2001 final rule (66 FR 39562), we announced the conversion of swing-bed hospitals to the SNF PPS, effective with the start of the provider's first cost reporting period beginning on or after July 1, 2002. We selected this date consistent with the statutory provision to integrate swing-bed hospitals into the SNF PPS by the end of the SNF transition period, that is, June 30, 2002.

As of July 31, 2003, the SNF PPS covers all swing-bed rural hospitals (as noted previously in section I.D of this final rule, section 203 of the BIPA exempted critical access hospital (CAH) swing-beds from the SNF PPS). Therefore, all rates and wage indices outlined in earlier sections of this final rule for SNF PPS also apply to all swing-bed hospitals. A complete discussion of assessment schedules, the MDS and the transmission software, Raven-SB for Swing Beds, can be found in the July 31, 2001 final rule (66 FR 39562). The latest changes in the MDS for swing-bed hospitals are listed on our SNF PPS Web site, *http://www.cms.hhs.gov/providers/snfpps/snfpps_mds.asp*.

K. Distinct Part Definition

In the May 16, 2003 proposed rule (68 FR 26777), we noted that while some SNFs function as separate, independent entities, we have recognized since the inception of the Medicare program that it is also possible for a SNF to operate as a component, or ''distinct part'' of a larger organization. However, there was no precise definition of a ''distinct part.'' In this final rule, we are clarifying the definition of a distinct part, by adopting a set of criteria that provides

more precise guidance to providers and State licensure and certification agencies. This guidance will assist providers in understanding the criteria that govern the financial and organizational structure of these entities to facilitate the Medicare and Medicaid approval process.

Further, we proposed adopting certain additional criteria that would apply specifically to what we define in the rule as a composite distinct part SNF and/or NF. Under these criteria, a composite distinct part would be treated as a single distinct part of the institution of which it is a distinct part, and, as such, would operate under a single provider agreement with a single provider number. Further, to ensure quality of care and quality of life for all residents, we proposed that the composite distinct part would be required to meet all of the participation requirements set forth in subpart B of part 483 independently in each location. We also proposed amending § 483.10 and § 483.12 to afford certain protections and rights to residents located in a composite distinct part SNF and/or NF.

Comment: A commenter believed that the new criteria for distinct part certification were intended to determine if a facility was provider-based and a distinct part of a larger facility. Several other commenters believe that if a SNF meets the requirements of § 413.65 (provider-based), it is automatically considered a distinct part of the hospital to which it claims to be based.

Response: The distinct part certification requirements set forth in § 483.5 are separate and apart from the requirements to be considered ''provider based'' as set forth in § 413.65. Indeed, SNFs are no longer required to request or be approved for provider-based status and are not subject to the provider-based regulations in § 413.65. Moreover, simply meeting the provider-based requirements, which, as we have previously stated do not apply to SNFs, does not translate to automatically meeting the distinct part requirements. Accordingly, we will evaluate each request for approval of a distinct part SNF or NF against the criteria outlined in § 483.5.

Comment: Several facilities have questioned whether the receipt of a higher rate of Medicaid reimbursement is a justifiable reason for us to determine that a particular nursing facility is a part of a distinct part composite.

Response: We do not consider it an efficient use of public monies to approve a composite distinct part or, for that matter, a distinct part for the sole purpose of enhancing its Medicaid payment.

Comment: Several commenters recommend that we eliminate the condition that beds cannot be scattered throughout the facility.

Response: The Committee Report that accompanied the original Medicare legislation (Sen. Fin. Comm. Rep. No. 404, 89th Congress, 1st Session 31–32 (1965)) stated that a posthospital extended care facility could be an institution such as a skilled nursing home or a distinct part of an institution, such as a ward or wing of a hospital or a section of a facility another part of which might serve as an old age home. The regulations at 42 CFR 440.155 describe a distinct part as '' * * * an identifiable unit such as an entire ward or contiguous ward, a wing, floor or building.'' Thus, we believe that there is no legal basis for permitting the scattering of beneficiaries throughout the institution's physical plant. Also, the scattering of beneficiaries throughout the physical plant would make the survey and certification of SNFs and NFs a much more burdensome and complicated process. Finally, it would mean that we would be applying our rules to residents or beds *per se* rather than to providers. We apply our requirements to facilities, not beds or residents. Thus, the institution must clearly designate the area that is the proposed distinct part SNF and/or NF.

Comment: Several commenters suggested that we allow facilities to designate the number of beds to be approved and to identify those beds anywhere within the facility for cost accounting or survey purposes. The commenters add that in the approval process of a SNF distinct part, the facility would demonstrate to us the cost accounting methodology for a Medicare distinct part. Regulations for cost accounting for a Medicaid distinct part would be at the discretion of the State. The commenters indicate that, during the onsite survey, the facility would disclose the beds/rooms that the facility has designated as comprising the SNF or NF distinct part.

Response: We agree that an institution or institutional complex should be allowed to identify the number of beds to be approved in accordance with our policy. We also agree that an institution or institutional complex be allowed to identify the building(s) or identify parts of building(s) (that is wings, wards, or floors) where the distinct part is located as long as the location comports with the distinct part rules. However, for both cost accounting and survey and certification purposes, we must know in advance of the initial or recertification surveys, the number of beds in the distinct part and the location of the distinct part with respect to the entire complex. This assures that the surveying entity, either the State survey agency or our regional office, can allocate adequate resources to conduct the survey and then proceed directly to the distinct part to begin the survey. It also provides for adequate cost information from the provider's records to support payments made for services furnished to beneficiaries. If there are changes in the number of distinct part beds and/or their location in an approved distinct part facility, we must approve those changes in accordance with established policy.

