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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 413, 424, and 489

[CMS–1163–F]

RIN 0938–AK47

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

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) 2002, as required by statute. 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. As part of this annual update, we are rebasing and revising the routine SNF market basket to reflect 1997 total cost data (the latest available complete data on the structure of SNF costs), and modifying certain variables for some of the cost categories. Finally, we are implementing the transition of swing-bed facilities to the SNF PPS, effective with cost reporting periods beginning on and after July 1, 2002.

EFFECTIVE DATE: These regulations are effective on October 1, 2001 for payment rates, and, for cost reporting periods beginning on or after July 1, 2002, for transition of swing-bed facilities to the SNF PPS.

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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:

ADL Activity of Daily Living
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
BEA (U.S.) Bureau of Economic Analysis
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
BES (U.S.) Business Expenditures Survey
BLS (U.S.) Bureau of Labor Statistics
CAH Critical Access Hospital
CFR Code of Federal Regulations
CMS Centers for Medicare & Medicaid Services
CPI Consumer Price Index
CPI–U Consumer Price Index-All Urban Consumers
CPT (Physicians') Current Procedural Terminology
DRG Diagnosis Related Group
ECI Employment Cost Index
FI Fiscal Intermediary
FR **Federal Register**
FY Fiscal Year
GAO General Accounting Office
HCPCS Healthcare Common Procedure Coding System
ICD–9–CM International Classification of Diseases, Ninth Revision, Clinical Modification

IFC Interim Final Rule with Comment Period
MDS Minimum Data Set
MEDPAR Medicare Provider Analysis and Review File
MIP Medicare Integrity Program
MSA Metropolitan Statistical Area
NECMA New England County Metropolitan Area
OIG Office of the Inspector General
OMRA Other Medicare Required Assessment
PCE Personal Care Expenditures
PPI Producer Price Index
PPS Prospective Payment System
PRM Provider Reimbursement Manual
RAI Resident Assessment Instrument
RAP Resident Assessment Protocol
RAVEN Resident Assessment Validation Entry
RUG-III Resource Utilization Groups, Version III
SCHIP State Children's Health Insurance Program
SNF Skilled Nursing Facility
STM Staff Time Measure

I. Background

On May 10, 2001, we published in the **Federal Register** (66 FR 23984), a proposed rule that set forth proposed updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2002. 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 the Medicare prospective payment system and consolidated billing for SNFs.

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

Section 4432 of the Balanced Budget Act of 1997 (BBA) amended section 1888 of the Act to provide for the implementation of a per diem PPS for SNFs, covering all costs (routine, ancillary, and capital) 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 2002. 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, had been paid under Part B but furnished to Medicare beneficiaries in a SNF during a Part A covered stay. The rates are adjusted annually using a SNF market basket index. Rates are 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 are also adjusted by the hospital wage index to account for geographic variation in wages. Additionally, as noted in the July 31, 2000 final rule (65 FR 46770), section 101 of BBRA also affects the payment rate. Finally, sections 311, 312, and 314 of the BIPA affect the Part A PPS payment rates for SNFs. These new provisions are discussed in detail in section I.D of this preamble.

• *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 facilities that received payment under the transition, the facility-specific rate was based on allowable costs from FY 1995; however, since the last year of the transition is FY 2001, all facilities will be paid at the full Federal rate by the coming fiscal year (FY 2002), for which we have now finalized rates. Therefore, unlike previous years, this final rule does not include adjustment factors related to facility-specific rates for the coming fiscal year.

• *Coverage.* Medicare's fundamental requirements for SNF coverage were not changed by BBA; however, because RUG–III classification is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have attempted, where possible, to coordinate claims review procedures with the outputs of beneficiary assessment and RUG–III classifying activities, as discussed in section III.F of this preamble.

• *Consolidated Billing.* The BBA included a billing provision that required a SNF to submit consolidated Medicare bills for its residents for almost all services that are covered under either Part A or Part B (the statute excluded a small list of services, primarily those of physicians and certain other types of practitioners). With the exception of physical therapy, occupational therapy, and speech-language therapy, section 313 of BIPA has now limited the scope of this provision to apply only to those services that are furnished during the course of a resident's covered Part A stay in the SNF, as discussed in section III.J of this preamble.

• *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. Part A currently pays for SNF services furnished by swing-bed hospitals on a cost-related basis. Section 1888(e)(7) of the Act requires the SNF PPS to encompass these services no earlier than cost reporting periods beginning on July 1, 1999, and no later than the end of the SNF PPS transition period described in section 1888(e)(2)(E) of the Act. In the proposed rule published in the **Federal Register** on May 10, 2001 (66 FR 23984), we proposed to implement the SNF PPS for swing-bed hospitals effective with cost reporting periods beginning on and after October 1, 2001. However, as discussed in section III.K of this preamble, based on concerns raised during the comment period, we are instead implementing the SNF PPS for swing-bed hospitals effective with cost reporting periods beginning on and after July 1, 2002.

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

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

1. The unadjusted Federal per diem rates to be applied to days of covered SNF services furnished during the FY.
2. The case-mix classification system to be applied with respect to these services during the FY.
3. The factors to be applied in making the area wage adjustment with respect to these services.

In the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the RUG–III classification structure.

Along with a number of other revisions discussed later in this preamble, this final rule provides the annual updates to the Federal rates as mandated by the Act.

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

There were several provisions in the BBRA that resulted in various adjustments, within specified timeframes, to the PPS for SNFs. The provisions were described in the final

rule that we published in the **Federal Register** on July 31, 2000 (65 FR 46770). In particular, section 101 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). 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. In addition, for certain SNFs located in Baldwin or Mobile County, Alabama, section 155 provided for a special 100 percent facility-specific payment rate for cost reporting periods beginning in FY 2000 and FY 2001. Finally, section 105 provided for payment at a 50 percent Federal, 50 percent facility-specific payment rate for SNFs serving certain specialized patient populations, which became effective on November 29, 1999, and expires on September 30, 2001.

We included further information on all of the provisions of the BBRA in Program Memorandums A–99–53 and A–99–61 (December 1999), and Program Memorandum AB–00–18 (March 2000).

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

As a result of enactment of the BIPA, there are several new provisions that result in adjustments to the PPS for SNFs. The following provisions were described in the proposed rule that we published on May 10, 2001 (66 FR 23984), and are discussed further in section III of this preamble, to the extent that we received public comments concerning them.

- *Section 203—Exemption of Critical Access Hospital (CAH) Swing-beds from SNF PPS.* This provision exempts swing-beds in CAHs from section 1888(e)(7) of the Act (as enacted by section 4432(a) of the BBA) which applies the SNF PPS to SNF services furnished by swing-bed hospitals. Accordingly, this provision enables CAHs to be paid for their swing-bed SNF services on a reasonable cost basis. This provision is effective with cost reporting periods beginning on or after December 21, 2000, the date of the enactment of the BIPA. We included further information on this provision in Program Memorandum A–01–09 (January 16, 2001).
- *Section 311—Elimination of Reduction in SNF Market Basket Update in 2001.* This provision eliminates the one percent reduction reflected in the update formula for the Federal rates for FY 2001 that was required by the BBA. In implementing this change, this provision also modifies the schedule and rates according to which Federal per diem payments are updated to FY 2002. For FY 2002 and FY 2003, the updates would be the market basket index increase minus 0.5 percentage points. This provision also provides a special rule that, for purposes of making payments under the SNF PPS for FY 2001, for the first half of FY 2001 (the period beginning October 1, 2000, and ending March 31, 2001), the market basket update remains at market basket minus 1, and for the second half of the fiscal year (the period beginning on April 1, 2001, and ending on September 30, 2001), the market basket update changes from market basket minus 1 to market basket plus 1.

In addition, this provision requires the General Accounting Office (GAO) to submit a report to Congress by July 1, 2002, on the adequacy of SNF payment rates. It also requires the Secretary to conduct a study of the different systems for categorizing patients in SNFs in a manner that accounts for the relative resource utilization of different patient types, and to submit a report to Congress not later than January 1, 2005.

- *Section 312—Increase in Nursing Component of PPS Federal Rate.* This provision requires the Secretary to increase by 16.66 percent the nursing component of the case-mix adjusted Federal rate specified in the July 31, 2000 final rule (65 FR 46770), as subsequently updated, for services furnished on or after April 1, 2001, and before October 1, 2002. This provision also requires the GAO to conduct an audit of SNF nursing staff ratios, and to submit a report to Congress by August 1, 2002, including a recommendation on whether the temporary 16.66 percent increase in the nursing component should be continued.
- *Section 313—Application of SNF Consolidated Billing Requirement Limited to Part A Covered Stays.* This provision repeals the consolidated billing requirement for services (other than physical therapy, occupational therapy, and speech-language therapy) furnished to those SNF residents who are in noncovered stays, effective January 1, 2001. It also directs the Secretary to monitor Part B payments for those services, in order to guard against duplicate billing and the excessive provision of services.
- *Section 314—Adjustment of Rehabilitation RUGs to Correct Anomaly in Payment Rates.* For services furnished from April 1, 2001, until the date that RUG refinements are implemented, this provision requires the Secretary to increase by 6.7 percent the adjusted Federal per diem rate for all of the following RUG–III rehabilitation groups: RUC, RUB, RUA, RVC, RVB, RVA, RHC, RHB, RHA, RMC, RMB, RMA, RLB, and RLA. This provision supersedes the 20 percent increase that section 101(b) of the BBRA had previously established for the RHC, RMC, and RMB rehabilitation groups, thereby correcting the resulting anomaly under which the payment rates for these particular groups were actually higher than the rates for some other, more intensive rehabilitation RUGs. This provision also requires the Office of Inspector General (OIG) to review whether the RUG payment structure in effect under the BBRA included incentives for the delivery of inadequate care and report to the Congress by October 1, 2001.
- *Section 315—Establishment of Process for Geographic Reclassification.* This provision explicitly permits the Secretary to establish a geographic reclassification procedure that is specific to SNFs, for purposes of payment for covered SNF services under the PPS. However, this cannot occur until the Secretary has collected 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. Skilled Nursing Facility Prospective Payment—General Overview

The Medicare SNF PPS was implemented for cost reporting periods beginning on or after July 1, 1998. Under the PPS, SNFs are paid 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 Part A covered 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 who were receiving Part A covered services in a SNF.

In developing the rates for the initial period, we updated costs to the first effective year of PPS (15-month period beginning July 1, 1998) using a SNF market basket index, and then standardized for the costs of facility differences in case-mix and for geographic variations in wages. Providers that received new provider exemptions from the routine cost limits were excluded from the database used to compute the Federal payment rates, as 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, RUG–III, utilizes beneficiary assessment data from the Minimum Data Set (MDS) completed by SNFs to assign beneficiaries to one of 44 groups. The May 12, 1998 interim final rule (63 FR 26252) included a complete and detailed description of the RUG–III classification system.

The Federal rates in this rule reflect an update to the rates in the July 31, 2000 update notice (65 FR 46770) equal to the SNF market basket index minus 0.5 percent, as well as the elimination of the 1 percent reduction reflected in the update formula for the FY 2001 payment rates under section 311 of the BIPA. According to section 311 of the BIPA, for FY 2002, we will update the rate by adjusting the current rates by the SNF market basket change minus 0.5 percent.

2. Payment Provisions—Transition Period

The SNF PPS includes an initial, phased transition from a facility-specific rate (which reflects the individual facility's historical cost experience) to the Federal case-mix adjusted rate. The transition extends through the facility's first three cost reporting periods under the PPS, up to and including the one that begins in FY 2001. Accordingly, starting with cost reporting periods that begin in FY 2002, we will base payments entirely on the Federal rates.

F. Skilled Nursing Facility Market Basket Index

Section 1888(e)(5) of the Act requires the Secretary 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. We have developed a revised and rebased SNF market basket index that consists of the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses. A complete discussion concerning the design and application of the SNF market basket index is presented in section III.H of this preamble.

II. Provisions of the Proposed Rule

The proposed rule that we published in the **Federal Register** on May 10, 2001 (66 FR 23984) included proposed FY 2002 updates to the Federal payment rates used under the SNF PPS. In accordance with section 1888(e)(4)(E)(ii)(II) of the Act, the updates reflect the SNF market basket percentage change for the fiscal year minus 0.5 percent, as well as the elimination of the 1 percent reduction reflected in the update formula for the FY 2001 payment rates under section 311 of the BIPA. The proposed rule described our process for revising and rebasing the market basket and included a discussion of a conceptual update framework. In addition, the proposed rule included a discussion of the feasibility of establishing a SNF-specific wage index. Further, the proposed rule described our methodology for adjusting the Federal rates in accordance with sections 311 and 312 of the BIPA, in order to reflect the elimination of the reduction in the market basket and the 16.66 percent increase in the nursing component. In accordance with section 314 of the BIPA, we also provided for an adjustment of rehabilitation RUGs to correct an existing anomaly in the payment rates. We also included a discussion of our commitment to monitor the RUG–III classification system and to pursue RUG refinements. Additionally, we discussed our ongoing efforts to ensure accurate payment for appropriate care in areas such as concurrent therapy, MDS accuracy, and program safeguards.

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

- In § 410.150, paragraph (b)(14) would be revised to reflect that Part B makes payment to the SNF for its resident's services only in those situations where the SNF itself furnishes the services, either directly or under an arrangement with an outside source.
- In § 411.15, paragraph (p)(1) would be revised to indicate that except for physical, occupational, and speech-language therapy, consolidated billing applies only to those services that a SNF resident receives during the course of a covered Part A stay. Conforming revisions would also be made in §§ 489.20(s) and 489.21(h), in the context of the requirements of the SNF provider agreement. Section 411.15(p)(2) would be revised to indicate that, for Part B services furnished to a SNF resident, the requirement to enter the SNF's Medicare provider number on the Part B claim (which previously applied only to claims for physician services) would apply to all types of Part B claims. Conforming revisions would also be made in the requirements regarding claims for payment, at §§ 424.32(a)(2) and (a)(5). The existing requirement in § 424.32(a)(5), that a SNF include appropriate HCPCS coding and its Medicare provider number on the claims that it files for its residents' services, would be revised by adding that these requirements also apply to these claims when they are filed by an outside entity. In addition, § 411.15(p)(3) would be revised to exclude from the definition of a SNF resident, for consolidated billing purposes, those individuals who reside in the noncertified portion of an institution that also contains a participating distinct part SNF.
- In accordance with section 1888(e)(2)(E) of the Act, § 413.114 would be revised to reimburse swing-bed services of rural hospitals (other than CAHs, which would be paid on a reasonable cost basis) under the SNF PPS described in regulations at subpart J of that part. This conversion to the SNF PPS was proposed to become effective for services furnished during

cost reporting periods beginning on or after October 1, 2001. (However, as discussed in section III.K of this preamble, the conversion will instead become effective for services furnished during cost reporting periods beginning on or after July 1, 2002.) In addition, paragraph (d)(1) of this section would be revised to reflect modifications to the special requirements for swing-bed facilities with more than 49 but fewer than 100 beds (as enacted by section 408 of the BBRA), and a conforming revision would be made in § 424.20(a)(2).

• In § 413.337, a new paragraph (e) would be added to clarify that the temporary increases in payment for certain RUGs under section 101 of the BBRA (as modified by section 314 of the BIPA) will no longer be applicable upon issuance of a new regulation that sets forth a refined case-mix classification system.

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 and Responses to Public Comments

In response to the publication of the proposed rule on May 10, 2001 (66 FR 23984), we received over 200 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.

A. Research on Case-Mix Refinements

In the proposed rule, we indicated that we would not be modifying the existing case-mix classification system during the current rulemaking cycle. Consequently, the add-ons to the Federal rates for specified RUG–III groups, as required by section 101 of the BBRA and modified by section 314 of the BIPA, will remain in effect during FY 2002.

Comment: We received a number of comments related to the proposed rule's discussion of efforts to refine the case-mix system. In that rule, we specifically invited comments on possible approaches to refining the current case-mix classification system, as well as on identifying and studying alternatives to the current system. Many commenters desired more information regarding our plans for refining the system. A number of commenters were supportive of efforts to refine the system but urged us to pursue approaches that were easy to administer and did not introduce a new burden for providers. A few commenters offered specific approaches to refining the system. These included the use of total cost per day and per Medicare covered episode (as the dependent variable in the analysis) to estimate the explanatory power of potential refinement approaches, and development of a medical complexity index that focuses on diagnoses, comorbidities, or other elements critical to describing the post acute care population. One commenter requested that we articulate in this final rule the principles we use to guide our approach to the SNF PPS and the case-mix refinement, and several others suggested principles they believe we should use in our case-mix refinement work. The suggested principles for our case-mix refinements included administrative feasibility, recognition of clinical complexity of the SNF population, and recognition of extraordinarily high-cost items and services. Several commenters recommended that we never implement refinements so that the additional payment add-ons associated with section 101 of the BBRA would be maintained.

Response: We believe that payments must continue to be adequate in order to support quality care and access to needed services for Medicare beneficiaries. In doing so, the PPS should avoid imposing undue burden on providers. With regard to our efforts to develop case-mix refinements, we intend to develop models that improve upon the statistical performance of the present case-mix system, and thus support accurate pricing of services, while minimizing complexity and controlling for any adverse incentives related to quality of care and program integrity. Achieving a result that reflects goals that are sometimes competing may require that we strike an appropriate balance. We believe the potential exists to find this balance and look forward to pursuing development of case-mix refinements. We believe that our approach to developing refinements will be both responsive to the provider community's concerns and support continued access to quality care for Medicare beneficiaries. As stated in the proposed rule, we are not implementing case-mix refinements for FY 2002. As a result, the 20 percent payment add-ons required by the BBRA (and subsequently modified by the BIPA) will be maintained for FY 2002. However, the Congress intended these payment add-ons to be a temporary measure, to remain in effect only until we provide for refinements to the classification system. Under provisions of the BBRA, implementation of the refinements will result in the expiration of these temporary increases in the payment rates. (In the proposed rule, we proposed to add a new paragraph (e) to § 413.337 to clarify this point.)

Accordingly, it is our intention to develop and implement refinements to the case-mix classification system as soon as feasible. To that end, we have awarded a contract to the Urban Institute for a research project that will, in the initial stages, address the feasibility of developing and implementing such refinements. We plan to review various approaches to determine the most appropriate methodology for the refinements. As we discussed in the proposed rule, this may include further analysis to develop a non-therapy ancillary index, similar to that proposed in the FY 2001 proposed rule. We are also interested in evaluating approaches that take into account proven indicators of resource use in other post acute settings, such as functional status, diagnosis, and comorbidities. We found the comments very helpful in this area and we will consider the specific suggestions of commenters as we continue this effort. Any specific refinement proposal resulting from this research will be included in a future **Federal Register** notice for public comment.

B. Clinical Issues

In the proposed rule published on May 10, 2001 (66 FR 23984), we included a description of our ongoing efforts to support accurate completion of the Minimum Data Set (MDS) 2.0, along with a discussion of our concerns about the provision of concurrent therapy—a practice in which an individual therapist simultaneously treats a number of beneficiaries who (unlike in group therapy) are not working on any common skill development.