Comment: One commenter states that we are forcing nursing homes to transfer residents to different rooms based on the certification of beds.

Response: We disagree with the commenter. It is the nursing home, not the Medicare or Medicaid program, that decides in which room an individual will be placed. As noted previously, facilities are certified, not beds. An individual, in selecting a nursing home for Medicare or Medicaid purposes, may choose any facility he/she likes provided the selected facility chooses to accept him or her. If a nursing home wants to place a person anywhere in the home, the facility could choose to have the entire nursing home participate in both Medicare and Medicaid.

Comment: Several commenters expressed concern with the ''close proximity'' requirements set forth in the definition of a distinct part relating to location. Another commenter even recommended that the definition of a distinct part exclude reference to location. Instead, the commenter suggested that the definition be revised to include being adjacent to, on the same campus of, or on multiple campuses of an institution that meets all the criteria of ownership and management control mentioned in § 483.5(b)(2). Yet another commenter believes that the requirements for location required that the distinct part be located strictly in the main building and not be allowed to exist at another location that is part of the institution's campus.

Response: In the definition of a distinct part set forth in the proposed rule of May 16, 2003 (68 FR 26758), we stated that an SNF or NF distinct part may be comprised of one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are—

• In the same physical area immediately adjacent to the institution's main buildings;

• Other areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and

• Any other areas that we determine on an individual basis, to be part of the institution's campus.

While we understand the concerns expressed by these commenters, we are retaining the language in the proposed rule regarding location and close proximity to afford flexibility in our determinations. It is our view that, in order to meet the requirements for supervision and control, and to function as an integral and subordinate part of the institution, with significant common resource usage of buildings, equipment, personnel and services, a distinct part would need to be located in close proximity to the institution of which it is a part. However, to clarify and address some of the commenters' concerns, we are revising § 483.5(b)(1) by clarifying that a distinct part SNF or NF is ''physically distinguishable from the larger institution'' rather than ''a physically identifiable component.'' As for concerns with respect to locations outside the institution's main building, we believe the definition provides flexibility to recognize distinct part SNFs or NFs that are not co-located at the institution's main building and, in conformity with the regulations as finalized, will continue to do so by making such determinations on an individual basis.

Comment: A commenter suggested that, instead of creating the term ''composite distinct part,'' we broaden the definition of distinct part, thus negating the necessity to make composite distinct part a separate term.

Response: Although we certainly want to keep our definitions of terms as simple and as realistic as possible, we are retaining our definition of a composite distinct part because the term best describes the situations we have encountered that were not previously addressed in regulations.

Comment: Several commenters recommended that existing SNFs and NFs that are a physically identifiable component of an institution be grandfathered as appropriate as a distinct part of that institution without having to submit a written request to us. Another commenter encouraged us to provide a transition period before implementation of the distinct part definition and composite distinct part definition to allow providers time to come into compliance with the accompanying requirements.

Response: We do not agree that existing distinct part SNFs and NFs should be grandfathered. All proposed and existing distinct parts must submit a written request to us as set forth at § 483.5(b)(2)(vi). At a minimum, an SNF and/or NF must demonstrate in writing how it meets the definition of a distinct part or composite distinct part. This definition has been discussed in detail in both the proposed rule and in this final rule, and provides extensive guidance to providers on compliance with these requirements.

The effective date of this final rule is October 1, 2003. However, in response to these comments, we will disseminate administrative guidance to implement the regulation with minimal burden to providers and States, in accordance with the requirement at § 483.5(b)(2)(vi).

Comment: A commenter suggested that we allow the approval to be a distinct part to be made on a retroactive basis.

Response: We disagree. The purpose of this regulation is to codify existing criteria for approval of distinct parts. For most facilities, the impact of this regulation will be that the criteria are easier to understand and can be more readily used by facility staff to monitor continued compliance. For those entities requesting initial Medicare and/or Medicaid approval, there is no reason that the SNF or NF could not be in compliance with the criteria at the time approval is requested. Indeed, we are requiring that a request for a distinct part be part of the Medicare and/or Medicaid approval process. The same is true in situations where there is a change of ownership or a change in bed size of an existing facility. When a provider is contemplating a change of ownership, the provider must notify us in advance; thus, we are requiring that a request for distinct part approval be included as part of its notification to us. In those instances where an existing SNF or NF requests a change in bed size, that request must be filed 45 days in advance of the change as stated in established policy; therefore, we are requiring that the request for distinct part approval be included in the request for a change in bed size.

Comment: There were a number of comments regarding specific administrative procedures, such as those relating to the process for requesting a distinct part approval and the appeal of a denial of a request.

Response: We believe that the detailed distinct part criteria set forth in the regulations, as discussed further in the proposed rule and in this final rule, already provide extensive guidance to providers on compliance with these requirements. However, as we noted in the July 31, 2000 final rule (65 FR 46791), and again in the July 31, 2001 final rule (66 FR 39588), specific operational instructions are beyond the scope of the SNF PPS final rule, and are addressed instead through program issuances.

Comment: A commenter had several questions regarding the term ''composite distinct part.'' The commenter asked whether an institution may operate two or more physically separate locations all of which would qualify as SNFs, and whether we will treat them as if they are a single SNF. On the other hand, if an institution operates a SNF at two locations, will only one location qualify as a SNF and the other will qualify as a NF? The commenter also asked whether all of the various locations comprise a single composite distinct part or whether each location itself qualifies as a composite distinct part.

Response: By definition, a composite distinct part is a combination of two or more physically separate locations where SNF and/or NF services are provided, all of which operate under a single Medicare or Medicaid provider agreement, constituting a single distinct part SNF and/or a single distinct part NF.

Comment: A commenter requested that we further explain the administrative implications relating to a composite distinct part SNF or NF. The commenter specifically asked for guidance with respect to the filing of the Medicare cost report, the selection of a cost reporting period, the issuance of a provider number, the selection of a fiscal intermediary, and any additional administrative requirements.

Response: As we have stated above, a composite distinct part is in fact a combination of two or more physically separated locations where SNF and/or NF services are provided, all of which operate under a single Medicare or Medicaid provider agreement, constituting a single distinct part SNF and/or a single distinct part NF. Therefore, a composite distinct part SNF must file a single Medicare cost report, use the same cost reporting period selected by the institution of which it is a distinct part, use a single provider number and the same fiscal intermediary as that selected by the institution of which it is a distinct part. The composite distinct part is subject to the change in bed size policies that we establish for all SNFs and NFs.

Comment: Several commenters were unclear as to the reason why we were creating the term ''composite distinct part.''

Response: As we stated in the proposed rule of May 16, 2003 (68 FR 26758), the growing frequency of hospital mergers (in which each of the merging hospitals brings its own distinct part SNF and/or NF into the merger) has created situations where the newly merged hospital entity includes multiple physical plants in which SNF and/or NF services are provided in different physical locations: that is, the creation of a composite distinct part SNF and/or NF. Moreover, that hospital might additionally purchase a freestanding SNF and/or NF for use in placing those of its inpatients who are ready for hospital discharge. Existing guidance on what constitutes a distinct part does not address these types of situations. Thus, we have established these criteria in an effort to reduce uncertainty and to allow providers to make informed decisions. This rule also establishes protections for beneficiaries who reside in composite distinct parts.

Comment: A commenter questioned if States would be required to apply the same definition in determining distinct part approval for purposes of State licensing and Medicaid reimbursement laws.

Response: The criteria and definitions set forth in this rule apply to SNFs and NFs that are approved to participate in either the Medicare program or the State Medicaid program (or both). As such, for participation in the Medicare and/or Medicaid programs, the criteria in this rule must be met.

Comment: A commenter stated that we should consider CMS staff time that will be required to approve mergers.

Response: Providers who are participating in the Medicare and/or Medicaid program are required to notify us of any proposed change of ownership before the effective date of the transaction, since these transactions directly affect the provider agreement. Reviewing these transactions is a function that our Regional Offices are currently performing and will not require additional CMS staff time.

In the proposed § 483.5(c)(2)(iii), we inadvertently used the term ''hospitals'' rather than ''institutions'' in our discussion of changes of ownership. We are revising § 483.5(c)(2)(iii) by replacing the word ''hospitals'' with ''institutions,'' since this provision is meant to apply more generally to institutions, which could include, but are not limited to, hospitals. We are also replacing the word ''merged'' with ''change of ownership'' throughout the regulations text since this provision more accurately applies in all cases where there is a change of ownership. For the same reason, we are deleting the examples referencing hospitals at § 483.5(b)(1).

Comment: A commenter stated that our policy of allowing only one distinct part SNF and/or one distinct part NF is problematic as it could jeopardize the funding for certain programs that are predicated on specific State program requirements.

Response: It has been our longstanding policy that an institution or institutional complex only be allowed to have one distinct part SNF and/or one distinct part NF. Moreover, our policy is based on sections 1819(a) and 1919(a) of the Act, which define a SNF and a NF, respectively, as ''an institution (or a distinct part of an institution). * * *'' It is our view that this reference to the singular, that is, ''a'' distinct part indicates that the Congress did not contemplate permitting the establishment of more than one distinct part SNF or NF in any given institution. This language is also reflected in the Committee Report accompanying the original Medicare legislation previously discussed in the May 16, 2003 proposed rule (68 R 26777).

Comment: Several commenters suggested the term ''distinct part'' be defined using language that had previously appeared in the State Operations Manual § 2110, ''The term 'distinct part' denotes that the unit is organized and operated to give a distinct type of care within a larger organization which otherwise renders other types or levels of care. * * *''

Response: We are not making the revision, as suggested by the commenters, because this would necessitate a change in the statute.

Comment: Two commenters expressed a concern that the restrictions on room changes made within the locations of the composite distinct part would affect the transfer of residents between levels of care (that is, skilled nursing facility services are provided in one location of the composite distinct part and nursing facility services are provided in another location of the composite distinct part.)

Response: We do not consider the resident protections in newly added § 483.12(a)(8) that apply to room changes to have any impact on residents transferring between different levels of care within a composite distinct part. There is a distinction between room changes and transfers. Room changes occur within the same certified facility, such as within a composite distinct part. Section 483.12(a)(1) defines transfers and discharges as, ''* * * movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to the movement of a resident within the same certified facility.''