1. Minimum Data Set

Comment: We received a few comments commending our efforts to provide more clear definitions of MDS elements, provide more explicit MDS coding instructions, and expand provider training on the MDS. In addition, we received a few comments regarding the complexity of the MDS and the continuing confusion regarding some of the scheduling and completion

requirements. They requested that we consider simplification of the MDS process and that we also make a special effort to make additional training available to professional therapists and other SNF staff in addition to the MDS coordinators.

Response: We appreciate the support of our efforts to clarify MDS elements and scheduling requirements, and to identify ways to simplify the requirements, and we intend to continue these efforts. We recently posted two sets of MDS 2.0 Questions and Answers on our web site at: *www.hcfa.gov/medicaid/mds20/default.htm.* The most recent set was posted in July 2001. As part of our ongoing effort to provide clarification in this area, we are also taking this opportunity to address a Medicare MDS scheduling issue that has come to our attention recently. We have become aware that there are instances in which providers have performed the Medicare-required 14-day assessment prior to the specified assessment window, days 11 through 14. In our discussion of the default rate in the preamble of the May 12, 1998, interim final rule (42 FR 26265) that implemented the SNF PPS, we focused on the default rate as a consequence of late assessments, since we expected late assessments to be the most likely reason for triggering a default payment.

In that discussion, we explained that when the assessment reference date of a Medicare-required assessment is set after the assessment window (including the grace days), the provider will be paid at the default rate for all of the days of the payment window, up until the assessment reference date of the late assessment. We did not include any explanation for the more unusual situation of an assessment reference date that is set prior to the assessment window. However, there have been instances in which assessments have been performed prior to the specified assessment window and questions have been raised about whether, and for how long, the default rate applies. It has been unclear whether the default rate was to be applied to the entire payment window, for the number of days between the assessment reference date and the due date for the assessment, or for the number of days by which the assessment is outside of the assessment window.

Although we did not discuss early assessments in the preamble of the interim final rule, the regulations in § 413.343(c) state that we pay a default rate for the Federal rate when a SNF fails to comply with the assessment schedule. A Medicare-required 14-day assessment with an assessment reference date on either day 9 or 10 is not in compliance with the assessment schedule and is, therefore, subject to payment at the default rate.

If the assessment was performed outside of the specified assessment window due to a scheduling or clerical error and there was no effect on payment as a result of performing the assessment too early, the default rate will be assessed only for the number of days the assessment is out of compliance. For example, a Medicare-required 14-day assessment performed on day 10 would be paid at the default rate for the first day of the payment period that begins on day 15. These claims may be subject to medical review, and the provider may be asked to explain the reason for early assessment and demonstrate that there was no impact on payment.

However, SNFs that systematically use early assessment reference dates will be handled in the same way as SNFs performing frequent late assessments. These facilities may be subject to an onsite review of assessment scheduling practices for the facility, in addition to the imposition of the default rate.

We understand that setting the assessment reference dates outside of the assessment window has usually occurred as a result of misunderstanding of the assessment schedule requirements by facility staff, and we will make every effort to work with providers and the contractor to resolve these issues.

We will expand the scope of our facility monitoring practices in order to detect patterns of assessment reference dates that are outside of, and prior to, the assessment windows. We believe that after three years of participation in the PPS, providers should be aware of, and comply with the required assessment schedule.

Comment: Some commenters noted requests for MDS repository data that had been denied, and asked why we are so restrictive with these data.

Response: MDS repository data contain beneficiary-level clinical information. The Privacy Act of 1974 allows us to disclose information without an individual's consent only if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. The Health Insurance Portability and Accountability Act of 1996 (HIPAA, Pub. L. 104–191) has only reinforced the need to safeguard beneficiary privacy. While we are committed to providing the public with appropriate access to our administrative data, we take beneficiary privacy concerns very seriously. It is our responsibility to protect the privacy of Medicare beneficiaries, and to comply with the related laws and regulations that safeguard their privacy.

A full description of the criteria that are used to determine who may obtain MDS Repository data and for what purposes is provided in the Notice of New System of Records that was published in the **Federal Register** on May 22, 1998 (63 FR 28396). The notice also is available on our web site at: *www.hcfa.gov/medicaid/mds20/mdssor.htm.* The notice makes clear that requests for the data are evaluated individually to determine whether the user qualifies for use of the data. We do provide technical assistance for those with a legitimate need for the data.

2. Therapy

Comment: A few commenters indicated that they were unfamiliar with the term concurrent therapy until encountering the concept in the discussion in the proposed rule. They asked whether it is the same as the practice referred to as dovetailing, and questioned whether it is a significant problem. We received a large number of comments encouraging us to continue to recognize concurrent therapy as skilled therapy. These commenters contended that therapists are treating more than one beneficiary concurrently only when appropriate. All of these commenters opposed any development of new guidance or regulation regarding the delivery of concurrent therapy services. However, some other comments indicated that our concerns regarding concurrent therapy were warranted. Several commenters reported that since the implementation of the SNF PPS, professional therapists are encountering increased pressure to be more productive than they have in the past, including the need to see more than one patient at a time, and performing documentation and collaboration with other members of the care team as non-reimbursed time.

Response: Concurrent therapy and dovetailing are synonymous terms. While the practice of providing concurrent therapy is by no means universal, we perceived a need to discuss this practice in the proposed rule, in order to alert providers to the inappropriate uses of this practice in certain areas of the country. We addressed the practice of concurrent therapy in the proposed rule (66 FR 23991) in order to reiterate Medicare policy and to solicit public comment. Our concern was two-fold: that therapists' professional judgment was

being overridden by pressures to be more productive by treating multiple beneficiaries concurrently; and that the Medicare policy (reiterated below) that allows for the treatment of multiple beneficiaries was being used inappropriately and could lead to diminished quality of care. Apparently, this may not be a problem in the particular localities of most of the commenters. However, we expect that our discussion in the proposed rule may raise awareness and help prevent the inappropriate use of this practice from becoming more widespread.

The proposed rule's discussion also provided an opportunity for us to reiterate Medicare coverage policy regarding skilled rehabilitation therapy. The Medicare SNF benefit provides coverage of skilled, individualized rehabilitation services that are of such a level of complexity and sophistication that the services can be safely and effectively performed only by or under the supervision of a qualified professional therapist. Accordingly, we wished to make clear that it is inappropriate to require, as a condition of employment, that a therapist agree to treat more than one beneficiary at a time in situations where providing treatment in such a manner would compromise the therapist's professional judgment. However, we continue to believe, as do many of the commenters, that concurrent therapy has a legitimate place in the spectrum of care options available to therapists treating Medicare beneficiaries. Our goals are to safeguard the health and safety of beneficiaries and assure that they are provided the most effective, skilled care available. We agree that, at times, such care can be provided concurrently with another therapy patient, as long as the decision to do so is driven by valid clinical considerations. At this time, we will not change our approach, but recognize that we may need to revisit this issue should the need to do so arise.

Comment: One commenter characterized the PPS methodology as creating a perception that the SNF is not paid for anything that is not counted as therapy minutes on the MDS.

Response: We would like to take this opportunity to clarify that this perception is inaccurate. The PPS rates were developed using all of the therapists' time, including both direct and indirect care time. The majority of comments on the proposed rule's discussion of concurrent therapy state that most therapy delivered to Medicare beneficiaries is performed on a one-to-one basis, as has always been the practice. We hope that this discussion will increase awareness among those who mistakenly believe that only the minutes on the MDS are covered by the rates.

Comment: We received many comments regarding language in the proposed rule about the increased financial incentives that BIPA creates for the rehabilitation categories and the potential for upcoding under the SNF PPS to gain higher payments (66 FR 23991). The commenters regarded this language as implying that providers are intentionally manipulating the payment system, and they viewed this to be unwarranted and unfair. They cited a recent report by the Office of the Inspector General that found no evidence of provider upcoding.

Response: The statement in the proposed rule was not intended to imply that large numbers of SNFs are behaving in an abusive manner. Since the implementation of the SNF PPS, the General Accounting Office and MedPAC have been critical of the payment system's method for classification into the rehabilitation groups. Specifically, they have questioned our methodology that assigns a beneficiary into the rehabilitation groups based on the amount of service provided. Thus, a beneficiary who is provided more services is assigned to a higher-paid RUG–III group.

Our purpose in making this observation in the proposed rule was to recognize the systemic potential for inappropriate upcoding in any PPS that uses clinical information as the basis for payment. We have not encountered evidence of a significant amount of upcoding under the SNF PPS. In the proposed rule, we were simply making the observation that the BIPA provisions tended to magnify existing adverse incentives, and reinforcing our policy regarding medical review.

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

1. Federal Prospective Payment System

This final rule sets forth a schedule of Federal prospective payment rates applicable to Medicare Part A SNF services beginning October 1, 2001. The schedule establishes 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. Tables 1 and 2 reflect the updated components of the unadjusted Federal rates.

The FY 2002 rates reflect an update using the latest market basket index minus 0.5 percentage point. The final FY 2002 market basket increase factor is 3.3 percent, and subtracting 0.5 percentage points yields an update of 2.8 percent. This final update factor reflects the latest available forecast of the SNF market basket, and is 0.4 percent higher than the factor reflected in the proposed rule. In accordance with section 101 of the BBRA and section 314 of the BIPA, we have provided for a temporary increase in the per diem adjusted payment rates of 20 percent for certain specified RUGs, and 6.7 percent for certain others. These temporary increases of 20 percent and 6.7 percent for certain specified RUGs will continue until implementation of case-mix refinements, as described in section 101 of the BBRA and section 314 of the BIPA. Also, in accordance with section 101 of the BBRA, we are providing a 4 percent increase in the adjusted Federal rate for FY 2002. These temporary adjustments (that is, 20 percent, 6.7 percent, or 4 percent) are not reflected in the rate tables (Tables 1, 2, 3, 4, 5, and 6 of this final rule). Rather, in accordance with the statute, they are applied only after all other adjustments (wage and case-mix) have been made (see Table 9). However, the 16.6 percent increase to the nursing component of the Federal rate, established under section 312 of the BIPA, is reflected in the rate tables (Tables 1 through 6).

TABLE 1.—UNADJUSTED FEDERAL RATE PER DIEM—URBAN

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$138.29	$89.29	$11.76	$60.50

TABLE 2.—UNADJUSTED FEDERAL RATE PER DIEM—RURAL

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$132.13	$102.96	$12.56	$61.62

2. Case-Mix Adjustment

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). Consequently, we will also maintain the add-ons to the Federal rates for specified RUG–III groups, as required by section 101 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 add-ons (that is, 20 percent, 6.7 percent, or 4 percent) provided for in the BBRA and the BIPA, which are applied only after all other adjustments (wage and case-mix) have been made, but do reflect the 16.66 percent increase in the nursing component of the rate required in section 312 of the BIPA.

TABLE 3.—CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—URBAN

RUG–III category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy component	Non-case mix component	Total rate
RUC	1.30	2.25	179.78	200.90	.....	60.50	441.18
RUB	0.95	2.25	131.38	200.90	.....	60.50	392.78
RUA	0.78	2.25	107.87	200.90	.....	60.50	369.27
RVC	1.13	1.41	156.27	125.90	.....	60.50	342.67
RVB	1.04	1.41	143.82	125.90	.....	60.50	330.22
RVA	0.81	1.41	112.01	125.90	.....	60.50	298.41
RHC	1.26	0.94	174.25	83.93	.....	60.50	318.68
RHB	1.06	0.94	146.59	83.93	.....	60.50	291.02
RHA	0.87	0.94	120.31	83.93	.....	60.50	264.74
RMC	1.35	0.77	186.69	68.75	.....	60.50	315.94
RMB	1.09	0.77	150.74	68.75	.....	60.50	279.99
RMA	0.96	0.77	132.76	68.75	.....	60.50	262.01
RLB	1.11	0.43	153.50	38.39	.....	60.50	252.39
RLA	0.80	0.43	110.63	38.39	.....	60.50	209.52
SE3	1.70	.....	235.09	.....	11.76	60.50	307.35
SE2	1.39	.....	192.22	.....	11.76	60.50	264.48
SE1	1.17	.....	161.80	.....	11.76	60.50	234.06
SSC	1.13	.....	156.27	.....	11.76	60.50	228.53
SSB	1.05	.....	145.20	.....	11.76	60.50	217.46
SSA	1.01	.....	139.67	.....	11.76	60.50	211.93
CC2	1.12	.....	154.88	.....	11.76	60.50	227.14
CC1	0.99	.....	136.91	.....	11.76	60.50	209.17
CB2	0.91	.....	125.84	.....	11.76	60.50	198.10
CB1	0.84	.....	116.16	.....	11.76	60.50	188.42
CA2	0.83	.....	114.78	.....	11.76	60.50	187.04
CA1	0.75	.....	103.72	.....	11.76	60.50	175.98
IB2	0.69	.....	95.42	.....	11.76	60.50	167.68
IB1	0.67	.....	92.65	.....	11.76	60.50	164.91
IA2	0.57	.....	78.83	.....	11.76	60.50	151.09
IA1	0.53	.....	73.29	.....	11.76	60.50	145.55
BB2	0.68	.....	94.04	.....	11.76	60.50	166.30
BB1	0.65	.....	89.89	.....	11.76	60.50	162.15
BA2	0.56	.....	77.44	.....	11.76	60.50	149.70
BA1	0.48	.....	66.38	.....	11.76	60.50	138.64
PE2	0.79	.....	109.25	.....	11.76	60.50	181.51
PE1	0.77	.....	106.48	.....	11.76	60.50	178.74
PD2	0.72	.....	99.57	.....	11.76	60.50	171.83
PD1	0.70	.....	96.80	.....	11.76	60.50	169.06
PC2	0.65	.....	89.89	.....	11.76	60.50	162.15
PC1	0.64	.....	88.51	.....	11.76	60.50	160.77
PB2	0.51	.....	70.53	.....	11.76	60.50	142.79
PB1	0.50	.....	69.15	.....	11.76	60.50	141.41
PA2	0.49	.....	67.76	.....	11.76	60.50	140.02
PA1	0.46	.....	63.61	.....	11.76	60.50	135.87

TABLE 4.—CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—RURAL

RUG–III category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy component	Non-case mix component	Total rate
RUC	1.30	2.25	171.77	231.66	.....	61.62	465.05
RUB	0.95	2.25	125.52	231.66	.....	61.62	418.80
RUA	0.78	2.25	103.06	231.66	.....	61.62	396.34
RVC	1.13	1.41	149.31	145.17	.....	61.62	356.10
RVB	1.04	1.41	137.42	145.17	.....	61.62	344.21
RVA	0.81	1.41	107.03	145.17	.....	61.62	313.82
RHC	1.26	0.94	166.48	96.78	.....	61.62	324.88
RHB	1.06	0.94	140.06	96.78	.....	61.62	298.46
RHA	0.87	0.94	114.95	96.78	.....	61.62	273.35
RMC	1.35	0.77	178.38	79.28	.....	61.62	319.28
RMB	1.09	0.77	144.02	79.28	.....	61.62	284.92
RMA	0.96	0.77	126.84	79.28	.....	61.62	267.74
RLB	1.11	0.43	146.66	44.27	.....	61.62	252.55
RLA	0.80	0.43	105.70	44.27	.....	61.62	211.59
SE3	1.70	.....	224.62	.....	12.56	61.62	298.80
SE2	1.39	.....	183.66	.....	12.56	61.62	257.84
SE1	1.17	.....	154.59	.....	12.56	61.62	228.77
SSC	1.13	.....	149.31	.....	12.56	61.62	223.49
SSB	1.05	.....	138.74	.....	12.56	61.62	212.92
SSA	1.01	.....	133.45	.....	12.56	61.62	207.63
CC2	1.12	.....	147.99	.....	12.56	61.62	222.17
CC1	0.99	.....	130.81	.....	12.56	61.62	204.99
CB2	0.91	.....	120.24	.....	12.56	61.62	194.42
CB1	0.84	.....	110.99	.....	12.56	61.62	185.17
CA2	0.83	.....	109.67	.....	12.56	61.62	183.85
CA1	0.75	.....	99.10	.....	12.56	61.62	173.28
IB2	0.69	.....	91.17	.....	12.56	61.62	165.35
IB1	0.67	.....	88.53	.....	12.56	61.62	162.71
IA2	0.57	.....	75.31	.....	12.56	61.62	149.49
IA1	0.53	.....	70.03	.....	12.56	61.62	144.21
BB2	0.68	.....	89.85	.....	12.56	61.62	164.03
BB1	0.65	.....	85.88	.....	12.56	61.62	160.06
BA2	0.56	.....	73.99	.....	12.56	61.62	148.17
BA1	0.48	.....	63.42	.....	12.56	61.62	137.60
PE2	0.79	.....	104.38	.....	12.56	61.62	178.56
PE1	0.77	.....	101.74	.....	12.56	61.62	175.92
PD2	0.72	.....	95.13	.....	12.56	61.62	169.31
PD1	0.70	.....	92.49	.....	12.56	61.62	166.67
PC2	0.65	.....	85.88	.....	12.56	61.62	160.06
PC1	0.64	.....	84.56	.....	12.56	61.62	158.74
PB2	0.51	.....	67.39	.....	12.56	61.62	141.57
PB1	0.50	.....	66.07	.....	12.56	61.62	140.25
PA2	0.49	.....	64.74	.....	12.56	61.62	138.92
PA1	0.46	.....	60.78	.....	12.56	61.62	134.96

D. 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 an appropriate wage index, as determined by the Secretary. Section 315 of the BIPA authorizes the Secretary to establish a reclassification system specifically for SNFs, similar to the hospital methodology. However, this reclassification system cannot be implemented until the Secretary has collected data necessary to establish an area wage index for SNFs based on wage data from such facilities. Pursuant to section 106(a) of the Social Security Act Amendments of 1994 (Pub.L. 103–432), the Secretary was directed to begin collecting data on employee compensation and paid hours of employment in SNFs for the purpose of constructing a SNF wage index. Since the inception of a PPS for SNFs, we have utilized hospital wage data in developing a wage index to be applied to SNFs.

The computation of the wage index is similar to past years because we incorporate the latest data and methodology used to construct the hospital wage index (for a discussion, see the May 12, 1998 interim final rule (63 FR 26274)). We apply the wage index adjustment to the labor-related portion of the Federal rate, which is 75.379 percent of the total rate. This percentage reflects the labor-related relative importance for FY 2002. The labor-related relative importance, which we calculate from the SNF market basket, approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2002. 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 2002 than the base year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2002 in four steps. First, we compute the FY 2002 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

2002 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2002 relative importance for each cost category by multiplying this ratio by the base year (FY 1997) weight. Finally, we sum the FY 2002 relative importance for each of the labor-related cost categories (that is, wages and salaries, employee benefits, nonmedical professional fees, labor-intensive services, and capital-related) to produce the FY 2002 labor-related relative importance.

Tables 5 and 6 show the Federal rates by labor-related and non-labor-related components. In addition, the wage index budget neutrality factor for FY 2002 is .99835.