Comment: The commenter urged us to implement the definitions for distinct parts and composite distinct parts in a manner that neither adds administrative burden on SNFs or NFs, nor adversely affects their quality of care or financial status. The commenter stated further that State Medicaid programs and other payers should not be required to use the new definitions, and that the creation of the definitions should not hamper their ability to use the previous definitions.

Response: It is not our intent in defining the terms distinct part and composite distinct part to add to a SNF's or NF's administrative burdens or to adversely affect the quality of care provided to the residents, or to affect the SNF's or NF's financial status. We believe that our definitions of these terms should be clearly stated in regulations in order to reduce uncertainty and allow providers to make informed decisions and enhance the survey and certification process.

We do expect that the distinct part regulations be applied to SNFs participating in the Medicare program and NFs participating in the Medicaid program in exactly the same manner. As we have discussed previously, the statutory definitions of a SNF and a NF that appear in sections 1819(a) and 1919(a) of the Act, respectively, use identical language, ''an institution (or a distinct part of an institution)'' and thus are not intended to be treated differently. Moreover, § 440.155 and the Medicare guidelines concerning distinct parts have always correlated, and we believe that to allow different distinct part rules for the two programs would only create confusion and would not be consistent with the intent of the Congress. We are also making editorial technical changes to § 440.40(a)(1)(ii)(A), § 483.5(b)(1), § 483.5(b)(2), § 483.5(c), and § 483.10(b)(12). These were made solely to clarify and make more understandable the regulations text.

L. Quality of Care Efforts Under the SNF PPS

In the supplemental proposed rule (68 FR 34772), we expressed our expectation that the majority of any additional payments that might result from the introduction of a forecast error adjustment (as discussed previously in section III.H.3 of this final rule) would be used for direct care services to nursing home residents and quality improvement activities and programs. We also solicited comments on how SNFs could account for these direct care

funds, and on how we can further promote quality improvement efforts among SNFs.

Comment: A number of commenters pointed out that a primary objective of any prospective payment system is to allow providers the flexibility to manage their facilities effectively and to allocate their funding to best serve the needs of their patients. These commenters generally agreed that providers should use this flexibility to develop innovative programs to ensure high quality care, but generally did not support targeting funding to a specific service or rate component. Several commenters referenced several locally-developed programs focusing on quality improvement and customer satisfaction as examples of provider initiatives in a PPS environment. On the other hand, a few commenters took a more positive view of targeted payment rates, and recommended that we consider recent State initiatives that incorporate quality incentives or establish mandatory SNF staffing ratios.

Response: In considering the adoption of a market basket forecast error adjustment, we carefully evaluated industry comments for the implications of targeting this additional funding to quality improvements. While generally positive about the need to maintain and enhance direct care services, many commenters strongly urged us to maintain the integrity of the PPS as the best means of achieving improved patient care. These commenters maintained that the most effective way to manage operations and improve quality is to allow managers the flexibility they need to address the needs of their patients quickly. They expressed concern that earmarking funds for a specific care component (such as nurse staffing or pharmaceuticals) would restrict rather than enhance this flexibility, and could result in a negative, rather than a positive impact on patient care. While we strongly support the development of quality incentives within the structure of our payment systems, we agree that any such initiatives will need to be carefully designed and tested to ensure an appropriate and beneficial effect on direct care and patient outcomes.

A few commenters recommended that we establish specific quality and/or staffing standards. Although we do have research data that links staffing levels and patient outcomes, these research projects have not provided us with the specific analyses (including the trade off between cost and quality) that we would need to establish either minimum or recommended staffing levels, or to adjust those staffing levels for specific acuity or functional limitation populations. Therefore, it became apparent that we do not currently have a clear way to target payments to quality improvements in a uniform manner that will benefit the Medicare program in general. However, we want to reiterate our expectation that this additional funding be used to improve direct care. We strongly encourage providers to continue their efforts to develop and expand programs such as the grass roots initiatives discussed later in this preamble that promote high quality care.

We are also continuing to explore a variety of quality initiatives, including the relationship between staffing and quality outcomes. We have recently awarded a contract to generate an informed set of CMS options for establishing a system of public reporting of nursing home staffing information. The report will detail a set of options for us to consider with respect to which data elements to collect, and how those data elements can best be transmitted, audited, and displayed on our Web site along with other consumer information. The data obtained with this contract will be used in continuing analysis of staffing levels and resident outcomes. We are also in the process of awarding another contract that will expand on the current nurse staffing study. This contract will examine staffing in general in an attempt to develop a quality measure(s) for reporting as part of the Nursing Home Quality Initiative (NHQI) effort.

Finally, the Department has recently completed, under contract, a study of State-initiated nursing home quality programs and will soon be completing another contracted study on State-initiated nursing home nurse staffing ratios. We plan to further investigate various State initiatives designed to integrate quality incentives into their payment systems. For example, some States already tie direct care reimbursement to actual direct care staffing expenditures. In addition, other States are looking at a variety of best practice standards that could be monitored and recognized through incentive payments. We plan to incorporate any promising State initiatives into our ongoing research efforts, which could serve as the basis for future recommendations.

Comment: Several commenters pointed out that the national nursing facility trade associations and their State affiliates are already strongly committed to enhancing quality, and described a number of grass roots initiatives, including State-wide customer service and public reporting programs, State-association-run quality monitoring and early warning systems, and a variety of programs to train staff, provide career ladders, and increase retention. These commenters pointed out that the national nursing facility trade associations have strongly supported the development of our quality measures, and are working in partnership with us on a number of other quality initiatives. Other commenters cited industry interest in and support for a number of initiatives, including the Eden Alternative, Wellspring, and the Pioneer Network, which have demonstrated the ability to attract and retain high quality staff.

Response: We have focused significant resources in the past two years on improving the quality of health care provided by Medicare providers. Our efforts with respect to nursing home quality have been particularly intensive. We recognize that several national organizations and their members have worked with us on several quality initiatives, including the Nursing Home Quality Initiative (NHQI). The NHQI is a four-prong effort that consists of—

- Regulation and enforcement efforts conducted by State survey agencies and by us;
- Improved consumer information on the quality of care in nursing homes;
- Continual, community-based quality improvement programs designed to help nursing homes improve their quality of care; and
- Collaboration and partnership to utilize available knowledge and resources effectively.

We are pleased that several commenters shared their efforts to have a positive impact on beneficiaries' outcomes. A variety of programs have been designed on the State or organization level to improve staff knowledge and expertise by providing unique training and educational opportunities. In addition, many providers are participating in several new and innovative programs that explore different ways to better serve patients. For example, the Pioneer Network, Eden Alternative, and Wellspring programs are designed to impart a culture change that positively influences the aging population. Providers involved in these three programs report improvements in staff retention, staff morale, and resident outcomes, including decreased pharmaceutical utilization and improved mobility. These improvements have also been associated with more positive patient outcomes, as evidenced by the results of State surveys.

We encourage the national associations and their affiliates to communicate information on these innovative programs to their entire membership, and to encourage expansion of these innovative programs across the country. We also encourage the development of partnerships among nursing homes, CMS, the State agencies, Quality Improvement Organizations (QIOs), consumers, and other stakeholders in developing and promoting programs designed to maintain and enhance high quality care. We also encourage the national organizations to continue to share information on potential quality initiatives with and between their State affiliates and providers. Finally, we encourage these stakeholders to work with us to design Federal demonstration projects to examine more fully a variety of quality models, including the development of payment systems with integrated quality incentives.

IV. Provisions of the Final Rule

The provisions of this final rule are as follows:

- We are revising § 411.15(p)(2)(xii) to incorporate additional chemotherapy service exclusions from SNF consolidated billing, as well as a conforming revision in the regulations at § 489.20(s)(12).
- We are revising § 413.337(d) by adding a new paragraph (2), which establishes an adjustment to the annual increase in the SNF market basket index amount to account for forecast error.
- We are revising § 483.5 to include specific definitions of the terms ''distinct part'' and ''composite distinct part.'' We are also making conforming changes in subpart B of part 483 of the regulations, as well as in parts 413 and 440.

In addition, we are making the following technical corrections in the regulations text, as discussed in the proposed rule:

- We are revising a cross-reference that appears in § 409.20(c) of the regulations. Section 409.20 provides a general introduction to the subsequent sections (§ 409.21 through § 409.36) that set forth the specific requirements pertaining to the SNF benefit. However, in referring to the sections that follow, the cross-reference in § 409.20(c) concerning terminology inadvertently omits a reference to § 409.21, and we are now correcting that omission by revising the cross-reference to read ''§ 409.21 through § 409.36''.
- We are correcting the spelling of the word ''describe'' as it appears in the second sentence of the regulations text at § 483.20(k)(1). Also, as discussed in the supplemental proposed rule, we are correcting the spelling of the word ''standardized'' in the second sentence of § 413.345 of the regulations. Further, we are taking this opportunity to make the following additional technical corrections:
- We are restoring a portion of the regulations text that was inadvertently deleted from § 488.438(d), dealing with civil money penalties. As originally published in the **Federal Register** on November 10, 1994 (59 FR 56248), paragraph (d) of § 88.438 contained three numbered paragraphs. However, when this section of the regulations was republished on March 18, 1999 (64 FR 13361), paragraph (3) was inadvertently omitted. Accordingly, we are now restoring this portion of the regulations text, which reads as follows: ''(3) Repeated deficiencies are deficiencies in the same regulatory grouping of requirements found at the last survey, subsequently corrected, and found again at the next survey.''
- In paragraph (d) of § 489.22, which deals with prepayment requirements in providers, we are correcting the phrase ''covered impatient services'' to read ''covered inpatient services''.

V. Waiver of Proposed Rulemaking

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

We find it unnecessary to undertake notice and comment rulemaking as to these technical changes as they merely provide technical corrections to the regulations and do not make any substantive changes to the regulations. Therefore, for good cause, we waive notice and comment procedures.

VI. 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.*).

VII. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, 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), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely assigns 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 final rule 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 increase payments to SNFs by approximately $400 million. In addition, we have adjusted the FY 2004 rates to reflect the 3.26 percent cumulative forecast error since the start of the SNF PPS on July 1, 1998. This adjustment increases payments to SNFs by an additional $450 million, for an aggregate increase in payments of $850 million.