Section 1888(e)(4)(G)(ii) of the Act also requires that the application of this wage index be made 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. As noted in the proposed rule (66 FR 23993), we are updating the wage index applicable to SNF payments using the most recent hospital wage data and applying the adjustment to fulfill the budget neutrality requirement. (For a discussion of how we calculate the adjustment, see our discussion in the proposed rule at 66 FR 23993.)

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	441.18	332.56	108.62
RUB	392.78	296.07	96.71
RUA	369.27	278.35	90.92
RVC	342.67	258.30	84.37
RVB	330.22	248.92	81.30
RVA	298.41	224.94	73.47
RHC	318.68	240.22	78.46
RHB	291.02	219.37	71.65
RHA	264.74	199.56	65.18
RMC	315.94	238.15	77.79
RMB	279.99	211.05	68.94
RMA	262.01	197.50	64.51
RLB	252.39	190.25	62.14
RLA	209.52	157.93	51.59
SE3	307.35	231.68	75.67
SE2	264.48	199.36	65.12
SE1	234.06	176.43	57.63
SSC	228.53	172.26	56.27
SSB	217.46	163.92	53.54
SSA	211.93	159.75	52.18
CC2	227.14	171.22	55.92
CC1	209.17	157.67	51.50
CB2	198.10	149.33	48.77
CB1	188.42	142.03	46.39
CA2	187.04	140.99	46.05
CA1	175.98	132.65	43.33
IB2	167.68	126.40	41.28
IB1	164.91	124.31	40.60
IA2	151.09	113.89	37.20
IA1	145.55	109.71	35.84
BB2	166.30	125.36	40.94
BB1	162.15	122.23	39.92
BA2	149.70	112.84	36.86
BA1	138.64	104.51	34.13
PE2	181.51	136.82	44.69
PE1	178.74	134.73	44.01
PD2	171.83	129.52	42.31
PD1	169.06	127.44	41.62
PC2	162.15	122.23	39.92
PC1	160.77	121.19	39.58
PB2	142.79	107.63	35.16
PB1	141.41	106.59	34.82
PA2	140.02	105.55	34.47
PA1	135.87	102.42	33.45

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	465.05	350.55	114.50
RUB	418.80	315.69	103.11
RUA	396.34	298.76	97.58
RVC	356.10	268.42	87.68
RVB	344.21	259.46	84.75
RVA	313.82	236.55	77.27

TABLE 6.—CASE-MIX ADJUSTED FEDERAL RATES FOR RURAL SNFS BY LABOR AND NON-LABOR COMPONENT—Continued

RUG–III category	Total rate	Labor portion	Non-labor portion
RHC	324.88	244.89	79.99
RHB	298.46	224.98	73.48
RHA	273.35	206.05	67.30
RMC	319.28	240.67	78.61
RMB	284.92	214.77	70.15
RMA	267.74	201.82	65.92
RLB	252.55	190.37	62.18
RLA	211.59	159.49	52.10
SE3	298.80	225.23	73.57
SE2	257.84	194.36	63.48
SE1	228.77	172.44	56.33
SSC	223.49	168.46	55.03
SSB	212.92	160.50	52.42
SSA	207.63	156.51	51.12
CC2	222.17	167.47	54.70
CC1	204.99	154.52	50.47
CB2	194.42	146.55	47.87
CB1	185.17	139.58	45.59
CA2	183.85	138.58	45.27
CA1	173.28	130.62	42.66
IB2	165.35	124.64	40.71
IB1	162.71	122.65	40.06
IA2	149.49	112.68	36.81
IA1	144.21	108.70	35.51
BB2	164.03	123.64	40.39
BB1	160.06	120.65	39.41
BA2	148.17	111.69	36.48
BA1	137.60	103.72	33.88
PE2	178.56	134.60	43.96
PE1	175.92	132.61	43.31
PD2	169.31	127.62	41.69
PD1	166.67	125.63	41.04
PC2	160.06	120.65	39.41
PC1	158.74	119.66	39.08
PB2	141.57	106.71	34.86
PB1	140.25	105.72	34.53
PA2	138.92	104.72	34.20
PA1	134.96	101.73	33.23

As we noted in the proposed rule, we have received many comments over the past few years, asking that we evaluate a SNF-specific wage index, which would be based solely on wage and hourly data from SNFs. Further, the collection of nursing home wage data necessary to develop a SNF-specific wage index is a prerequisite for establishing a SNF-specific geographic reclassification procedure, as authorized by section 315 of the BIPA. To develop this analysis, we have added a schedule to the cost report to gather wage and hourly data from each SNF. In the proposed rule, we published a wage index prototype based on SNF data, along with the wage index based on the hospital wage data that was used in the FY 2001 final rule published July 31, 2000 in the **Federal Register** (65 FR 46770). In addition, we discussed in the proposed rule 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. Table 7 shows the hospital wage index for urban areas and Table 8 shows the hospital wage index for rural areas.

TABLE 7.—WAGE INDEX FOR URBAN AREAS

Urban area (Constituent counties or county equivalents)	Wage index
0040 Abilene, TX	0.7965
Taylor, TX	
0060 Aguadilla, PR	0.4683
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9876
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0640
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY	0.8500
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9750
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.8029
Rapides, LA	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index
0240 Allentown-Bethlehem-Easton, PA	1.0077
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9126
Blair, PA	
0320 Amarillo, TX	0.8711
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2570
Anchorage, AK	
0440 Ann Arbor, MI	1.1098
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8276
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.9241
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4630
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9200
Buncombe, NC	
Madison, NC	
0500 Athens, GA	0.9842
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA	1.0058
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
De Kalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic City-Cape May, NJ	1.1293
Atlantic City, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8230
Lee, AL	
0600 Augusta-Aiken, GA-SC	0.9970
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX	0.9597
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA	0.9470
Kern, CA	
0720 Baltimore, MD	0.9856
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Annes, MD	
0733 Bangor, ME	0.9593
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.3626
Barnstable, MA	
0760 Baton Rouge, LA	0.8149
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8442
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1826
Whatcom, WA	
0870 Benton Harbor, MI	0.8810
Berrien, MI	
0875 Bergen-Passaic, NJ	1.1689
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9352
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8440
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY	0.8446
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.8808
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7984
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8842
Monroe, IN	
1040 Bloomington-Normal, IL	0.9038
McLean, IL	
1080 Boise City, ID	0.9050
Ada, ID	
Canyon, ID	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1289
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	0.9799
Boulder, CO	
1145 Brazoria, TX	0.8209
Brazoria, TX	
1150 Bremerton, WA	1.0758
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.9012
Cameron, TX	
1260 Bryan-College Station, TX	0.9328
Brazos, TX	
1280 Buffalo-Niagara Falls, NY	0.9459
Erie, NY	
Niagara, NY	
1303 Burlington, VT	0.9883
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4699
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.8956
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9496
Natrona, WY	
1360 Cedar Rapids, IA	0.8699
Linn, IA	
1400 Champaign-Urbana, IL	0.9306
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9206
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.9264
Kanawha, WV	
Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC-SC	0.9348
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0566
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.9369
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY	0.8288
Laramie, WY	
1600 Chicago, IL	1.1046
Cook, IL	
De Kalb, IL	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index
Du Page, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	0.9856
Butte, CA	
1640 Cincinnati, OH-KY-IN	0.9473
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	0.8337
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH	0.9457
Ashtabula, OH	
Geauga, OH	
Cuyahoga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9744
El Paso, CO	
1740 Columbia, MO	0.8686
Boone, MO	
1760 Columbia, SC	0.9492
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL	0.8440
Russell, AL	
Chattanoochee, GA	
Harris, GA	
Muscogee, GA	
1840 ColumbusOH	0.9565
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8341
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1646
Benton, OR	
1900 Cumberland, MD-WV	0.8306
Allegany, MD	
Mineral, WV	
1920 Dallas, TX	0.9936
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index
1950 Danville, VA	0.8613
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8638
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9225
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.8982
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8775
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL	0.7987
Macon, IL	
2080 Denver, CO	1.0328
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.8779
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI	1.0487
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7948
Dale, AL	
Houston, AL	
2190 Dover, DE	1.0296
Kent, DE	
2200 Dubuque, IA	0.8519
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0284
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0532
Dutchess, NY	
2290 Eau Claire, WI	0.8832
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9215
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9638
Elkhart, IN	
2335 Elmira, NY	0.8415
Chemung, NY	
2340 Enid, OK	0.8357
Garfield, OK	
2360 Erie, PA	0.8716
Erie, PA	
2400 Eugene-Springfield, OR	1.1471
Lane, OR	
2440 Evansville-Henderson, IN-KY	0.8514
Posey, IN	
Vanderburgh, IN	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9267
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.9027
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8445
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.0556
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.0913
Genesee, MI	
2650 Florence, AL	0.7845
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8722
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0045
Larimer, CO	
2680 Ft. Lauderdale, FL	1.0293
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9374
Lee, FL	
2710 Fort Pierce-Port StLucie, FL	1.0214
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.8053
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.9002
Okaloosa, FL	
2760 Fort Wayne, IN	0.9203
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Fort Worth-Arlington, TX	0.9394
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	0.9887
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8792
Etowah, AL	
2900 Gainesville, FL	0.9481
Alachua, FL	
2920 Galveston-Texas City, TX	1.0313
Galveston, TX	
2960 Gary, IN	0.9530
Lake, IN	
Porter, IN	
2975 Glens Falls, NY	0.8336
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8709
Wayne, NC	
2985 Grand Forks, ND-MN	0.9069
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9569

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index
Mesa, CO	
3000 Grand Rapids-Muskegon-Holland, MI	1.0048
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.8870
Cascade, MT	
3060 Greeley, CO	0.9495
Weld, CO	
3080 Green Bay, WI	0.9208
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC	0.9539
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9289
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9217
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.8365
Washington, MD	
3200 Hamilton-Middletown, OH	0.9287
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9425
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT	1.1533
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 Hattiesburg, MS	0.7476
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9367
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1539
Honolulu, HI	
3350 Houma, LA	0.7951
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX	0.9631
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index
3400 Huntington-Ashland, WV-KY-OH	0.9616
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8883
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN	0.9698
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9859
Johnson, IA	
3520 Jackson, MI	0.9257
Jackson, MI	
3560 Jackson, MS	0.8491
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.9013
Chester, TN	
Madison, TN	
3600 Jacksonville, FL	0.9223
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC	0.7622
Onslow, NC	
3610 Jamestown, NY	0.8050
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9739
Rock, WI	
3640 Jersey City, NJ	1.1178
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8617
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8723
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.8425
Craighead, AR	
3710 Joplin, MO	0.8727
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battle Creek, MI	1.0639
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	0.9889
Kankakee, IL	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index
3760 Kansas City, KS-MO	0.9536
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	0.9568
Kenosha, WI	
3810 Killeen-Temple, TX	0.7292
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8890
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.9126
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.9250
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8526
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.9121
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7765
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.9067
Polk, FL	
4000 Lancaster, PA	0.9296
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9653
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.7849
Webb, TX	
4100 Las Cruces, NM	0.8621
Dona Ana, NM	
4120 Las Vegas, NV-AZ	1.1182
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.8656
Douglas, KS	
4200 Lawton, OK	0.8682
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9287
Androscoggin, ME	
4280 Lexington, KY	0.8791
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index
Woodford, KY	
4320 Lima, OH	0.9470
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	1.0173
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8955
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8571
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA	1.1948
Los Angeles, CA	
4520 Louisville, KY-IN	0.9529
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8449
Lubbock, TX	
4640 Lynchburg, VA	0.9103
Amherst, VA	
Bedford City, VA	
Bedford, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.8957
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0337
Dane, WI	
4800 Mansfield, OH	0.8708
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4860
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8378
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0314
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.9913
Brevard, Fl	
4920 Memphis, TN-AR-MS	0.8978
Crittenden, AR	
De Soto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	0.9757
Merced, CA	
5000 Miami, FL	0.9950
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ	1.1469
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 Milwaukee-Waukesha, WI	0.9971
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St Paul, MN-WI	1.0930
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	0.9364
Missoula, MT	
5160 Mobile, AL	0.8082
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0820
Stanislaus, CA	
5190 Monmouth-Ocean, NJ	1.0870
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8201
Ouachita, LA	
5240 Montgomery, AL	0.7359
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.9939
Delaware, IN	
5330 Myrtle Beach, SC	0.8771
Horry, SC	
5345 Naples, FL	0.9699
Collier, FL	
5360 Nashville, TN	0.9754
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY	1.3643
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2238
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT	1.1526
New London, CT	
5560 New Orleans, LA	0.9036
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	1.4427
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ	1.1622
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1113
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA-NC	0.8579
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City VA	
Williamsburg City, VA	
York, VA	
5775 Oakland, CA	1.5319
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9556
Marion, FL	
5800 Odessa-Midland, TX	1.0104
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK	0.8694
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.1350
Thurston, WA	
5920 Omaha, NE-IA	0.9712
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA	1.1123
Orange, CA	
5960 Orlando, FL	0.9642
Lake, FL	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8334
Daviess, KY	
6015 Panama City, FL	0.9061
Bay, FL	
6020 Parkersburg-Marietta, WV-OH	0.8133
Washington, OH	
Wood, WV	
6080 Pensacola, FL	0.8329
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8773
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA-NJ	1.0947
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ	0.9638
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7895
Jefferson, AR	
6280 Pittsburgh, PA	0.9560
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA	1.0278
Berkshire, MA	
6340 Pocatello, ID	0.9448
Bannock, ID	
6360 Ponce, PR	0.5218
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9427
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR-WA	1.1111
Clackamas, OR.	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Pawtucket, RI	1.0805
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	0.9843
Utah, UT	
6560 Pueblo, CO	0.8604
Pueblo, CO	
6580 Punta Gorda, FL	0.9015
Charlotte, FL	
6600 Racine, WI	0.9333
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC	0.9818
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8869
Pennington, SD	
6680 Reading, PA	0.9583
Berks, PA	
6690 Redding, CA	1.1155
Shasta, CA	
6720 Reno, NV	1.0440
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.0960
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9678
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 Riverside-San Bernardino, CA	1.1111
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8371
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.1462
Olmsted, MN	
6840 Rochester, NY	0.9347
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9204
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9109
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA	1.1831
El Dorado, CA	
Placer, CA	
Sacramento, CA	
A6960 Saginaw-Bay City-Midland, MI	0.9590
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 StCloud, MN	0.9851
Benton, MN	
Stearns, MN	
7000 StJoseph, MO	0.9009
Andrews, MO	
Buchanan, MO	
7040 StLouis, MO-IL	0.8931
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	1.0011
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4684
Monterey, CA	
7160 Salt Lake City-Ogden, UT	0.9863
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8193
Tom Green, TX	
7240 San Antonio, TX	0.8584
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA	1.1265
San Diego, CA	
7360 San Francisco, CA	1.4140
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA	1.4193
Santa Clara, CA	
7440 San Juan-Bayamon, PR	0.4762
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	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index
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	1.0990
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0802
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.3970
Santa Cruz, CA	
7490 Santa Fe, NM	1.0194
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.3034
Sonoma, CA	
7510 Sarasota-Bradenton, FL	1.0090
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9243
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton--Wilkes-Barre--Hazleton, PA	0.8683
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA	1.1361
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA	0.7926
Mercer, PA	
7620 Sheboygan, WI	0.8427
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9373
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.9050
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.8767
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9139
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9993
St. Joseph, IN	
7840 Spokane, WA	1.0668
Spokane, WA	
7880 Springfield, IL	0.8676
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8567
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.0881
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.9133
Centre, PA	
8080 Steubenville-Weirton, OH-WV	0.8637
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0815
San Joaquin, CA	
8140 Sumter, SC	0.7794
Sumter, SC	
8160 Syracuse, NY	0.9621
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1616
Pierce, WA	
8240 Tallahassee, FL	0.8527
Gadsden, FL	
Leon, FL	
8280 Tampa-St. Petersburg-Clearwater, FL	0.8925
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN	0.8532
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana,AR-Texarkana, TX	0.8327
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9809
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.8912
Shawnee, KS	
8480 Trenton, NJ	1.0416
Mercer, NJ	
8520 Tucson, AZ	0.8967
Pima, AZ	
8560 Tulsa, OK	0.8902
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8171
Tuscaloosa, AL	
8640 Tyler, TX	0.9641
Smith, TX	
8680 Utica-Rome, NY	0.8329
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3562
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.0994
Ventura, CA	
8750 Victoria, TX	0.8328
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0441
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA	0.9610
Tulare, CA	
8800 Waco, TX	0.8129
McLennan, TX	
8840 Washington, DC-MD-VA-WV	1.0962
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	0.8041
Black Hawk, IA	
8940 Wausau, WI	0.9696
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL	0.9777
Palm Beach, FL	
9000 Wheeling, OH-WV	0.7985
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9606
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.7867
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8521
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.0877
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9409
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0567
Yakima, WA	
9270 Yolo, CA	0.9701
Yolo, CA	
9280 York, PA	0.9441
York, PA	

TABLE 7.—WAGE INDEX FOR URBAN AREAS—Continued

Urban area (Constituent counties or county equivalents)	Wage index
9320 Youngstown-Warren, OH	0.9563
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0359
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.8989
Yuma, AZ	

TABLE 8.—WAGE INDEX FOR RURAL AREAS

Rural area	Wage index
Alabama	0.7339
Alaska	1.1862
Arizona	0.8681
Arkansas	0.7489
California	0.9772
Colorado	0.8811
Connecticut	1.2077
Delaware	0.9589
Florida	0.8812
Georgia	0.8295
Guam	0.9611
Hawaii	1.1112
Idaho	0.8718
Illinois	0.8053
Indiana	0.8721
Iowa	0.8147
Kansas	0.7769
Kentucky	0.7963
Louisiana	0.7601
Maine	0.8721
Maryland	0.8859
Massachusetts	1.1454
Michigan	0.9010
Minnesota	0.9035
Mississippi	0.7528
Missouri	0.7778
Montana	0.8655
Nebraska	0.8142
Nevada	0.9673
New Hampshire	0.9803
New Jersey [1]	.....
New Mexico	0.8676
New York	0.8547
North Carolina	0.8539
North Dakota	0.7879
Ohio	0.8668
Oklahoma	0.7566
Oregon	1.0027
Pennsylvania	0.8617
Puerto Rico	0.4800
Rhode Island [1]	.....
South Carolina	0.8512
South Dakota	0.7861
Tennessee	0.7928
Texas	0.7712
Utah	0.9051
Vermont	0.9466
Virginia	0.8241
Virgin Islands	0.6747
Washington	1.0209
West Virginia	0.8067
Wisconsin	0.9079

TABLE 8.—WAGE INDEX FOR RURAL AREAS—Continued

Rural area	Wage index
Wyoming	0.8747

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

Comment: Several commenters expressed concern that we may discard the SNF-specific wage index without further work or development to ensure its accuracy. Many commenters suggested that we work with the industry to improve the cost reporting forms used in collecting the data, thus improving the editing and auditing that would lead to an improved SNF-specific wage index. Virtually all commenters agreed that the proposed SNF wage index prototype is not appropriate and should not be implemented with the current data shortcomings. We also received many comments suggesting that the SNF-specific wage index is not valid, and that there is no evidence to indicate it would be any better than the hospital wage index currently in use. These commenters maintained that imposing a SNF-specific wage index before improving the data quality would not be justified.

Response: As discussed in the proposed rule, there is a great deal of volatility in the SNF-specific wage index prototype—not only between the hospital wage data, but also between the two years of data that we utilized 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 that is required by law. We are considering initiation of a process to develop and make appropriate changes to the cost report to improve the quality of the wage data reported, and intend to work with the industry representatives and others in this effort. We agree that auditing all SNFs would provide more accurate and reliable data; however, this approach involves a significant commitment of resources by us and our contractors and places a burden on providers in terms of recordkeeping and completion of the cost report worksheet. Developing a desk review and audit program similar to what is required in the hospital setting would require significant resources. The fiscal intermediaries (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. 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 FIs' workload and budgets in this area.

We are committed to using a wage index under the SNF PPS that results in enhancing our current payment methodology. In fact, we are continuing to look at ways to improve the processing and accuracy of the current hospital wage data to improve its accuracy and reliability further, especially since these data are currently being used for payment purposes for hospitals and a variety of other providers. While we are committed to improving the accuracy of payments for SNFs, we do not expect to propose a SNF-specific wage index until its impact both on payments and resources is more clearly understood. This will include evidence demonstrating that a SNF-specific wage index would significantly improve our ability to determine payments for facilities, justifying the resources required to collect the data and the burden on providers.

We realize, as a number of commenters suggested, that the impact of any new wage index would vary from one area to another. However, because of the problems associated with the current data, and our inability to demonstrate that the SNF-specific wage index is 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: Two commenters suggested that even though we cannot now implement a SNF-specific wage index, we should encourage legislation that would implement a geographic reclassification system for SNFs using the hospital wage index.

Response: We believe that this is a matter for the Congress to address, as it did in the BIPA. Under section 315 of the BIPA, providers would be allowed to seek geographic reclassification to an adjacent area. However, the statute specifically noted that such reclassification could not be implemented until we have collected the data necessary to establish a SNF-specific wage index. Accordingly, under the current legislative authority, we are prohibited from implementing a SNF reclassification system until such an index becomes available.

Comment: Two commenters suggested that a blend between a hospital wage

index and a SNF-specific wage index might be an appropriate adjustment or phase-in of a SNF-specific wage index, while the data quality is being improved.

Response: If, in the future, we propose to move to a SNF-specific wage index, this approach may be appropriate. However, we do not believe that a blend between a hospital wage index and SNF-specific wage index is currently warranted, nor do we believe that a blend should be implemented until the SNF data is reliable. Calculating a wage index on a blend of hospital data and inaccurate SNF-data is not likely to improve the accuracy of our payments. As we have already indicated, we have concerns about establishing a wage index based on SNF-specific wage data that is unreliable and unaudited, since this could have an arbitrary impact on providers. Accordingly, we do not believe that it would be appropriate to use a blend that, at the present time, includes unreliable and unaudited SNF data.

Comment: Some commenters pointed out two typographical errors in Table 5 of the proposed rule (66 FR 23992), which showed the labor portion of the adjusted Federal rate for RUG–III group BA1 as $704.20, and the total rate for RUG–III group PE2 as $780.99.

Response: The correct dollar amounts for these two items are $104.20 and $180.99, respectively.

Comment: One commenter reported discovering an error in the hospital wage data that was used in computing the current (FY 2001) wage index for the Baltimore MSA. The error was corrected in a timely fashion for the wage index data published in this final rule; however, the commenter indicated that because the hospital(s) did not accurately report their costs on prior year cost reports, the current wage index is incorrect and an adjustment should be made to account for this error.

Response: For the reasons discussed previously, we are continuing to use the hospital wage index under the SNF PPS. Thus, corrections in the underlying data would be made in accordance with the existing process for developing the hospital wage index. We note that this process already includes numerous review and editing procedures, and also provides numerous opportunities for hospitals and other interested parties to detect and question any discrepancies in the data and seek revisions to that data.

E. Updates to the Federal Rate

In accordance with section 1888(e)(4)(E) of the Act and section 311 of the BIPA, the payment rates listed here reflect an update equal to the SNF market basket minus 0.5 percentage point, which equals 2.8 percent. For each succeeding FY, we will publish the rates in the **Federal Register** before August 1 of the year preceding the next Federal FY.

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

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 that beneficiaries who are correctly assigned to one of the upper 26 RUG–III groups in the initial 5-day, Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to that point. (Those beneficiaries assigned to any of the lower 18 groups are not automatically classified as either meeting or not meeting the definition, but instead receive an individual level of care determination using the existing administrative criteria.)

In the proposed rule published in the **Federal Register** on May 10, 2001 (66 FR 24011), we proposed to continue the existing designation of the upper 26 RUG–III groups for purposes of this administrative presumption, consisting of 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: Commenters expressed support for our proposal to continue the existing designation of the upper 26 RUG–III groups for purposes of the administrative presumption regarding level of care. They noted that since we are not introducing case-mix refinements in the current rulemaking cycle, the existing designation should also remain unchanged.

Response: Consistent with the comments, we are continuing the existing designation of the upper 26 RUG–III groups for purposes of this administrative presumption, consisting of 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.

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

Using the example of 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, 2001. Table 10 displays the 44 RUG–III categories and their respective add-ons, as provided in the BBRA and the BIPA.

TABLE 9.—SNF XYZ IS LOCATED IN STATE COLLEGE, PA WITH A WAGE INDEX OF 0.9133

RUG Group	Labor portion [1]	Wage index	Adjusted labor	Nonlabor portion [1]	Adjusted rate	Percent adjustment	Medicare days	Payment
RVC	$258.30	0.9133	$235.91	$84.37	$320.28	[2] 354.55	50	$17,728
SSC	172.26	0.9133	157.33	56.27	213.60	[3] 264.86	25	6,622
IA2	113.89	0.9133	104.02	37.20	141.22	[4] 146.87	25	3,672
Total							100	27,022

[1] From Table 5.
[2] Reflects a 10.7 percent adjustment (the 4 percent adjustment from section 101(d) of the BBRA and the 6.7 percent adjustment from section 314 of the BIPA).
[3] Reflects a 24 percent adjustment (the 4 percent and 20 percent adjustments from sections 101(a) and (d) of the BBRA).
[4] Reflects the 4 percent adjustment from section 101(d) of the BBRA.

TABLE 10.—BBRA 1999 & BIPA 2000 ADD-ONS, BY RUG–III CATEGORY

RUG–III category	4% [1]	10.7% [2]	24% [3]
RUC		X	
RUB		X	
RUA		X	
RVC		X	
RVB		X	
RVA		X	
RHC		X	
RHB		X	
RHA		X	
RMC		X	
RMB		X	
RMA		X	
RLB		X	
RLA		X	
SE3			X
SE2			X
SE1			X
SSC			X
SSB			X
SSA			X
CC2			X
CC1			X
CB2			X
CB1			X
CA2			X
CA1			X
IB2	X		
IB1	X		
IA2	X		
IA1	X		
BB2	X		
BB1	X		
BA2	X		
BA1	X		
PE2	X		
PE1	X		
PD2	X		
PD1	X		
PC2	X		
PC1	X		
PB2	X		
PB1	X		
PA2	X		
PA1	X		

[1] Represents the 4% increase from the BBRA.
[2] Includes the 4% increase from the BBRA and the 6.7% increase from the BIPA.
[3] Includes the 4% and 20% increases from the BBRA.

For rates addressed in this final rule, we are using wage index values that are based on hospital wage data from cost reporting periods beginning in FY 1997.

H. The Skilled Nursing Facility Market Basket Index

1. Background

Section 1888(e)(5)(A) of the Act requires the Secretary to establish a market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in the SNF PPS. Effective for cost reporting periods beginning on or after July 1, 1998, we revised and rebased our 1977 routine costs input price index and adopted a total expenses SNF input price index using data from 1992 as the base year.

The term ''market basket'' technically describes the mix of goods and services needed to produce SNF care, and is also commonly used to denote the input price index that includes both weights (mix of goods and services) and price factors. The term ''market basket'' used in this rule refers to the SNF input price index.

The 1992-based SNF market basket represents routine costs, costs of ancillary services and capital-related costs. The percentage change in the market basket reflects the average change in the price of a fixed set of goods and services purchased by SNFs to furnish all services. For further background information, see the May 12, 1998 **Federal Register** (63 FR 26289).

For purposes of SNF PPS, the SNF market basket is a fixed-weight (Laspeyres type) price index. (A Laspeyres type index compares the cost of purchasing a specified group of commodities in a selected base period to the cost of purchasing that same group at current prices.) The SNF market basket is constructed in three steps. First, a base period is selected and total base period expenditure shares are estimated for mutually exclusive and exhaustive spending categories. Total costs for routine services, ancillary services, and capital are used. These proportions are called cost or

expenditure weights. The second step is to match each expenditure category to a price/wage variable, called a price proxy. These price proxy variables are drawn from publicly available statistical series published on a consistent schedule, preferably at least quarterly. In the final step, the price level for each spending category is multiplied by the expenditure weight for that category. The sum of these products (that is, weights multiplied by proxy index levels) for all cost categories yields the composite index level in the market basket for a given quarter or year. Repeating the third step for other quarters and years produces a time series of market basket index levels, from which rates of growth can be calculated.

The market basket is described as a fixed-weight index because it answers the question of how much more or less it would cost, at a later time, to purchase the same mix of goods and services that was purchased in the base period. The effects on total expenditures resulting from changes in the quantity or mix of goods and services purchased subsequent or prior to the base period are, by design, not considered.

As discussed in the May 12, 1998 **Federal Register** (63 FR 26252), to implement section 1888(e)(5)(A) of the Act, we revised and rebased the market basket so the cost weights and price proxies reflected the mix of goods and services that SNFs purchase for all costs (routine, ancillary, and capital-related) encompassed by SNF PPS in fiscal year 1992.

2. Rebasing and Revising the Skilled Nursing Facility Market Basket

The terms ''rebasing'' and ''revising'', while often used interchangeably, actually denote different activities. Rebasing means shifting the base year for the structure of costs of the input price index (for example, for this rule, we shift the base year cost structure from fiscal year 1992 to fiscal year 1997). Revising means changing data sources, cost categories, and/or price proxies used in the input price index.

We have rebased and revised the SNF market basket to reflect 1997 total cost data (routine, ancillary, and capital-related). Fiscal year 1997 was selected as the new base year because 1997 is the most recent year for which relatively complete data are available. These data include settled 1997 Medicare Cost Reports as well as 1997 data from two U. S. Department of Commerce surveys: The Bureau of the Census' Business Expenditures Survey, and the Bureau of Economic Analysis' Annual Input-Output tables. Preliminary analysis of 1998 data from Medicare Cost Reports showed little change in cost shares from those in the 1997 Medicare Cost Reports.

In developing the market basket, we reviewed SNF expenditure data from Medicare Cost Reports for FY 1997 for each freestanding SNF that had Medicare expenses. FY 1997 Cost Reports are those with cost reporting periods beginning after September 30, 1996 and before October 1, 1997.

Comment: Some commenters believe that the weights derived for use in the revised and rebased market basket are not valid, because only freestanding facility data were used.

Response: As described in the proposed rule, we used SNF expenditure data from Medicare Cost Reports for FY 1997 for each freestanding SNF that had Medicare expenses. We maintained our policy of using data from freestanding SNFs because they reflect the actual cost structure faced by the SNF. Expense data for a hospital-based SNF are affected by the allocation of overhead costs over the entire institution (hospital, hospital-based SNF, hospital-based home health agency, etc). Due to the method of allocation, total expenses will be correct, but the individual components' expenses may be skewed. Therefore, if data from hospital-based SNFs were included, the resultant cost structure could be unrepresentative of the costs facing an average SNF.

Data on SNF expenditures for six major expense categories (wages and salaries, employee benefits, contract labor, pharmaceuticals, capital-related, and a residual ''all other'') were edited and tabulated. Using these data, we then determined the proportion of total costs that each category represented. The six major categories for the revised and rebased cost categories and weights derived from SNF Medicare Cost Reports are summarized in Table 10.A.

TABLE 10.A—1992 AND 1997 SKILLED NURSING FACILITY MAJOR COST CATEGORIES AND WEIGHTS FROM MEDICATE COST REPORTS

Cost categories	1992-based skilled nursing facility weights	1997-based skilled nursing facility weights
Wages and Salaries	47.805%	46.889%
Employee Benefits	10.023	9.631
Contract Labor	12.852	6.478
Pharmaceuticals	2.531	3.006
Capital-related Costs	9.778	9.877
All Other Costs	17.012	24.119
Total Costs	100.000	100.000

We fully discuss the methodology for developing these weights in Appendix A. The main methodological difference between the 1992-based SNF market basket and the 1997-based market basket is in the calculation of the contract labor weight. For the 1992-based market basket, we estimated this share using non-salary costs for therapy cost centers. For the 1997-based index, we used the contract labor amounts for a subset of edited reports from Worksheet S–3 in the Medicare Cost Reports. We believe this new methodology provides a more accurate reflection of the share of total costs that are attributable to contract labor. The data from this worksheet were not available in the 1992 Medicare Cost Reports.

Relative weights within the six major categories were derived using relative cost shares from the Bureau of the Census' 1997 Business Expenditures Survey (BES), 1997 Medicare Cost Reports, and the Bureau of Economic Analysis' (BEA) 1997 Annual Input-Output tables. They were used to disaggregate and allocate costs within the six major categories determined from the 1997 SNF Medicare Cost Reports. The BEA Input-Output database is benchmarked at 5-year intervals and updated annually between benchmarks. We are using the annual update for 1997. The BES is updated every five years.

The capital-related portion of the rebased and revised SNF PPS market basket employs the same overall methodology used to develop the capital-related portion of the 1992-based SNF market basket, described in the May 12, 1998 **Federal Register** (63 FR 26289). It is also the same methodology used for the inpatient hospital PPS capital input price index described in the **Federal Register** May 31, 1996 (61 FR 27466) and August 30, 1996 (61 FR 46196). The strength of this methodology is that it reflects the vintage nature of capital, which represents the acquisition and use of capital over time.

Our work resulted in 21 separate categories for the rebased and revised SNF market basket. The 1992-based total cost SNF market basket also had 21 separate cost categories. Detailed descriptions of each cost category and respective price proxy in the 1997-based SNF market basket are provided in Appendix A to this final rule.

Comment: Several commenters felt that the methodology and data sources used by CMS in the development of the market basket raise questions about the transparency and consistency of the index. The commenters were particularly concerned with the use of a fixed-weight (Laspeyres type) index that was only updated periodically and thus did not capture the changing dynamics of the SNF industry.

Response: The methodology and data sources used by CMS for the SNF market basket are consistent with those used in the development of the hospital, home health, and physician market baskets, and prior versions of the SNF market basket. These market baskets have been used over the past two decades to update payments to providers of Medicare services, and the theory and methodology behind these market baskets have been continually revised and refined. We feel the current SNF market basket is based on a sound methodology that is completely consistent with price index theory as used in the development of other official government price indexes, such as those developed by the Bureau of Labor Statistics (BLS) and the Bureau of Economic Analysis (BEA). While the data sources available to develop the SNF market basket are limited, we feel our methodology ensures that these data sources are appropriately used and consistently combined, with great care taken to account for definitional and methodological differences in the data.

As we stated in the proposed rule, our primary data source for developing the SNF market basket is the actual data submitted by SNFs in the Medicare cost reports. Using these data to develop the major cost category weights, we have used actual SNF data that reflect the actual cost experience faced by SNFs in providing care. We use as much detail as is available and accurately reported in the cost reports, and then supplement this information with data reported by nursing homes, of which SNFs represent a significant proportion, as part of official government statistics published by the Bureau of the Census and Bureau of Economic Analysis. These official government statistics are publicly available and also reflect the actual cost experience faced by SNFs and nursing homes. We use the distribution of costs reported in these official statistics, not actual cost levels, to further refine the distribution of the major cost categories measured by the Medicare cost reports. Thus our methodology makes the maximum use of Medicare cost report data submitted by SNFs and uses official government statistics based on data provided by nursing homes and SNFs to develop an index that fully reflects a mutually exclusive and exhaustive set of input costs facing SNFs. In the proposed rule, we specifically identified the data source (even providing the specific worksheets for the Medicare cost report data) from which each index weight was determined.

The SNF market basket is a fixed-weight (Laspeyres type) index that measures how much more or less it would cost, at a later time, to purchase the same mix of goods and services (inputs) that was purchased in the base period. Thus it reflects the pure price change between the current and base period of a fixed set of inputs. Over time, SNFs may alter their mix of inputs, generally from higher cost inputs to lower cost inputs, although this change may reflect a number of different factors. In order to reflect the change in mix over time, we periodically rebase the SNF market basket to a more recent base year. The rebased SNF market basket reflects the mix of inputs for 1997. However, like any fixed-weight index, the SNF market basket does reflect the current prices facing the SNF. So, while the base weights may be from a prior year, the price changes reflected in the index are reflective of the current trends in the SNF industry.

We do not share the commenters' concerns that using a fixed-weight (Laspeyres type) index biases the index or makes it less representative of the changing dynamics of the SNF industry. Unlike the official BLS and BEA price indexes, which generally measure consumption patterns of consumers and producers that can change drastically over a short period of time and for which many interchangeable products exist, the cost distribution of inputs for the SNF in providing services does not vary much over time. As such, the substitution bias that can exist with a fixed-weight price index is not evidenced in our SNF market basket. Thus, while the commenters feel that using a chain-weight or another type of alternative index formulation would make the SNF market basket more reflective of the changing dynamics in the SNF industry, in actuality these alternative index formulas would have no noticeable effect on the annual percent change in the market basket. As shown in Table 10.A., the weights of the major cost categories did not change significantly between 1992 and 1997, other than a methodological change we made in calculating the contract labor weight. The impact of rebasing the index is presented in Table 10.D., and shows that between FYs 1995 and 2000 the impact was always less than 0.1 percentage points, and on average, the 1992-based and 1997-based indexes grew at exactly the same rate during that time. In addition, when we looked at 1998 Medicare cost report data (the most recent year of complete data) we found very little difference in the major cost weights.

We have explored in the past the idea of using alternative index formulations, such as a Paasche, Fisher, Tornqvist, and chained-versions of these indexes, that do not rely on a fixed-weight (Laspeyres type) index formula. In doing this research we found very little variation in the change in the index over time, mostly the result of weights that were relatively stable, as explained above. In addition, developing these alternative index formulations was affected by significant lags in data availability; the Medicare cost report data are at least three years old due to processing time, and the Census and BEA data are available only every five years. Given these outcomes, we did not feel it would be beneficial to switch from the current fixed-weight methodology. We again note that the current methodology is both accurate and conceptually sound in measuring the change in input prices for SNFs, hospitals, HHAs, and physicians.