The update set forth in this final rule applies to payments in FY 2004. Accordingly, the analysis that follows describes the impact of this one fiscal year only. In accordance with the requirements of the Act, we will publish a notice for each subsequent fiscal year that will provide for an update to the payment rates and that will 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.

This final rule updates the SNF PPS rates published in the July 31, 2002 update notice (67 FR 49798), thereby increasing aggregate payments by an estimated $850 million. As indicated in Table 11, the effect on facilities will be an aggregate positive impact of 6.4 percent. We note that some individual providers may experience larger increases in payments than others due to the distributional impact of the FY 2004 wage indices and the degree of Medicare utilization. While this final rule is a major rule, its overall impact is extremely small; that is, less than 3 percent of total SNF revenues from all payor sources. Since 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. For a final rule, 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 payment rates set forth in this final rule also affect rural hospital swing-bed services, we believe that this final rule will have a positive fiscal impact on small rural hospitals. However, because this incremental increase in payments for Medicare swing-bed services is relatively minor in comparison to overall rural hospital revenues, this final rule will not have a significant impact on the overall operations of these small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 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 final rule will increase payments to SNFs by over 6 percent, but will have no other substantial effect on State, local, or tribal governments. Again, we believe that the aggregate impact of this major rule is positive, and does not meet the significance thresholds for determining added costs under the Unfunded Mandates Reform Act.

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

The purpose of this final rule is not to initiate significant policy changes with regard to the SNF PPS; rather, it is to provide an update to the rates for FY 2004 and to address a number of policy issues related to the PPS. We believe that the revisions and clarifications mentioned elsewhere in this final rule (for example, with respect to determining distinct part status) will have, at most, only a negligible overall effect upon the regulatory impact estimate specified in the rule. As such, these revisions will not represent an additional burden to the industry.

B. Anticipated Effects

This final rule sets forth updates of the SNF PPS rates contained in the July 31, 2002 update (67 FR 49798). The impact analysis of this final rule represents the projected effects of the changes in the SNF PPS from FY 2003 to FY 2004. 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.

This analysis incorporates the latest estimates of growth in service use and payments under the Medicare SNF benefit, based on the latest available Medicare claims from 2001. 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, 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, the payment rates for FY 2004 are updated by a factor equal to the market basket index percentage increase to determine the payment rates for FY 2004. We note that in accordance with section 101(a) of the BBRA and section 314 of the BIPA, the existing, temporary increase in the per diem adjusted payment rates of 20 percent for certain specified RUGs (and 6.7 percent for certain others) remains in effect until the implementation of case-mix refinements. In updating the rates for FY 2004, 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 indices used for adjusting the Federal rates). These revisions will increase payments to SNFs by approximately $400 million. In addition, we have adjusted the FY 2004 rates to reflect the 3.26 percent cumulative forecast error since the start of the SNF PPS on July 1, 1998. This adjustment increases payments to SNFs by an additional $450 million, for an aggregate increase in payments of $850 million.

The impacts are shown in Table 11. 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 next twenty rows show the effects on urban versus rural status by census region. The final four rows show the effects on facilities by ownership type.

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. The total impact of this change is zero percent; however, there are distributional effects of the change.

The fourth column of the table shows the effect of all of the changes on the FY 2003 payments. The market basket increase of 3.0 percentage points is constant for all providers and, though not shown individually, is included in the total column. Similarly, the 3.26 percent forecast error adjustment is included in the fourth column and is constant for all providers. It is projected that aggregate payments will increase by 6.4 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.

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Table 11

Projected Impact of FY 2004 Update to the SNF PPS

	Number of facilities	Wage Index Change	Total FY 2004 change
Total	13,944	0.0%	6.4%
Urban	9,485	-0.1%	6.3%
Rural	4,459	0.5%	6.9%
Hospital based urban	1,049	-0.1%	6.3%
Freestanding urban	7,885	-0.1%	6.3%
Hospital based rural	660	0.5%	6.9%
Freestanding rural	3,500	0.5%	6.9%
Urban by region			
New England	911	0.1%	6.5%
Middle Atlantic	1,469	-0.7%	5.6%
South Atlantic	1,522	0.2%	6.6%
East North Central	1,823	-0.5%	5.8%
East South Central	410	0.4%	6.8%
West North Central	662	0.4%	6.8%
West South Central	847	0.2%	6.6%
Mountain	413	0.8%	7.2%
Pacific	1,422	0.1%	6.5%
Rural by region			
New England	129	-0.2%	6.1%
Middle Atlantic	238	-0.4%	5.9%
South Atlantic	627	0.3%	6.7%
East North Central	845	0.9%	7.3%
East South Central	479	-0.2%	6.1%
West North Central	1,045	1.7%	8.2%
West South Central	605	-0.1%	6.3%
Mountain	303	1.3%	7.7%
Pacific	188	0.4%	6.8%
Ownership			
Government	701	0.0%	6.4%
Proprietary	8,839	0.0%	6.4%
Voluntary	3,514	-0.1%	6.3%

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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 RUG-III 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 publish the payment rates for each new fiscal year in 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.

D. Conclusion

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 final rule 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.

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 413

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

42 CFR Part 440

Grants programs—health, Medicaid.