As in the 1992-based SNF market basket, the 1997-based SNF market basket does not include a separate cost category for professional liability insurance. Our analysis of the BEA 1997 Annual Input-Output survey indicated that the general category for insurance carriers (which includes professional liability insurance as a subset) was, at

just 0.2 percent, a small share of the total costs in 1997. It has been our policy in the past not to provide detailed breakouts of cost categories unless they represent a significant portion of the providers' costs. We also reviewed data available on professional liability insurance from Worksheet S–2 of the SNF Medicare Cost Reports, but found that nearly all SNFs did not report data for malpractice premiums, paid losses, or self-insurance in 1997.

Comment: Several commenters recommended that CMS quickly develop an appropriate weight and price measure to capture professional liability insurance costs.

Response: As we stated in the proposed rule, we have been investigating sources of professional liability insurance costs for SNFs but have been unable to find an existing data source with this information. We are encouraged that the commenters are also interested in CMS acquiring this information, and would appreciate their input on any currently available data or possible approaches to obtaining the data. One possible data source for this information would be the Medicare cost reports. We note, however, that the Medicare cost reports for 1997 did not contain complete information for these costs. We encourage all providers to fully fill out the categories for malpractice premiums, paid losses, or self insurance on the Medicare cost reports. This would likely be the quickest and most efficient way to collect the data. In addition, we will continue to research possible data sources and may pursue data collection efforts if we cannot find the necessary data from publicly available, timely, unbiased sources.

After the 21 cost weights for the revised and rebased SNF market basket were developed, we selected the most appropriate wage and price proxies currently available to monitor the rate of change for each expenditure category. With three exceptions (all for the capital-related expenses cost category), the wage and price proxies are based on Bureau of Labor Statistics (BLS) data and are grouped into one of the following BLS categories:

• *Employment Cost Indexes.* Employment Cost Indexes (ECIs) measure the rate of change in employment wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. They are not affected by shifts in occupation or industry mix. ECIs are superior to Average Hourly Earnings (AHEs) as price proxies for input price indexes for two reasons: (1) They measure pure price change, and (2) they are available by both occupational group and by industry.

• *Producer Price Indexes.* Producer Price Indexes (PPIs) measure price changes for goods sold in other than retail markets. PPIs were used when the purchases of goods or services were made at the wholesale level.

• *Consumer Price Indexes.* Consumer Price Indexes (CPIs) measure change in the prices of final goods and services bought by consumers. CPIs were only used when the purchases were similar to those of retail consumers rather than purchases at the wholesale level, or if no appropriate PPI was available.

The contract labor weight of 6.478 was reallocated to (1) wages and salaries, and (2) employee benefits, so that the same price proxies that we use for direct labor costs are applied to contract costs.

The rebased and revised cost categories, weights, and price proxies for the 1997-based SNF market basket are listed in Table 10.B.

TABLE 10.B.—1997-BASED SNF MARKET BASKET COST CATEGORIES, WEIGHTS, AND PRICE PROXIES

Cost category	1997-based skilled nursing facility market basket weight	Price proxy
Operating Expenses	90.123	
Compensation	62.998	
Wages and Salaries	52.263	ECI for Wages and Salaries for Private Nursing Homes.
Employee benefits	10.734	ECI for Benefits for Private Nursing Homes.
Nonmedical professional fees	2.634	ECI for Compensation for Private Professional, Technical and Specialty workers.
Utilities	2.368	
Electricity	1.420	PPI for Commercial Electric Power.
Fuels, nonhighway	0.426	PPI for Commercial Natural Gas.
Water and sewerage	0.522	CPI–U for Water and Sewerage.
All Other Expenses	22.123	
Other Products	13.522	
Pharmaceuticals	3.006	PPI for Prescription Drugs.
Food	4.136	
Food, wholesale purchase	3.198	PPI for Processed Foods.
Food, retail purchase	0.937	CPI–U for Food Away From Home.
Chemicals	0.891	PPI for Industrial Chemicals.
Rubber and plastics	1.611	PPI for Rubber and Plastic Products.
Paper products	1.289	PPI for Converted Paper and Paperboard.
Miscellaneous products	2.589	PPI for Finished Goods less Food and Energy.
Other Services	8.602	
Telephone Services	0.448	CPI–U for Telephone Services.
Labor-intensive Services	4.094	ECI for Compensation for Private Service Occupations
Non labor-intensive services	4.059	CPI–U for All Items
Capital-related Expenses	9.877	
Total Depreciation	5.266	
Building & Fixed Equipment	3.609	Boeckh Institutional Construction Index (vintage-weighted over 23 years).
Movable Equipment	1.657	PPI for Machinery & Equipment (vintage-weighted over 10 years).
Total Interest	3.852	

TABLE 10.B.—1997-BASED SNF MARKET BASKET COST CATEGORIES, WEIGHTS, AND PRICE PROXIES—Continued

Cost category	1997-based skilled nursing facility market basket weight	Price proxy
Government & Nonprofit SNFs	1.890	Average Yield Municipal Bonds (Bond Buyer Index-20 bonds) (vintage-weighted over 22 years).
For-Profit SNFs	1.962	Average Yield Moody's AAA Bonds (vintage-weighted over 22 years).
Other Capital-related Expenses	0.760	CPI–U for Residential Rent.
Total	*100.000	

*Total may not equal 100 due to rounding

In the 1997-based SNF market basket, the labor-related share for FY 1997 is 73.588 percent, while the non-labor-related share is 26.412 percent. The labor-related share reflects the proportion of the average SNF's costs that vary with local area wages. This share includes wages and salaries, employee benefits, professional fees, labor-intensive services, and a 39.1 percent share of capital-related expenses, as shown in Table 10.C. By comparison, the labor-related share of the 1992-based SNF market basket was 75.888 percent. The labor-related share of the market basket is the sum of the weights for those cost categories that are influenced by the local labor market. The labor-related share is calculated from the base year, which for the revised and rebased SNF market basket is FY 1997.

The labor-related share for capital-related expenses was estimated using a statistical analysis of individual SNF Medicare Cost Reports for 1997, similar to the analysis done on the 1992 SNF Medicare Cost Reports and explained in the May 12, 1998 **Federal Register** (63 FR 26289). The statistical analysis was necessary because the proportion of capital-related expenses related to local area wage costs cannot be directly determined from the SNF capital-related portion of the market basket. We used regression analysis with total costs per day in SNFs as the dependent variable and relevant explanatory variables for size, complexity, efficiency, age of capital, and local wage variation. To account for these factors, we used number of beds, case-mix indexes, occupancy rate, ownership, age of assets, length of stay, FTEs per bed, and wage index values based on the hospital wage index (wages and employee benefits) as independent variables. Our regression analysis indicated that the coefficient on the area wage index was 73.588, which represents the proportion of total costs that vary with local labor markets, holding constant other factors. From the operating portion of the market basket, we can specifically identify cost categories that reflect local labor markets and include them in the labor-related share. These cost categories equal 69.727, and reflect approximately 77 percent of operating costs. Thus, the labor-related share for capital-related costs is 3.861 (73.588 minus 69.727), and reflects approximately 39 percent of capital-related costs.

Capital-related expenses are determined in some proportion by local area labor costs (such as construction worker wages and building materials costs) that are reflected in the price of the capital asset. However, many other inputs that determine capital costs are not related to local area wage costs, such as equipment prices and interest rates. Thus, it is appropriate that capital-related expenses would vary less with local wages than would operating expenses for SNFs. Therefore, we use this analysis in determining the labor-related share for SNF PPS.

All price proxies for the revised and rebased SNF market basket are listed in Table 10.B and summarized in Appendix A to this final rule. A comparison of the yearly historical percent changes from FY 1995 through FY 2000 for the current 1992-based market basket and the 1997-based market basket is shown in Table 10.D.

TABLE 10.C.—1992- AND 1997-BASED LABOR-RELATED SHARE

Cost category	1992-based skilled nursing facility market basket weight	1997-based skilled nursing facility market basket weight
Wages and Salaries	54.262	52.263
Employee Benefits	12.797	10.734
Nonmedical Professional Fees	1.916	2.634
Labor-intensive Services	3.686	4.094
Capital-related	3.227	3.861
Total	75.888	73.588

TABLE 10.D.—COMPARISON OF THE 1992-BASED SKILLED NURSING FACILITY MARKET BASKET AND THE 1997-BASED SKILLED NURSING FACILITY MARKET BASKET, PERCENT CHANGES, 1995–2000

Fiscal years beginning October 1	1992-based skilled nursing facility market basket	1997-based skilled nursing facility market basket
Historical:		
October 1994, FY 1995	2.9	3.0
October 1995, FY 1996	2.7	2.7
October 1996, FY 1997	2.4	2.4
October 1997, FY 1998	2.8	2.8
October 1998, FY 1999	3.1	3.0
October 1999, FY 2000	4.1	4.0
Historical average 1995–2000	3.0	3.0

Released by CMS, OACT, National Health Statistics Group.

The historical average rate of growth for 1995 through 2000 for the SNF 1997-based market basket is similar to that of the 1992-based market basket. The 1997-based SNF market basket provides a more current measure of the annual

price increases for total care than the 1992-based SNF market basket because the cost weights reflect the structure of costs for the most recent year for which there are relatively complete data. The forecasted rates of growth for FY 2002 for the 1997-based and 1992-based SNF market basket are shown in Table 10.E.

TABLE 10.E.—COMPARISON OF FORECASTED CHANGE FOR THE 1992-BASED SKILLED NURSING FACILITY MARKET BASKET, AND THE 1997-BASED SKILLED NURSING FACILITY MARKET BASKET PERCENT CHANGE FOR FY 2002

Fiscal year beginning October 1	1992-based skilled nursing facility market basket	1997-based skilled nursing facility market basket
October 2001, FY 2002	3.5	3.3

Source: Global Insights, Inc., DRI–WEFA, 2nd QTR, 2001; @USMACRO/MODTREND @CISSIM/TRENDLONG0501. Released by CMS, OACT, National Health Statistics Group.

Comment: One commenter indicated that there should be a mechanism to account for forecast error since forecasts of the market basket are used to determine the following year payment update.

Response: Research is currently under way in developing an update framework for the SNF PPS. A conceptual discussion of this framework was presented in the proposed rule. The SNF PPS framework discussed in the proposed rule is similar to the one currently used by us and MedPAC to recommend annual updates to inpatient hospital payments. This framework would account for all non-price factors needed in an update, such as a forecast error correction. Although this would not impact the legislated payment update, the framework would give us the ability to factor in a forecast error adjustment in our recommendation for an update to SNF payments. In addition, our policy has been to use the most recent forecast of the market basket available to update the payment rates. These updated forecasts reflect expectations based on the most up-to-date price data. We note, however, that by definition, the forecasts may differ from later projections or the final number recorded for a given year.

Comment: One comment noted that the base year used to establish the PPS rates was nonrepresentative and, thus, did not reflect the full cost of care. This comment also requested us to explain an apparent discrepancy between the rise in SNF costs between 1995 and 1998 and the market basket increase used to establish the initial rates under the PPS. The commenter noted a disparity of 19.2 percent over this period.

Response: While we agree that certain costs were removed from the 1995 base year data used to establish the initial SNF PPS rates in 1998, the BBA specifically required that these costs not be included in the calculation of the rates. In addition, the removal of these costs from the 1995 base year data does not indicate that the rates are in any way inadequate. In direct contrast to the commenters' statement, the Office of Inspector General (OIG) issued a report shortly after the implementation of SNF PPS entitled ''Review of the Health Care Financing Administration's Development of a Prospective Payment System for Skilled Nursing Facilities'' (Number A–14–98–00350), which asserted that the cost base used to establish the PPS rates was inflated with unnecessary and improperly billed services. In addition, the General Accounting Office (GAO) and MedPAC have both recently stated in reports and testimony before the Congress that the payment rates are adequate.

In addition, while we were unable to confirm the percentage difference referred to in the comment, we would note that the market basket and measures of reported costs represent two entirely different concepts. Accordingly, we do not believe there is a discrepancy, as the concepts cannot be compared to each other.

The market baskets used by Medicare for SNF PPS and other payment systems are, by design, intended to recognize changes from year to year in the price of goods and services purchased by SNFs in providing covered Medicare services. Reported costs, on the other hand, reflect amounts billed by providers and paid for by Medicare. As such, they reflect an array of factors not reflected in the market basket. For example, measures of reported costs would reflect changes in the intensity of services billed for, and the amounts charged to, Medicare. In this case, an examination of the period between 1995 and 1998 shows substantial increases in the price and number of ancillary services billed to Medicare. This certainly appears to be a primary cause of the large increases in reported costs. However, it is unclear from the comment why the payment rates (or the market basket) should be expected to capture such non-price related changes. MedPAC has noted in testimony before the Congress and in recent reports that these cost increases between 1995 and 1998 were not related to changes in the overall case-mix or acuity of the patients served in SNFs or changes in input prices. As an illustrative example, the GAO and OIG have published numerous reports related to this period detailing instances of unnecessary services improperly billed by SNFs. In this context, it would not seem appropriate to capture changes in reported costs associated with improper or unnecessary service delivery in establishing the initial PPS rates.

We believe the SNF market basket, as a measure of input prices, was established consistent with the statute and the methods used to develop such indexes under SNF cost limits and other Medicare payment systems in 1998 and at the present time. Congress mandated that, in establishing the rates, the base year costs from 1995 be updated to 1998 by the market basket. Differences between that update and the increases in reported costs over that period relate to the fundamental differences between the two measurement concepts and are to be expected.

Comment: We received several comments recommending that we undertake a thorough review of the SNF market basket. These comments suggested that we examine the full range of market basket components, including the weights and price proxies used in the current SNF market (with particular attention to wages, benefits, professional liability, and pharmaceuticals), and the appropriateness of using a Laspeyres fixed weight input price index for updating PPS payments. The comments also suggested that we initiate a collaborative process with the nursing home industry and other entities aimed at redesigning the SNF market basket. Several comments suggested that we initiate formal regulations negotiations on the issue of the SNF market basket.

Response: We are committed to ensuring the continued adequacy of our payments to SNFs under the Medicare

program. Our ongoing efforts to refine the case-mix methodology and revise and rebase the market basket offer evidence of our efforts to keep the SNF PPS current in a continually evolving health care environment.

As in the past, we are interested in maintaining a dialogue with the industry, beneficiaries, and other interested parties on this important issue. We will continue to be receptive to new ideas on this and other issues. In the proposed rule, we specifically requested comments on the market basket for the purpose of eliciting ideas and recommendations on refining the market basket components and methodology used for the SNF PPS. While we received few concrete recommendations or suggestions on this subject, a number of important issues and questions were raised which we have and will continue to examine closely. While formal regulations negotiations may offer a good opportunity for us to collaborate with the industry and other interested parties on important regulatory policy initiatives, we believe that without an understanding of the scope and direction of any potential regulatory effort in this area, it is premature for us to comment on whether this issue would be a good candidate for future formal negotiations. We will consider the potential for this in the future and we appreciate the continued interest and thinking of commenters in this area.

I. Update Framework

Medicare payments to SNFs are based on a predetermined national payment amount per day. Annual updates to these payments are required by section 1888(e) of the Act. These updates are usually based on the increase in the SNF market basket. For FY 2002, the update is set at market basket minus 0.5 percent. Our goal is to develop a method for analyzing and comparing expected trends in the underlying cost per day to use in establishing these updates. For a complete discussion of the conceptual framework, see the May 10, 2001 proposed rule (66 FR 23984).

The SNF market basket, or input price index, developed by our Office of the Actuary (OACT), is just one component in the SNF cost per day amount. It captures only the pure price change of inputs (labor, materials, and capital) used by the SNF to produce a constant quantity and quality of care. Other factors also contribute to the change in costs per day, which include changes in case-mix, intensity, and productivity.

In the proposed rule, we outlined a conceptual approach for a SNF-specific update framework, and invited comments on the utility and feasibility of that approach for SNFs, as well as whether certain factors should be accounted for in the framework. We also invited suggestions for potential data sources and analysis to support the model.

Comment: We received numerous comments on the update framework discussed in the proposed rule. These commenters focused on a range of issues related to the framework, including its purpose, structural design, and the data required to operate such a tool effectively. Some commenters recommended that the annual update to payment rates continue to be based solely on the market basket due to concerns that the framework may be too subjective and unpredictable and the data sources potentially unreliable. Others offered technical suggestions related to the data sources and methodology used to develop the different components of the update framework.

Response: As discussed in the proposed rule, an update framework, used in combination with the market basket, seeks to enhance the system for updating payments by addressing factors beyond changes in pure input price. These factors are not reflected in the market basket used for establishing SNF payments, but often have an effect on changes in cost per day. Other factors that result in changes in the cost of SNF services from year to year include such things as patient acuity, intensity of services, and productivity.

Like the update framework used for Medicare's inpatient hospital PPS, an update framework in the context of the SNF PPS would provide a comprehensive and objective tool for measuring and understanding changes in cost per day. These factors are not reflected in the market basket but often have an effect on cost per day from year to year. It can provide information that policy officials in the executive branch and the Congress can use in making decisions about the magnitude of updates each year. This will support the continued accuracy of SNF payments and ensure that the SNF PPS keeps pace with changing economic and health care market trends. We believe the potential value of the framework justifies continued research and development in this area.

We appreciate the comments and technical suggestions offered by commenters concerning potential data sources and methodological approaches for the development of an update framework. While we are not addressing each technical comment individually in this final rule, we wish to assure the commenters that we will take them into consideration as we continue to pursue development efforts in this area. As stated in the proposed rule, we are not proposing to apply an update framework in a recommendation to the Congress at this time. After considerable research and analysis, our intention is to include a specific proposal for an update framework in a future **Federal Register** notice for public comment. This proposal would clearly detail the methodology, data sources, and potential impact of applying an analytical update framework under the SNF PPS.

J. Consolidated Billing

As enacted in section 4432(b) of the BBA, the consolidated billing requirement places with the SNF itself the Medicare billing responsibility for virtually all of the services that a SNF resident receives. In defining the scope of this provision, the original legislation made no distinction between services furnished during the course of a covered Part A SNF stay and those furnished during a SNF stay that Medicare does not cover. However, as we noted in the proposed rule, we did not initially implement the Part B aspect of this provision (in connection with those services furnished during a noncovered SNF stay), because doing so would require making significant systems modifications, which were delayed by systems constraints that arose in connection with achieving Y2K compliance. Accordingly, in the July 30, 1999 final rule (64 FR 41671), we announced an indefinite postponement in the implementation of Part B consolidated billing, along with our intention to publish a notice of the anticipated implementation date for this aspect of consolidated billing in the **Federal Register** at least 90 days in advance.

Subsequently, effective January 1, 2001, section 313 of the BIPA repealed the Part B aspect of SNF consolidated billing, except for physical, occupational, and speech-language therapy, which remain subject to consolidated billing whenever furnished to a SNF resident, regardless of whether Medicare covers that resident's stay in the SNF. In the proposed rule, we set forth several conforming revisions in the regulations to implement these statutory changes in the consolidated billing requirement.

We note that section 313 of the BIPA does not delay the implementation of Part B consolidated billing, but repeals it (except for physical, occupational, and speech-language therapy) completely. Therefore, we hereby

withdraw our previously announced plan to provide 90 days advance notice in the **Federal Register** of an implementation date for Part B consolidated billing with regard to nontherapy services, since this aspect of the provision has now been eliminated and, thus, does not need to be implemented. Further, with regard to physical, occupational, and speech-language therapy furnished during noncovered SNF stays, the Part B billing and tracking responsibilities for SNFs have already been effectively implemented, as SNFs already have specific responsibility for these services, pursuant to the separate Part B therapy payment cap provision enacted by section 4541 of the BBA (see our discussion in the proposed rule, at 66 FR 24020). Accordingly, there is no need to announce a separate implementation date specifically for these three services.

Notwithstanding the repeal of Part B consolidated billing by section 313 of the BIPA, the consolidated billing requirements for services furnished to a SNF resident during the course of a covered Part A stay remain in effect. Further, as we noted in the proposed rule, to the extent that SNFs continue to submit Part B bills, the repeal of Part B consolidated billing would not affect the applicable requirements for fee schedule payment and appropriate HCPCS coding, which remain in the law (at sections 1888(e)(9) and (10) of the Act, respectively).

Comment: Although the BIPA legislation affected only those aspects of consolidated billing relating to the Part B repeal, a number of commenters took this opportunity to reiterate concerns about other aspects of consolidated billing that originally had been expressed during the public comment periods in prior years. For example, we received a number of comments concerning the possible exclusion of additional services from SNF consolidated billing. While the BIPA made no revisions to the statutory list of services that are excluded from consolidated billing, the preceding year's legislation (the BBRA) had created several new categories of excluded services. These exclusions encompassed certain individual services (identified in the statute by HCPCS code) within the categories of chemotherapy and its administration, radioisotope services, and customized prosthetic devices, as well as ambulance services that are furnished in connection with Part B dialysis services. During the public comment period for last year's SNF PPS rule (which implemented these statutory exclusions), a number of commenters recommended designating a broader set of services for exclusion. 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. They also advocated expanding the existing exclusion for certain high-intensity outpatient hospital services to encompass services furnished in other, nonhospital, settings. Many of the comments on this year's SNF PPS proposed rule reiterated these previous recommendations. In addition, a number of commenters now recommended a further set of services for temporary exclusion from the requirement, with possible reinstatement upon implementation of case-mix refinements that might, in their view, better account for these services. These additional services are blood transfusions, total parenteral nutrition, liquid oxygen, specialty beds for patients with severe skin breakdown, and certain I.V. medications. Some commenters also suggested that our evaluation of any case-mix refinements should include consideration of the ability to account accurately for these types of services. One commenter reiterated concerns that many commenters had expressed in previous years about ensuring that a SNF makes timely payment to its suppliers, while another commenter requested that the final rule contain detailed billing instructions concerning the requirement to include the SNF's Medicare provider number on all Part B claims.

Response: When we declined last year to adopt the recommendations to exclude additional services from consolidated billing, we noted that we do not view making additions to the list of excluded services as a part of a process of continual expansion to encompass an ever-broadening array of excluded services. Further, we indicated that an ongoing expansion of the existing exclusions (in the absence of significant changes in the current state of medical practice) would be contrary to the fundamental purpose of the consolidated billing provision, which is to make the SNF responsible for billing Medicare for essentially all of its residents' services, other than those identified in a small number of narrow and specifically delimited statutory exclusions. We do not find in the current public comments any additional evidence, beyond what was advanced previously, to support the recommendations for further exclusions. Therefore, for the reasons set forth in the final rule for FY 2001, we once again decline to adopt these recommendations. Further, 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. As indicated in our discussion of research on case-mix refinements in section III.A of this preamble, we agree with the recommendation to evaluate the ability of any case-mix refinements to support accurate pricing of services, and we plan to do so as the research in this area proceeds.

In connection with the commenter's concern about ensuring that a SNF pays its suppliers in a timely manner, we noted in the July 30, 1999 final rule (64 FR 41677) that under consolidated billing, a SNF's relationship with its suppliers is a contractual one, in which the terms of the suppliers' payment by the SNF are agreed upon through negotiation between the parties. Accordingly, a supplier can best resolve any concerns that it may have about the adequacy or timeliness of the SNF's payment by ensuring that these concerns are addressed to its satisfaction in its contract with the SNF. Finally, regarding the comment about specific billing procedures for including the SNF's Medicare provider number on Part B claims, we noted in last year's SNF PPS final rule (65 FR 46791, July 31, 2000) that specific operational instructions (such as those describing the details of particular billing procedures) are beyond the scope of the SNF PPS final rule, and are addressed instead through program issuances.

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

In the proposed rule, we outlined our plans for converting rural swing-bed hospitals to the SNF PPS. We proposed to make the conversion effective with cost reporting periods beginning on and after October 1, 2001, a timeframe consistent with the implementation time limits prescribed in the law. We received a number of comments on this swing bed proposal, nearly all of which expressed concern about the impact that introducing the MDS would have on

facility costs, staffing levels, and patient care. We have carefully considered these comments, and agree that, since our mutual objective is the efficient provision of high quality care, our requirements should be framed in a way that both protects the integrity of the Medicare program and supports provider efforts in this direction. As a result, we have revised our initial proposal in several ways that minimize burden and support swing-bed hospitals in providing quality care while still maintaining the accuracy of our payments.

Comment: Several commenters expressed concern about the long-term adequacy of the SNF PPS rate structure, and urged us to continue our work to develop SNF PPS refinements. Comments received from swing-bed providers generally described their beneficiary populations as medically complex patients who are often difficult to place following discharge from an acute care hospital stay. They stressed the importance of accurate payment for non-therapy ancillaries in maintaining access for this segment of the Medicare population and for maintaining the financial viability of the swing-bed hospitals.

Response: During the past year, OIG, GAO and MedPAC have reviewed the adequacy of the SNF PPS rates. They have each determined that the current rate structure, including the increases mandated under the BBRA and BIPA, is adequate to maintain access and provide aggregate payments at a level sufficient to provide quality care to Medicare beneficiaries. As stated in our May 10, 2001 proposed rule (66 FR 23984), the need to reflect differences in ancillary usage accurately and the resulting impact on facility costs is a major focus of our research to refine the SNF PPS. Since this research will include analyses of patients currently classified in the Extensive Care and Rehabilitation groups (the two most common types of swing-bed patients), we believe that the needs of swing-bed providers will be addressed. A more detailed discussion of our research plans is provided in section III.A.

Comment: A number of commenters focused on issues related to reimbursement of non-therapy ancillaries, and concluded that a transition to the SNF PPS (which would eliminate cost reimbursement for swing bed ancillary services) would not fully cover the costs of at least some of the beneficiaries currently served. These commenters were concerned about their continued ability to care for medically complex beneficiaries by providing them with the costly services they need, or even to stay in operation. Other commenters pointed out that the anticipated 9 percent increase in overall swing-bed reimbursement, combined with the elimination of restrictions on swing-bed utilization, are likely to increase swing-bed participation rather than reduce the number of swing-bed programs.

Response: In a prospective payment system, costs may exceed payments for an individual patient or group of patients. It is equally possible for payments to exceed costs. However, as stated above, OIG, GAO and MedPAC have concluded that aggregate payments under the SNF PPS are sufficient to maintain access for beneficiaries and to provide needed patient care. In fact, in section V, we have projected an aggregate increase in swing-bed reimbursement using calendar year 1999 actual claims data that includes all therapy and non-therapy ancillary services provided to Medicare beneficiaries. Moreover, the claims data included all ancillary services, including some high-cost services that have been excluded from the SNF PPS under the consolidated billing regulations. As discussed below, swing-bed hospitals will be separately reimbursed for these excluded services, which encompass such high-cost items as MRIs, CAT scans, and intensive chemotherapy. While utilization patterns may change over time, we are not anticipating any sudden, immediate changes in either the type of beneficiaries served or the type of services needed. Therefore, we believe that the providers can continue to provide high quality services to all types of Medicare beneficiaries, even those with complex medical needs who may require a high level of ancillary services, under the current SNF PPS rate structure.

Comment: A small number of commenters suggested that rural swing-bed hospitals with less than 50 beds or those providers designated as sole community hospitals (SCHs) should be exempted from the SNF PPS and reimbursed on a cost basis like swing-beds in critical access hospitals (CAHs). A few commenters recommended that these types of rural hospitals be given a choice between the SNF PPS and the current payment methodology.

Response: Section 203 of the BIPA specifically exempted swing-bed services furnished in CAHs from the SNF PPS. The requirements for swing-beds in rural hospitals were not changed. The statute requires payment to all swing-beds in rural hospitals, including those designated as sole community hospitals, under the SNF PPS after June 30, 2002, the end of the SNF PPS transition period. The statute does not provide any authority for payment to swing-bed hospitals under any other payment system.

Comment: A large number of comments proposed the possibility of an alternative payment mechanism that would assign payment rates solely on the basis of UB–92 information. (The Uniform Bill (UB)–92 also known as the HCFA–1450) form and instructions are used by institutional and other selected providers to complete a Medicare, Part A paper claim for submission to Medicare FIs.) They asked us to consider offering this model to swing-bed hospitals as a voluntary alternative to the SNF PPS.

Response: The statute requires that resident assessment data be used as necessary to develop and implement the SNF PPS rates. Currently, the claims form data do not contain the information necessary to develop the SNF PPS rates. Moreover, as noted previously, the statute is very clear that payment to swing-bed hospitals must be made under the SNF PPS and does not provide for an alternative method of payment after the SNF PPS transition period. However, we acknowledge the considerable amount of time and effort that went into developing the proposal, and the degree of interest generated. Accordingly, we will discuss the proposal in greater detail later in this section, and will ask our contractor to include an analysis of a claims-based classification system in its analysis of program refinements.

Comment: We received a number of comments questioning the use of the full MDS for a new provider group at a time when we are committed to restructuring and streamlining the MDS instrument. These commenters pointed out the inefficiency of training clinical staff on an instrument that will only remain in use for a limited time. Several of these commenters suggested that the conversion to the SNF PPS be postponed until the introduction of the revised MDS.

Response: The statute does not provide any authority to postpone the conversion of swing bed hospitals to the SNF PPS beyond the last day of the SNF PPS transition period; i.e., July 1, 2002. While we are working on a reexamination of our post-acute care data needs consistent with the provisions of section 545 of the BIPA, any new assessment tools will not be available in time for the swing-bed conversion to SNF PPS.

Comment: We also received a few comments supporting our original MDS proposal. These commenters believe

that swing-bed hospitals providing SNF-level services should be subject to the same requirements as SNFs. These commenters pointed out that uniformity is not just a question of fairness, but the only way we could truly compare SNFs and swing-beds in terms of quality, skilled care utilization, and costs.

Response: It is necessary to distinguish between the short-term and long-term effects of our policies. We are certainly committed to reviewing the purposes of collecting data and specifying comparable and compatible data elements across Medicare providers, including post-acute care services and swing-bed hospitals, when such common data elements will allow us to achieve our objectives. Our reevaluation of our patient assessment data needs will start by first examining what we need the data for and whether comparable and compatible data across Medicare providers are appropriate. However, since this review is not yet complete, we must also be sensitive to the short-term impact of imposing a policy that cannot be clearly justified in terms of patient care and program integrity.

Comment: Comments from swing-bed hospitals consistently focused on the burden of using the full MDS, and stressed that they already use a variety of functional screening tools to implement care plans upon admission, and have mechanisms in place to monitor quality. Commenters concluded that requiring the care planning and quality monitoring components of the MDS would be time-consuming and labor intensive without contributing to improved beneficiary outcomes. However, a few commenters questioned the prevailing assumption that swing-bed hospitals were better able to manage care planning and quality monitoring functions than SNFs, and believed the MDS care planning and quality monitoring components would have value for swing-bed hospitals.

Response: In considering the applicability of the full MDS 2.0 for swing-bed hospitals, we considered the usefulness of the MDS instrument for both payment and patient care purposes. In this analysis, we looked at similarities and differences between swing-bed and other SNF service delivery systems. At the time of SNF PPS national implementation, the MDS had already been in use in SNFs for 7 years and was the standard for care planning and quality monitoring. By contrast, although swing-bed hospitals use care planning and quality tools, these are not standard across providers. Further, these tools will continue to be required for the acute care patients in the swing-bed hospital. The introduction of the MDS into the swing-bed setting poses an additional burden to the clinical staff since they will be required to master the MDS as well as maintain their mastery of the tools that the hospital uses for its acute care patients.

As mentioned above, an additional consideration at this time is the impending revision of the MDS 2.0 by CMS. This work is underway, but the revised instrument will not be ready for use before 2003, at the earliest. Intensive training will be required for the swing-bed clinical staff to be able to use the full MDS 2.0 and an additional burden may be imposed as it is expected that more training will be required when the new assessment tool is introduced.

Further, the length of stay for Medicare Part A beneficiaries in swing-beds is much shorter than for similar beneficiaries in SNFs. This shorter length of stay minimizes the usefulness of the MDS-based Quality Indicator system in identifying poor patient outcomes. Finally, by requiring the full MDS at this time, we would be mandating not one but two major changes in swing-bed clinical operations, the current MDS and the next generation of streamlined data assessment tools that are already in the planning stages.

Therefore, we will not require swing-bed facilities to perform the care planning and quality monitoring components included in the full MDS at this time. We will include an analysis of swing-bed requirements in our comprehensive reevaluation of all post-acute data needs, and in the design of any future assessment and data collection tools. In addition, we reserve the right to modify the swing-bed hospital conditions of participation in response to the identification of significant quality concerns.

As specified in section 1888(e)(7) of the Act, we have now determined that an appropriate manner in which to apply the SNF PPS to swing-beds is to establish a unique MDS for swing-bed hospitals. This new 2-page MDS for Swing-Bed Hospitals will use a subset of the MDS information, and will include only those items needed for payment and ongoing analysis of the SNF PPS. This 2-page MDS for Swing-Bed Hospitals may be viewed on our web site at http://www.hcfa.gov/medicare/SNFPPS.gov. Appendix B contains a comparison between the full, six-page MDS and this new, 2-page MDS for Swing-Bed Hospitals.

Comment: Almost every comment on swing-beds that we received raised the issue of the MDS. Most commenters were extremely concerned that the proposed MDS requirements were likely to divert nursing resources from patient care to MDS preparation, increase facility costs by requiring additional nursing staff (if staff were even available in this period of nursing shortages) and possibly reduce the quality of care that the swing-bed hospital is able to provide. Other commenters asserted that swing-bed hospitals providing SNF-level services should be subject to the same requirements as SNFs, in order to maintain a level playing field. They pointed out that there is no data to support a conclusion that rural hospitals are better able to provide care than SNFs, and that data are needed to monitor and evaluate swing-bed services. They also pointed out that SNFs (particularly small rural SNFs) provide the same types of services, but have to respond to the same issues and pressures.

Response: The comments described a wide range of potential outcomes, from minor adjustments in staff assignments to staffing increases of 0.1 to 2.0 FTEs, restrictions on access, negative patient outcomes, and swing-bed closures. Generally, providers commenting on costs estimated that one-third to one-half of the proposed rate increases would be required to comply with the MDS requirements. Even though this information is anecdotal (and still assumes an overall increase in rates), it did raise concerns about the benefits of using the full MDS. By using the customized 2-page MDS for Swing-Bed Hospitals, we will focus our data collection efforts on those items needed for payment and ongoing analyses of the characteristics and service utilization patterns of swing-bed hospital patients. Most of these items are typically part of the routine physical assessment performed by nursing staff and documented in the medical record, and will require little or no extra work by clinical staff.

Comment: A number of commenters questioned the cost estimates provided in our proposed rule. They expressed concern that we had underestimated both the number of staff needing training and the time it would take to prepare, review, encode, and transmit data. Several providers also expressed concern about the cost of computer software needed to support the MDS function. There was also some concern related to the level of effort needed to implement the changes so quickly.

Response: These comments applied to use of the full MDS form, not the customized 2-page MDS for Swing-Bed Hospitals that will actually be used. We have taken these comments into

consideration in updating the cost estimates for this final rule. See sections V and VI.B of this preamble for a more detailed discussion.

We note that we have attempted to address concerns and support the swing-bed hospital conversion effort as much as possible. First, in response to comments, we have revised the implementation date to cost report periods starting on and after July 1, 2002, the latest date permitted by the statute. Second, we have reduced the burden associated with MDS completion by creating a separate 2-page Swing-bed Hospitals MDS. This new instrument will use a subset of the MDS information and will include only those items needed for payment and ongoing analyses of the characteristics and service utilization patterns of care of swing-bed hospital patients. Third, we will develop and distribute a Swing-Bed Manual that will include instructions for MDS coding and related issues. Fourth, we have committed to the development of customized swing-bed MDS software that will be available without charge to each swing-bed provider. Fifth, we have committed to an extensive provider training and support program. Help Desks will be established to respond to clinical and technical questions from swing-bed staff. We are also planning a series of training programs on MDS completion and electronic transmission procedures. We are confident that these initiatives will minimize the disruption to swing-bed operations and provide needed support during the transition period.

Comment: Several commenters indicated that the SNF PPS assessment frequency (5, 14, 30, 60, and 90 days from the start of the Part A stay) was unnecessary in the swing-bed hospital setting. They recommended various alternatives, including eliminating one or more of the current assessments, or requiring only a single MDS to be completed at the end of the stay.

Response: Based on the most recent available data, the average length of stay in a hospital swing-bed is under 9 days. Since the 5-day MDS is used to determine payment for the first 14 days of the stay, hospital staff will generally complete only one MDS for each beneficiary. Furthermore, we note that eliminating some or all of the remaining SNF PPS assessments (14, 30, 60, and 90 days from the start of the Part A stay) would affect only a very limited number of swing-bed providers.

We also note that the type and intensity of care typically changes during the course of a stay. For beneficiaries with short stays, reliance on the 5-day assessment is appropriate, since the intensity level is likely to remain relatively constant over a short time period. However, for longer-stay patients, the intensity of care generally changes over the course of the stay. We recently compared the RUG–III classifications reported on the Medicare 5-day and 14-day assessments, and we found that the data showed an increased acuity level on the 14 day assessment. Thus, collecting MDS data at different points in the stay enables our payments to reflect the actual intensity of care more accurately. Reliance on a single MDS, either the initial 5-day assessment or an MDS completed at the time of discharge, would not as accurately reflect beneficiary resource use. In addition, the data on longer stays will be used to monitor changes in swing-bed utilization patterns and care practices, and to evaluate the need for adjustments to the current swing-bed conditions of participation and care planning requirements.

For these reasons, we have concluded that swing-bed providers must comply with the SNF PPS assessment schedule. Since the MDS for Swing-Bed Hospitals will contain only a small subset of the full MDS items, MDS completion times will be greatly reduced.

Comment: We received a few comments from swing-bed providers concerned that the SNF PPS requirements would have a disproportionate impact on their facilities. For example, one facility mentioned the large number of MDSs that would be required in a facility with short lengths of stay and rapid patient turnover. Another commenter was concerned that time would be wasted by complying with the assessment window for the 14-day assessments (days 11–14) for beneficiaries expected to be discharged before the start of the next SNF PPS payment period.