42 CFR Part 483

Grants programs-health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

42 CFR Part 488

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

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

PART 409—HOSPITAL INSURANCE BENEFITS

■ 1. The authority citation for part 409 continues to read as follows:

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

Subpart C—Posthospital SNF Care

■ 2. In § 409.20, the introductory text to paragraph (c) is revised to read as follows:

§ 409.20 Coverage of services.

* * * * *

(c) *Services not generally provided by (or under arrangements made by) SNFs.* In § 409.21 through § 409.36—

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

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

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

Subpart A—General Exclusions and Exclusion of Particular Services

■ 2. Section 411.15 is amended by:

■ A. Republishing the introductory text to the section and the paragraph (p)(2) introductory text.

■ B. Revising paragraph (p)(2)(xii).

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage.

* * * * *

(p) *Services furnished to SNF residents.* * * *

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

* * * * *

(xii) Those chemotherapy items identified, as of July 1, 1999, by HCPCS codes J9000–J9020; J9040–J9151; J9170–J9185; J9200–J9201; J9206–J9208; J9211; J9230–J9245; and J9265–J9600; and, as of January 1, 2004, by HCPCS codes A9522 and A9523.

* * * * *

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).

Subpart E—Payments to Providers

■ 2. In § 413.65, paragraph (a)(1)(ii)(D) is revised to read as follows:

§ 413.65 Requirements for a determination that a facility or an organization has provider-based status.

(a) *Scope and definitions.* (1) *Scope.* * * *

(ii) * * *

(D) Skilled nursing facilities (SNFs) (determinations for SNFs are made in accordance with the criteria set forth in § 483.5 of this chapter).

* * * * *

Subpart J—Prospective Payment for Skilled Nursing Facilities

■ 3. In § 413.337, paragraph (d)(2) is revised to read as follows:

§ 413.337 Methodology for calculating the prospective payment rates.

* * * * *

(d) *Annual updates of Federal unadjusted payment rates.*

(2) For subsequent fiscal years, the unadjusted Federal rate is equal to the rate for the previous fiscal year increased by the applicable SNF market basket index amount. Beginning with fiscal year 2004, an adjustment to the annual update of the previous fiscal year's rate will be computed to account for forecast error. The initial adjustment (in fiscal year 2004) to the update of the previous fiscal year's rate will take into account the cumulative forecast error between fiscal years 2000 and 2002. Subsequent adjustments in succeeding fiscal years will take into account the forecast error from the most recently available fiscal year for which there is final data.

* * * * *

§ 413.345 [Amended]

4. In the second sentence of § 413.345, the word ''tandardized'' is removed and the word ''standardized'' is added in its place.

PART 440—SERVICES: GENERAL PROVISIONS

■ 1. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart A—Definitions

■ 2. In § 440.40, paragraph (a)(1)(ii)(A) is revised to read as follows:

§ 440.40 Nursing facility services for individuals age 21 or older (other than services in an institution for mental disease), EPSDT, and family planning services and supplies.

(a) * * *

(1) * * *

(ii) * * *

(A) A facility or distinct part (as defined in § 483.5(b) of this chapter) that meets the requirements for participation under subpart B of part 483 of this chapter, as evidenced by a valid agreement between the Medicaid agency and the facility for providing nursing facility services and making payments for services under the plan; or

* * * * *

■ 2a. In § 440.155, the introductory text to paragraph (c) is revised to read as follows:

§ 440.155 Nursing facility services, other than in institutions for mental diseases.

* * * * *

(c)''Nursing facility services'' may include services provided in a distinct part (as defined in § 483.5(b) of this chapter) of a facility other than a nursing facility if the distinct part (as defined in § 483.5(b) of this chapter)—

* * * * *

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

■ 1. The authority citation for part 483 continues to read as follows:

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

Subpart B—Requirements for Long Term Care Facilities

■ 2. Section 483.5 is revised to read as follows:

§ 483.5 Definitions.

(a) *Facility defined.* For purposes of this subpart, *facility* means a skilled nursing facility (SNF) that meets the requirements of sections 1819(a), (b), (c), and (d) of the Act, or a nursing facility (NF) that meets the requirements of sections 1919(a), (b), (c), and (d) of the Act. ''Facility'' may include a distinct part of an institution (as defined in paragraph (b) of this section and specified in § 440.40 and § 440.155 of this chapter), but does not include an institution for the mentally retarded or persons with related conditions described in § 440.150 of this chapter. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the ''facility'' is always the entity that participates in the program, whether that entity is comprised of all of, or a distinct part of, a larger institution. For Medicare, an SNF (*see* section 1819(a)(1) of the Act), and for Medicaid, an NF (*see* section 1919(a)(1) of the Act) may not be an institution for mental diseases as defined in § 435.1009 of this chapter.

(b) *Distinct part*—(1) *Definition.* A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it, meets the requirements of this paragraph and of paragraph (b)(2) of this section, and meets the applicable statutory requirements for SNFs or NFs in sections 1819 or 1919 of the Act, respectively. A distinct part SNF or NF may be comprised of one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are: In the same physical area immediately adjacent to the institution's main buildings; other areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution's campus. A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant. The term ''distinct part'' also includes a composite distinct part that meets the additional requirements of paragraph (c) of this section.