Response: We agree that individual facility characteristics are a factor in determining the impact of any policy. It is true that a swing-bed hospital serving a high-volume, short stay population may do more than the average number of MDS assessments. We believe that the new 2-page Swing-Bed Hospitals will reduce the burden on clinical staff. We also suggest that, prior to coming under the SNF PPS system, staff evaluate their admission, care planning, and documentation processes, and make changes to integrate the MDS requirements into their daily routines. This will help avoid the documentation burden associated with a new assessment tool caused by putting the new requirements on top of the old and duplicating efforts.

A solid understanding of the assessment schedule will also help staff to maximize their resources and avoid unnecessary work. For example, some flexibility has been built into the assessment schedule through the designation of grace days. In the example described above, the assessment reference date for the 14-day assessment can be performed at any time during the assessment window, from day 11 to as late as day 19. These grace days should be utilized when scheduling assessments for beneficiaries likely to be discharged by day 14.

Comment: A few commenters questioned why swing-bed hospitals need to complete the discharge and reentry tracking forms.

Response: Completion of the discharge and reentry tracking forms will provide us a clear picture of the interaction between acute and post-acute care that may be unique to patients in hospital swing-beds. This data needs to be incorporated into our payment design efforts so that our analyses of the methodologies used accurately reflect swing-bed as well as SNF utilization patterns. Second, the discharge and reentry information is needed to monitor the appropriateness of transfers between acute and post-acute levels of care in swing-bed hospitals.

Comment: A few commenters opposed the development of a swing-bed-specific reason for assessment that would allow swing-bed providers to report changes in patient status that result in a change in RUG–III group but do not require the completion of a Significant Change in Status Assessment (SCSA). These commenters recommended that swing-bed providers subject to the SNF PPS be required to use the same criteria for reporting status changes as SNFs.

Response: The swing-bed conditions of participation do not currently require swing-bed hospitals to perform and transmit SCSAs. As explained below, we have determined that a change in these conditions of participation at this time is not warranted. We also believe that the inability to report clinical changes would decrease the accuracy of SNF PPS payment to swing-bed hospitals. For this reason, we will establish a swing bed-specific reason for assessment that will allow swing-bed providers to complete and transmit MDS data reflecting significant clinical changes in patient status.

Comment: Several commenters recommended the creation of a unique payment mechanism for swing-beds that would eliminate the use of the MDS entirely. The commenters suggested that

a system similar to the MEDPAR analog should be designed to determine payment groups based on the UB–92 claim form. The MEDPAR analog was a tool that we used for estimating SNF case-mix in the development of the initial PPS rates (see 63 FR 26289, May 12, 1998). These commenters suggested that we allow swing-bed hospitals to choose between the regular SNF PPS and this alternative payment model.

Response: Before considering the specifics of this proposal, it is important to state that, while we do have some flexibility in transitioning into the SNF PPS, the statute does limit the options that can be considered. The statute, in section 1888(e)(7) of the Act, does provide us with the authority to determine an appropriate manner in which to apply the provisions of the SNF PPS (as described throughout section 1888(e)) to swing-bed hospital units. We have determined that the framework of SNF PPS and the general requirements of that subsection are appropriate in transitioning these providers to SNF PPS. Specifically, the statute requires, in section 1888(e)(6), that a SNF, or a hospital swing-bed unit must provide the us, in a manner and within the time frames prescribed by the us, the resident assessment data necessary to develop and implement the rates. The statute does not provide authority to develop an entirely new or optional payment system for this class of providers. Similarly, the statute does not provide any authority to replace the existing case-mix system (the RUG–III classification) with the MEDPAR analog, an entirely different modeling system that we had developed to approximate acuity levels on a per stay basis.

We realize that the suggestion of developing a voluntary alternative to the SNF PPS (that would use neither the MDS nor the RUG–III system) stems from concerns over the time requirements for training and MDS preparation. We understand that some commenters were willing to accept a lower degree of rate-setting accuracy by using the approximate acuity level determined from the UB–92, in exchange for eliminating the MDS requirement. However, it is unclear whether the majority of those submitting comments understood that reduced accuracy is likely to result in reduced payment for their medically complex patients, since we would have to establish some type of average payment rate for each of the levels in the payment hierarchy. Beneficiaries who would group into the highest levels of the Extensive Care or Special Care categories would also likely receive lower payments under this option. In addition, the MEDPAR analog was designed as an analytical tool for estimating case-mix in the aggregate for the purpose of standardizing the initial payment rates under the PPS (see 63 FR 26259, May 12, 1998). It was not developed for determining claims level payments to providers, nor do we believe it is appropriate for such an application.

The proposed 9-group charge-based system that these commenters advocated is also vulnerable in its heavy reliance on charges to establish classification criteria or break points. Under this proposal, historical claims data would be used to establish the break points between the different levels of the hierarchy, a method similar to the one used for DRG development. However, in the DRG system, billed charges do not affect the assignment to a specific group. Under the commenters' proposal, the classification breakpoints would be applied to current charges. Any facility could change its payment level by simply modifying its charge structure for specified ancillary services; such as therapy and medical supplies.

In addition, the burden associated with reporting items needed to calculate payment rates is not eliminated under this proposal; it is merely shifted from the clinical staff to medical records and billing staff. Since this proposal assumes that the necessary payment information is present in the medical record, it actually increases the burden on the billing/coding staff without any real reduction in workload for the clinicians. The creation of the new 2-page Swing-Bed Hospital MDS will permit easy recording of the data necessary for RUG–III calculation and billing without requiring major changes to UB–92 preparation requirements.

While we understand the attraction to providers of an option that completely eliminates the MDS documentation and reporting process, the statute does not provide for the establishment of this type of option. Further, we do not believe that this proposal, as presently drafted, is an appropriate way to provide SNF PPS payment to swing-bed hospitals. Moreover, as discussed above, contrary to the commenters' perception, it may not effectively address the burden associated with the MDS, is susceptible to manipulation and abuse, and most seriously, might not provide sufficient payment to a critical and vulnerable sector of our national health care system. For these reasons, we cannot support this proposal, and will instead implement the SNF PPS for swing-bed hospitals, as described in this final rule.

Comment: A few commenters expressed concern about the lack of lead time to prepare for the transition to the SNF PPS. They cited a number of recent changes, such as Outcome and Assessment Information Set (OASIS) and hospital outpatient Ambulatory Payment Classifications (APCs), that have strained hospital resources. They believed that the short timeframes would be disruptive to rural hospitals and detract from patient care.

Response: We agree that ensuring a smooth transition should be a high priority. After considering the concerns raised by the commenters in this regard, we have determined that providing increased lead time would be appropriate. Therefore, in this final rule, we are revising the effective date for swing-bed conversion to the SNF PPS to the start of the provider's first cost reporting period that begins on or after July 1, 2002, the latest possible implementation time frame authorized in the law.

Comment: In the proposed rule, we solicited comments on the possibility of modifying the swing-bed conditions of participation. A number of commenters stated that swing-beds are already subject to the overall hospital certification requirements in addition to the specialized swing-bed conditions of participation. They do not believe that a change in the swing-bed conditions of participation is warranted. Others recommended that all providers that furnish SNF-level services should be subject to the same requirements, and that we should revise the swing-bed conditions of participation to reflect the new SNF PPS requirements.

Response: The Medicare conditions of participation establish standards for patient care, and reflect the needs of different provider types. The fact that two types of providers are reimbursed in the same way is not, in and of itself, a reason to change these requirements. However, we realize that, by eliminating restrictions on swing-bed length of stay and by changing the way services are reimbursed, we may see changes in the type, intensity, and duration of care furnished in swing-bed hospitals. We plan to monitor swing-bed utilization to identify changes that could affect patient care, and to address these issues quickly and appropriately. Accordingly, we believe that it would be premature to revise the existing conditions of participation at this time.

We also considered the current conditions of participation in light of the provisions in section 408 of the BBRA that remove restrictions on swing-bed length of stay. It is possible that these legislative changes, especially

when combined with a new set of payment incentives and disincentives associated with the SNF PPS, will result in longer lengths of stay and changes in the type of beneficiaries treated in swing beds. In other words, swing-bed hospitals could start to resemble SNFs more closely. In that case, the full MDS may be needed to address issues applicable to beneficiaries with longer lengths of stay and different care needs. We plan to monitor swing-bed activity to identify changes in practice patterns.

Comment: In addition to comments on swing-bed requirements, we also received a number of comments questioning the effectiveness of the MDS requirements that are currently in effect for swing beds in critical access hospitals (CAHs). Generally, the comments focused on the time/staff requirements and the effectiveness of completing an assessment instrument that is not collected or used for program monitoring.

Response: CAH swing beds are required to use the MDS for care planning and quality monitoring as part of the CAH conditions of participation. We agree that MDS requirements for swing beds in CAHs should be considered within the scope of our comprehensive reevaluation of post-acute data needs. Therefore, we have chosen not to address CAHs in this regulation.

Comment: In the proposed rule, we noted that swing-bed services are not subject to the SNF consolidated billing requirement at section 1862(a)(18) of the Act (since that provision applies to services that are furnished to residents of SNFs), but are instead subject to the hospital bundling requirement at section 1862(a)(14) of the Act (which applies to services furnished to inpatients of hospitals). Several commenters expressed concern about reconciling hospital bundling requirements and the services excluded from Part A consolidated billing under the SNF PPS. They observed that the hospital bundling requirement is slightly broader in scope than the SNF consolidated billing provision, in that the former provision does not exclude certain types of services that the latter provision specifically excludes (such as Part B dialysis, erythropoietin (EPO), certain services involving chemotherapy and its administration, certain customized prosthetics, and radioisotope services, as described in sections 1888(e)(2)(A)(ii) and (iii) of the Act). The commenters requested clarification on how such services are to be billed when furnished to SNF-level inpatients of those swing-bed hospitals that come under the SNF PPS.

Response: The swing-bed provision is unique in that it represents a hybrid benefit. Although the services that a swing-bed provider furnishes under its swing-bed agreement are SNF services, the provider itself is a hospital (and, as such, is subject to the requirements that pertain to hospitals, including hospital bundling). Accordingly, under the SNF PPS, we must consider both the SNF Part A consolidated billing requirements and the hospital bundling requirements. The costs of the high-cost ancillary services (such as MRIs and radioisotope services) that are excluded from the SNF consolidated billing requirement are not included in the SNF PPS per diem. Accordingly, a swing-bed hospital will be permitted to submit a separate bill to its FI for these excluded services, and will receive payment for these high-cost ancillary services over and above the SNF PPS per diem.

Based on our analysis of swing-bed claims data, we have estimated that the conversion to the SNF PPS will increase payments to swing-bed hospitals by over $18 million. These projections are based on claims filed in compliance with the hospital bundling requirements. As such, the claims include charges for ancillary services that will, under the SNF PPS, be separately payable. As a result, actual payment increases should exceed the estimates for swing-bed hospitals serving high-acuity beneficiaries who would be more likely to require these high-cost non-therapy ancillary services.

Comment: In response to our request for comments in the proposed rule on the applicability of the post-acute transfer policy enacted in section 4407 of the BBA to swing-bed hospitals, we received a mixed response. SNF providers advocated inclusion of swing-bed hospitals as a matter of equity. Comments from hospital providers questioned the value of applying this provision to transfers between acute care and swing-bed extended care services. One commenter pointed out that the policy would have limited impact, since beneficiaries in the DRG categories covered by the transfer policy are usually transferred to larger, tertiary care facilities rather than to a rural hospital swing-bed.

Response: As noted by several commenters, swing-bed providers were specifically excluded from this transfer provision of the BBA. However, we plan to monitor swing-bed utilization, and, if inappropriate transfer patterns develop, to recommend legislative action to extend the transfer policy to swing-beds.

Comment: We received a few comments on implementation issues, including the way SNF PPS billing and medical review policies will be applied to swing beds. These commenters urged that SNF and swing-bed bills be reviewed under the same protocols and by the same contractors. For example, a SNF that files more than 2 percent of claims for services in the lower 18 RUG–III categories may be subject to focused medical review. As one commenter pointed out, approximately 9 percent of the swing-bed claims used in our projections grouped in the lower 18 RUG–III groups. If this pattern continues under the SNF PPS, these swing-bed claims should be subject to the same scrutiny as SNF bills.

Response: We agree that all providers reimbursed under the SNF PPS must comply with program requirements. We are also in full agreement that operating policies and procedures should be applied consistently. Over the next few months, we will be finalizing our operating instructions, and will incorporate these comments into our program design efforts. We also welcome additional ideas and suggestions related to billing, medical review, or other program operation functions.

IV. Provisions of the Final Regulations

The provisions of this final rule are as follows:

- In § 410.150, we are revising paragraph (b)(14) to reflect that Part B makes payment to the SNF for its resident's services only in those situations where the SNF itself furnishes the services, either directly or under an arrangement with an outside source.
- In § 411.15, we are revising paragraph (p)(1) to indicate that, except for physical, occupational, and speech-language therapy (to which consolidated billing applies regardless of whether the resident who receives them is in a covered Part A stay), consolidated billing applies only to those services that a SNF resident receives during the course of a covered Part A stay. We are also making conforming revisions in §§ 489.20(s) and 489.21(h), in the context of the requirements of the SNF provider agreement. We are revising paragraph (p)(2) of § 411.15 to indicate that, for Part B services furnished to a SNF resident, the requirement to enter the SNF's Medicare provider number on the Part B claim (which previously applied only to claims for physician services) applies to all types of Part B claims. We are also making conforming revisions in the requirements regarding claims for payment, at §§ 424.32(a)(2) and (a)(5). We are revising the wording of the existing requirement in § 424.32(a)(5) for a SNF to include

appropriate HCPCS coding and its Medicare provider number on the Part B claims that it files for its residents' services, by adding that these requirements also apply to such claims when they are filed by an outside entity. In addition, we are revising § 411.15(p)(3) to exclude from the definition of a SNF resident, for consolidated billing purposes, those individuals who reside in the noncertified portion of an institution that also contains a participating distinct part SNF. We are also clarifying that, for services other than physical, occupational, and speech-language therapy, a beneficiary's resident status ends along with Part A coverage of his or her SNF stay (or, if earlier, when one of the events described in §§ 411.15(p)(3)(i)–(iv) occurs).

- In accordance with section 1888(e)(2)(E) of the Act, we are revising § 413.114 to reimburse swing-bed services of rural hospitals (other than CAHs, which will be paid on a reasonable cost basis) under the SNF PPS described in regulations at subpart J of that part. This conversion to the SNF PPS would be effective for services furnished during cost reporting periods beginning on or after July 1, 2002. We are also revising paragraph (d)(1) of this section to reflect modifications to the special requirements for swing-bed facilities with more than 49 but fewer than 100 beds (as enacted by section 408 of the BBRA), and are making a conforming revision in § 424.20(a)(2).
- In § 413.337, we are adding a new paragraph (e) to clarify that the temporary increases in payment for certain RUGs under section 101 of the BBRA (as modified by section 314 of the BIPA) will expire upon the issuance of a new regulation with the newly refined case-mix classification system.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 60-day notice in the **Federal Register** and solicit public comment when a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To evaluate fairly whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comments on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

§ 413.114(a)(2)—In the May 10, 2001 proposed rule (66 FR 23984), we estimated swing-bed hospital start-up costs and the ongoing costs associated with the use of the MDS for calculating the SNF PPS per diem payment. Those estimates were based on the use of the full MDS, a 6-page paper assessment tool containing more than 400 data items. After careful consideration of the comments received, we have eliminated the requirement for the full MDS and created a 2-page MDS for swing-bed hospitals that reduces the number of data items by approximately 75 percent. We have also carefully considered comments related to our initial time and cost estimates in updating this impact analysis.

As stated in the proposed rule, we used the best available 1999 claims data, and identified 1,250 swing-bed facilities and 97,576 swing-bed stays. The average number of admissions is 78 per swing-bed hospital. Using the same 1999 claims data, the average length of stay is 8.79 days. On average, a typical swing-bed facility would need to complete only one MDS per admission, since the PPS 5-day assessment governs payment for the first 14 days of the stay.

Data Entry: In our proposed rule, we based our projections upon our experience with SNF providers, and adjusted those estimates to reflect the smaller scale of swing bed operations. We received a number of comments expressing concerns that we may have underestimated staffing needs and completion times for the MDS and data entry functions. For example, we estimated that swing beds would generally need to train at least one staff person to handle the MDS data entry and transmission system. The commenters generally recommended training 2 individuals to ensure adequate back-up. We agree that additional training would be appropriate, and have adjusted our estimates.

State agencies currently train SNF staff on these functions, and the training is generally completed in one 4-hour session. Additional training materials and updates to program requirements are generally posted on the MDS web sites, and are available to staff at no cost. By distributing information electronically, and providing Help Desks for software and transmission problems, we minimize the need for staff travel, and reduce the ongoing costs associated with encoding and transmitting MDS data. We have used the original estimate of 4 hours of training time (as published in the proposed rule (66 FR 23984)), since the reduction in MDS requirements has no impact on data entry staff training time. We did not increase the estimates to reflect the cost of replacement staff, since short absences can usually be handled by adjusting work schedules. We did, however, add 2 hours per trainee to reflect travel time.

We also received a number of comments that the estimated data entry time was too low, particularly for staff unfamiliar with the MDS. The substitution of the 2-page Swing-Bed Hospitals MDS for the full MDS should simplify the data entry effort. We expect that the data entry time for the 2-page form will average less than the 15 minutes per assessment we had estimated for the full form. However, in view of the concerns raised in the comments and our unfamiliarity with this new form, we have not reduced our data entry projections. We are also maintaining our projections for approximately 2 hours per month to perform system-related functions, such as processing corrections, retrieving assessment information, printing copies, verifying the accuracy of the data entered into the system, and reviewing program updates and training materials.

These data entry estimates assume that facilities may choose among a variety of approaches to encode the MDS data in electronic format. In many SNFs, the nurses conducting the assessments input their responses directly into the computer, and the data entry time is incorporated into the MDS preparation time. In others, a data entry operator is used to input the MDS data and maintain the MDS processing system. In some facilities, data may be extracted and/or compiled and data-entered by a combination of clinical and technical staff under the overall supervision of an RN. We estimated the hourly rate for data entry at $15, which reflects the salary differentials between the two types of staff typically performing this function: RNs and data operators.

Electronic Transmission: Swing-bed staff will also need training on data transmission procedures. Again, State agencies have already developed training programs in this area, and this training will be available to swing-bed personnel. In response to the comments, we have increased our estimates to include sending two staff employees to a 4-hour training program. We estimated the training time at 4 hours per person plus 2 hours per person travel time.

These employees would be responsible for handling data transmission functions, and would be expected to train other facility staff on a time-available basis. Once the assigned employees have been trained, we estimate that the MDS transmission will take approximately one hour per month.

We projected the hourly rate of data transmission at $15, which reflects the salary differentials between the two types of staff typically performing this function: RNs and data operators. Again, training costs are not affected by the reduction in the MDS requirements, and the cost estimates are the same as those presented in the proposed rule.