(2) *Requirements.* In addition to meeting the participation requirements for long-term care facilities set forth elsewhere in this subpart, a distinct part SNF or NF must meet all of the following requirements:

(i) The SNF or NF must be operated under common ownership and control (that is, common governance) by the institution of which it is a distinct part, as evidenced by the following:

(A) The SNF or NF is wholly owned by the institution of which it is a distinct part.

(B) The SNF or NF is subject to the by-laws and operating decisions of a common governing body.

(C) The institution of which the SNF or NF is a distinct part has final responsibility for the distinct part's administrative decisions and personnel policies, and final approval for the distinct part's personnel actions.

(D) The SNF or NF functions as an integral and subordinate part of the institution of which it is a distinct part, with significant common resource usage of buildings, equipment, personnel, and services.

(ii) The administrator of the SNF or NF reports to and is directly accountable to the management of the institution of which the SNF or NF is a distinct part.

(iii) The SNF or NF must have a designated medical director who is responsible for implementing care policies and coordinating medical care, and who is directly accountable to the management of the institution of which it is a distinct part.

(iv) The SNF or NF is financially integrated with the institution of which it is a distinct part, as evidenced by the sharing of income and expenses with that institution, and the reporting of its costs on that institution's cost report.

(v) A single institution can have a maximum of only one distinct part SNF and one distinct part NF.

(vi) (A) An institution cannot designate a distinct part SNF or NF, but instead must submit a written request with documentation that demonstrates it meets the criteria set forth above to CMS to determine if it may be considered a distinct part.

(B) The effective date of approval of a distinct part is the date that CMS determines all requirements (including enrollment with the fiscal intermediary (FI)) are met for approval, and cannot be made retroactive.

(C) The institution must request approval from CMS for all proposed changes in the number of beds in the approved distinct part.

(c) *Composite distinct part*—(1) *Definition.* A composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in § 413.65(a)(2) of this chapter.

(2) *Requirements.* In addition to meeting the requirements of paragraph (b) of this section, a composite distinct part must meet all of the following requirements:

(i) A SNF or NF that is a composite of more than one location will be treated

as a single distinct part of the institution of which it is a distinct part. As such, the composite distinct part will have only one provider agreement and only one provider number.

(ii) If two or more institutions (each with a distinct part SNF or NF) undergo a change of ownership, CMS must approve the existing SNFs or NFs as meeting the requirements before they are considered a composite distinct part of a single institution. In making such a determination, CMS considers whether its approval or disapproval of a composite distinct part promotes the effective and efficient use of public monies without sacrificing the quality of care.

(iii) If there is a change of ownership of a composite distinct part SNF or NF, the assignment of the provider agreement to the new owner will apply to all of the approved locations that comprise the composite distinct part SNF or NF.

(iv) To ensure quality of care and quality of life for all residents, the various components of a composite distinct part must meet all of the requirements for participation independently in each location.

■ 3. In § 483.10, the following new paragraph (b)(12) is added to read as follows:

§ 483.10 Resident rights.

* * * * *

(b) * * *

(12) *Admission to a composite distinct part.* A facility that is a composite distinct part (as defined in § 483.5(c) of this subpart) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under § 483.12(a)(8).

* * * * *

■ 4. In § 483.12, the following changes are made:

■ A. A new paragraph (a)(8) is added.

■ B. A new paragraph (b)(4) is added.

The additions read as follows:

§ 483.12 Admission, transfer, and discharge rights.

(a) * * *

(8) *Room changes in a composite distinct part.* Room changes in a facility that is a composite distinct part (as defined in § 483.5(c)) must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.

* * * * *

(b) * * *

(4) *Readmission to a composite distinct part.* When the nursing facility to which a resident is readmitted is a composite distinct part (as defined in § 483.5(c) of this subpart), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of readmission, the resident must be given the option to return to that location upon the first availability of a bed there.

* * * * *

§ 483.20 [Amended]

■ 3. In § 483.20(k)(1), the word ''describer'' is revised to read ''describe''.

PART 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

■ 1. The authority citation for part 488 continues to read as follows:

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

■ 2. In § 488.438, a new paragraph (d)(3) is added to read as follows:

§ 488.438 Civil money penalties: Amount of penalty.

* * * * *

(d) * * *

(3) Repeated deficiencies are deficiencies in the same regulatory grouping of requirements found at the last survey, subsequently corrected, and found again at the next survey.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

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

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

Subpart B—Essentials of Provider Agreements

■ 2. Section 489.20 is amended by:

■ A. Republishing the introductory text and paragraph (s) introductory text.

■ B. Revising paragraph (s)(12).

§ 489.20 Basic commitments.

The provider agrees to the following:

* * * * *

(s) In the case of an SNF, either to furnish directly or make arrangements (as defined in § 409.3 of this chapter) for all Medicare-covered services furnished to a resident (as defined in § 411.15(p)(3) of this chapter) of the SNF, except the following:

* * * * *

(12) Those chemotherapy items identified, as of July 1, 1999, by HCPCS codes J9000–J9020; J9040–J9151; J9170–J9185; J9200–J9201; J9206–J9208; J9211; J9230–J9245; and J9265–J9600; and, as of January 1, 2004, by HCPCS codes A9522 and A9523.

§ 489.22 [Amended]

■ 3. In § 489.22(d), the word ''impatient'' is removed, and the word ''inpatient'' is added in its place.

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

Dated: July 10, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 25, 2003.

Tommy G. Thompson,

Secretary.

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