MDS Coding: As stated in the proposed rule, we advise each swing-bed hospital to designate an RN to assume lead responsibility, and ensure that this RN is fully trained. Based on the comments, we have increased our training estimates from one to two RNs to reflect the need for backup on the MDS function. We have also adjusted our projections for training time. Our preliminary estimates were for two full days of formal training in MDS clinical coding and SNF PPS assessment scheduling. In view of the reduced MDS coding required using the 2-page Swing-Bed Hospital MDS, we have revised our formal training estimate to 12 hours, plus 4 hours travel time for each RN attending the training.

In addition, we have also reduced our estimates for MDS completion time to reflect the major reduction in the number of MDS items to be completed. In making this adjustment, we recognized that different MDS items may take different amounts of time to complete, and did not assume a direct relationship between the number of items and the total completion time, a methodology that would have resulted in an estimated completion time of approximately 15 minutes.

Instead, we have used an estimated completion time of 30 minutes per swing-bed MDS, or 67 percent of the time originally estimated to complete the full 6-page MDS. Again, as stated in the proposed rule, we believe that swing-bed hospital staff have some advantages when they complete the initial MDS, since they are more familiar with each beneficiary's condition and have full access to the hospital record. However, we have not reduced the time estimate to take these factors into account. Instead, we are using the higher number to reflect the expected learning curve over the first year as staff become more familiar with and proficient in completing the MDS.

As stated above, swing-bed providers averaged 78 stays per year with an average swing-bed length of stay of slightly under 9 days. Therefore, swing-bed providers would generally complete just one SNF PPS assessment for most patients, the 5-day assessment that governs payment for the first 14 days of a stay. To calculate the costs of preparing the MDS, we used 1998 Bureau of Labor Statistics nursing wage data, including fringe benefits, updated to FY 2002 levels using the SNF market basket factor. The average hourly rate of $24.70 is used in the calculations shown in Table 11. In reviewing the cost data in Table 11, we found that the aggregate MDS preparation cost had been transcribed incorrectly in the proposed rule, resulting in an understatement of approximately $1.6 million. This error has been corrected in Table 11, and the adjustments discussed in this section have been incorporated into Table 11 of this final rule, rounded to the nearest dollar.

As shown in Table 11, swing-bed start up costs are expected to average between $2,650 and $4,550 per facility. This estimate includes the cost of hardware and software costs as well as the total start up burden associated of 56 staff hours for staff training on the MDS function. Although the range seems fairly broad, the variations are based on choices that individual facilities will make in setting up their MDS processing and staff support functions. The biggest factor in the cost variation is the selection of MDS software. Facilities choosing to purchase proprietary software (estimated at an initial cost of $1,200) will incur higher start up costs. For each succeeding year, these facilities will incur additional costs for software maintenance and support services (data for second year costs are not shown).

The CMS software is being customized specifically for use with the 2-page Swing-Bed MDS, and will provide all of the basic services needed to store and transmit MDS data used for SNF PPS payment. A Help Desk will also be available to assist swing-bed hospital staff with data transmission problems and support in learning how to use the software efficiently. We have estimated a total burden of 72.5 hours per facility of staff time annually for ongoing administration the MDS function. As indicated in Table 11, we also included the costs for supplies and computer maintenance in our estimates, and projected average facility operating costs of $1,766 for swing-bed hospitals performing one assessment per beneficiary. Although almost all swing-bed facilities submitting comments indicated that their lengths of stay were under 10 days, there were a few swing-bed hospitals with longer lengths of stay. In considering the impact on these facilities, we do recognize a slight additional burden. We have estimated that a facility performing two MDS assessments on 30 percent of its Medicare beneficiaries would require approximately 18 additional hours per year (data not shown). However, the cost of performing these additional assessments would only increase a facility's MDS-related costs from $1.40 to $1.83 per day per patient.

We received a significant number of comments claiming that the operating cost estimates are understated because they do not reflect increased clinical staffing needs associated with MDS preparation and overall coordination of the MDS process within the facility. The impact on swing-bed facility staffing was one of the issues that we considered in our decision to reduce the MDS requirements to the two-page Swing-Bed MDS. We also considered the impact of a new payment system on staff operations, and the need to integrate the MDS process into day-to-day operations. We were concerned that the October 1, 2001 implementation set forth in the proposed rule would not give facility staff enough time to assess their existing operations and make the modifications needed to implement the MDS function smoothly. We believe that, by establishing the 2-page Swing-Bed MDS and by revising the implementation schedule to provide additional time for staff to adjust facility procedures and operating protocols, the MDS function can be integrated into swing-bed operations with existing staff.

TABLE 11.—SWING-BED RURAL HOSPITAL COST OF COMPLETING MDS

Category	Basic option—cost/facility	Small business option—cost/facility	Aggregate cost—basic option	Aggregate cost—small business option
Start Up Costs				
Hardware	$1,400	$2,100	$1,750,000	$2,625,000
Comm. Software	100	100	125,000	125,000
MDS Sftwre-CMS	0	0	0	0
MDS Sftwre—Purchased	1,200	1,200	1,500,000	1,500,000
Staff Training—MDS Coding	790	790	988,000	988,000
Staff Training—Other	360	360	450,000	450,000
Start-Up Subtotal				
With CMS Sftwre	$2,650	$3,350	$3,313,000	$4,188,000
With Purchased Software	$3,850	$4,550	$4,813,000	$5,688,000
Operating Cost				
MDS Preparation	963	963	1,204,125	1,204,125
MDS Entry	323	323	403,125	403,125
MDS Transmission	180	180	225,000	225,000
Supplies	200	200	250,000	250,000
Maintenance	100	100	125,000	125,000
Operating Cost	$1,766	$1,766	$2,207,250	$2,207,250
First Year Costs				
With CMS Sftwre	$4,416	$5,116	$5,520,250	$6,395,250
With Purchased Software	$5,616	$6,316	$7,020,250	$7,895,250

§ 424.32(a)(5)—In the proposed rule (66 FR 34984), we proposed to revise § 424.32(a)(5) to reflect the new statutory requirement that all Part B claims for services furnished to SNF residents must include the SNF's Medicare provider number. Because the burden associated with this additional requirement is incidental to the completion of a claim, we were unable to estimate the burden associated with this new requirement, and explicitly solicited comment on this point. As a result of this new requirement, we will be revising the OMB clearance package for the CMS–1500 (Common Claim Form), OMB number 0938–0008, which we will submit to OMB for review.

We have submitted a copy of this final rule to OMB for its review of the information collection requirements in §§ 413.411(a)(2) and 424.32(a)(5). These requirements are not effective until they have been approved by OMB.

VI. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order (EO) 12866, the Unfunded Mandate Reform Act (UMRA, Pub. L. 104–4), the Regulatory Flexibility Act (RFA, Pub. L. 96–354), and the Federalism Executive Order (EO) 13132.

Executive Order 12866 directs agencies to assess costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). This final rule is a major rule as defined in Title 5, United States Code, section 804(2), because we estimate its impact will be to increase the payments to SNFs by approximately $1.5 billion in FY 2002, or 10.3 percent. The update set forth in this final rule applies to payments in FY 2002. Accordingly, the analysis that follows describes the impact of this one year only. In accordance with the requirements of the Act, we will publish a notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis.

The UMRA also requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in an expenditure in any year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million or more. This rule will have no consequential effect on State, local, or tribal governments. We believe the private sector cost of this rule falls below these thresholds as well.

Executive Order 13132 (effective November 2, 1999) establishes certain requirements that an agency must meet when it promulgates regulations that impose substantial direct compliance costs on State and local governments, preempt State law, or otherwise have Federalism implications. As stated above, this rule will have no consequential effect on State and local governments.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most SNFs and most other providers and suppliers are small entities, either by virtue of their nonprofit status or by having revenues of $10 million or less annually. For purposes of the RFA, all States and tribal governments are not considered to be small entities, nor are intermediaries or carriers. Individuals and States are not included in the definition of a small entity.

The policies contained in this final rule would update the SNF PPS rates by increasing the payment rates published in the July 31, 2000 notice (65 FR 46770). While we do not believe that this will have a significant effect upon small entities overall, some individual

providers may experience significant increases in payments, while others (those that are concluding their final year under the transition from facility-specific to full Federal rates) may experience decreases, as discussed later in this section.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. Although we are delaying implementation for the 1,250 swing-bed facilities that would start receiving payment under the SNF PPS until July 1, 2002, we do find that the payments to these facilities will increase overall. Some swing-bed facilities may receive significant increases in Medicare related payments, as described later in this section. Accordingly, the following analysis includes a specific examination of the projected impact of these provisions on small rural hospitals.

A. Background

Section 1888(e) of the Act establishes the SNF PPS for the payment of Medicare SNF services for periods beginning on or after July 1, 1998. This section specifies that the base year cost data to be used for computing the RUG–III payment rates must be from cost reporting periods beginning in FY 1995 (that is, 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.

This final rule sets forth updates of the SNF PPS rates contained in the July 31, 2000 final rule (65 FR 46770). Table 12 presents the projected effects of the policy changes in the SNF PPS from FY 2001 to FY 2002, as well as statutory changes effective for FY 2001 and FY 2002. In so doing, we estimate the effects of each policy change 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 our policy 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 data and MDS 2.0 assessment data from 2000. 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, 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 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.

B. Impact of the Final Rule

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 2002. We believe that the revisions and clarifications mentioned elsewhere in the preamble (for example, the update to the wage index used for adjusting the Federal rates) 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.

The aggregate increase in payments associated with this final rule is estimated to be $1.5 billion, or 10.3 percent. The current estimate varies substantially from that computed for the proposed rule, which forecast an increase in payment of only $300 million, or 2.1 percent. In reviewing the estimate used for the proposed rule, an error was discovered in the component of the calculations associated with determining the impact of the expiration of the transition. This error caused the downward effect on payments associated with the transition's expiration to be magnified. This error has now been corrected and a more accurate estimate of this effect now appears in Table 12.

The effect of the 20 percent add-on from the BBRA (as subsequently revised by the BIPA) is $1.0 billion; however, since this add-on became effective in FY 2001, it has already been reflected in the impact analysis for last year's final rule (65 FR 46770) and, thus, does not represent a new, additional impact for the FY 2002 payment rates. There are three areas of change that produce this increase for facilities:

1. The effect of facilities being paid the full Federal rate.

2. The implementation of provisions in the BIPA, such as the 16.6 percent increase in the nursing component of the Federal rate and the elimination of the one percent reduction in the SNF market basket update for FY 2001.

3. The total change in payments from FY 2001 levels to FY 2002 levels. This includes all of the previously noted changes in addition to the effect of the annual update to the rates.

As seen in Table 12, some of these areas are expected to result in increased aggregate payments and others are expected to tend to lower them. The breakdown of the various categories of data in the table is as follows:

The first row of figures in the table describes the estimated effects of the various policies on all facilities. The next six rows show the effects on facilities split by hospital-based, freestanding, urban and rural categories. The remainder of the table shows the effects on urban versus rural status by census region.

The second column in the table shows the number of facilities in the impact database. The third column shows the effect of the expiration of the transition and movement to the full Federal rates for all SNFs. This change has an overall effect of lowering payments by an estimated 1.6 percent, affecting hospital-based facilities more than freestanding facilities. The main reason for such a large decrease is the BBRA provision that allowed facilities to choose the full Federal rate. When given the option to do so, an estimated 74 percent of the facilities elected to go to the full Federal rate. This meant that the only facilities left to transition to the full Federal rate are ones for which the expiration of the transition will cause a decrease in reimbursement. In contrast, those facilities receiving the full Federal rate will experience a 12.1 percent increase in payments. The overall effect of the expiration of the transition was to reduce reimbursement, but the effects across regions are quite variable.

The fourth column shows the projected effect of the 16.66 percent add-on to the nursing portion of the Federal rate mandated by BIPA 2000. As expected, this results in an increase in payments for all facilities; however, as seen in the table, the varying effect of the SNF PPS transition results in a distributional impact. In addition, since this increase only applies to the nursing

portion of the payment rate, the effect on total expenditures is less than 16.66 percent.

The fifth column of the table shows the effect of the change in the add-on for the rehabilitation RUGs. The total impact of this change is zero percent; however, there are distributional effects of this change, as seen in the table.

The sixth 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 seventh column of the table shows the effect of all of the changes on the FY 2002 payments. This includes all of the previous changes, including the update to this year's payment rates by the market basket. Rebasing of the market basket index from 1992 to 1997 had little impact on the overall changes displayed in this column. It is projected that payments will increase by 10.3 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 the changes vary widely by specific types of providers and by location. For example, freestanding facilities experience payment increases, while the effects of the transition cause decreases in payments for hospital-based providers.

TABLE 12.—PROJECTED IMPACT OF FY 2002 UPDATE TO THE SNF PPS

	Number of facilities	Transition to Federal rates	Add-on to nursing rates	Add-on to rehab RUGs	Wage index change	Total FY 2002 change
Total	9037	−1.6%	8.0%	0.0%	0.0%	10.3%
Urban	6300	−1.7%	8.1%	0.1%	0.1%	10.5%
Rural	2737	−1.1%	7.8%	−0.7%	−0.3%	9.6%
Hospital based urban	683	−4.1%	8.6%	−0.8%	−1.0%	6.2%
Freestanding urban	5617	−1.3%	8.0%	0.3%	0.2%	11.2%
Hospital based rural	533	−2.3%	8.5%	−2.0%	−1.7%	6.0%
Freestanding rural	2204	−0.9%	7.7%	−0.4%	0.0%	10.3%
Urban by Region						
New England	630	−0.3%	8.4%	0.0%	0.2%	12.4%
Middle Atlantic	877	−0.4%	8.4%	−1.4%	−2.2%	8.1%
South Atlantic	959	−2.5%	7.8%	0.9%	1.3%	11.5%
East North Central	1232	−0.8%	8.2%	0.6%	0.3%	12.4%
East South Central	212	−1.8%	8.0%	0.0%	1.3%	11.5%
West North Central	469	−1.5%	8.0%	−0.2%	−0.4%	9.8%
West South Central	519	−4.7%	8.4%	0.3%	−0.5%	7.0%
Mountain	303	−3.4%	7.6%	1.1%	1.2%	10.4%
Pacific	1070	−2.9%	7.9%	0.6%	0.6%	10.1%
Rural by Region						
New England	88	−0.3%	8.0%	−0.3%	0.3%	11.8%
Middle Atlantic	144	−0.3%	8.0%	−1.8%	−1.6%	8.0%
South Atlantic	373	−1.0%	7.8%	0.2%	0.4%	11.4%
East North Central	561	−0.5%	7.8%	−0.3%	0.0%	11.0%
East South Central	255	−1.5%	7.9%	−2.3%	−2.0%	5.6%
West North Central	581	−1.5%	7.9%	−1.5%	−0.4%	8.2%
West South Central	354	−2.5%	8.0%	−0.1%	1.0%	10.3%
Mountain	204	−1.0%	7.3%	−0.4%	−0.2%	9.6%
Pacific	151	−0.9%	7.4%	0.3%	−0.8%	9.9%

As noted earlier, in accordance with section 1888(e)(7) of the Act, we are providing in this final rule to pay rural hospitals for SNF-level swing-bed services under the SNF PPS, effective with cost reporting periods beginning on and after July 1, 2002. In doing so, we have examined the anticipated impact of this payment change on swing-bed facilities.

We analyzed data from swing-bed claims for calendar years 1996 through 1998 to determine Medicare payments made under the current swing-bed payment system. The claims data reflect the predetermined routine cost payments and the interim payment for ancillary services. While the interim payment rate for ancillary services is subject to final cost settlement, it represents a reasonable proxy for actual swing-bed payments.

We then adjusted the historical data on swing-bed payments to 2002 levels. For calendar years 1999 through 2001, we projected the average payment per day, using the 6.5 percent growth rate calculated from the most recent available data from calendar years 1997 and 1998. For 2002, we used a blended growth rate that reflects a projected increase in payment for routine services equal to the market basket of 2.4 percent, but retains the historical growth factor of 6.5 percent for ancillary payments. In 1998, the average payment per day was $205.41. The estimated swing-bed payment per day for 2002 under the existing method of reimbursement is $258.41.

We then estimated the amount that would have been paid for the same services under the SNF PPS. This estimate reflected both adjustments for geographic variation and case-mix. For the geographic adjustment, we used the average rural wage index for FY 2001 (that is, 0.8700). In preparing this final rule, we found a minor error in the calculation of the estimate published in the proposed rule that slightly overstated anticipated payments for swing-bed hospitals under the SNF PPS. We corrected the error and recalculated this impact analysis. The revised data are presented in this final rule.

As described in the proposed rule, we used the MEDPAR case-mix analog (described in detail in the SNF PPS interim final rule published on May 12, 1998 (63 FR 26252)) to estimate how the national swing-bed population would classify into RUG–III categories. We found that 69 percent of the covered days would be assigned to just two RUG–III categories (or six groups):

Medium Rehabilitation and Extensive Services.

We also noted that 9 percent of the covered days were assigned to categories that are not typically associated with a Medicare level of care (Impaired Cognition and lower groups). We have not assumed that these claims were paid in error. Rather, we are assuming that these patients had skilled care needs other than ones that could be captured using the MEDPAR case-mix analog, and we have included these stays in our analysis.

TABLE 13.—RUG–III FREQUENCY DISTRIBUTION USING CALENDAR YEAR 1999 CLAIMS

RUG–III category level	Number of days paid	Percent of total days
Ultra High Rehab	30,618	3%
Very High Rehab	33,687	4%
High Rehab	76,596	9%
Medium Rehab	264,614	30%
Low Rehab	58,016	7%
Extensive Services	288,131	33%
Special Care	11,540	1%
Clinically Complex	35,304	4%
Impaired Cognition	4,737	1%
Other	72,293	8%
Total	875,536	100%

Our next step was to project the SNF PPS payments for these swing-bed services. For the purposes of this analysis, we used the calendar year frequency distribution and number of covered swing-bed days shown in Table 13. Unique nursing case-mix weights have already been developed for each level of the MEDPAR case-mix analog. These weights were used to adjust the FY 2002 rural SNF PPS rates set forth in this final rule to determine the SNF PPS rates used in this estimate. We adjusted these rates for all the BBRA and the BIPA add-ons applicable for FY 2002.

Based on our analysis, the FY 2002 SNF PPS payment amount exceeds the projected payments under the current swing-bed payment system for that year in 5 of the 10 case-mix analog categories that included 79 percent of the swing-bed days. In fact, for the two most common RUG–III categories, medium rehabilitation and extensive services, the projected increases are substantial: 10 percent for medium rehabilitation and 12 percent for extensive services. In addition, in two categories, Impaired Cognition and Other, where the projected SNF PPS rate is lower than the projected swing-bed payment amount, the MDS records are likely to group into much higher categories when using the full RUG–III algorithm.

In terms of aggregate Medicare expenditures, we estimate that the transition to SNF PPS will increase payments for SNF-level swing-bed services by 8 percent, or approximately $18.3 million. Aggregate start-up costs are estimated to be between $3.3 and $5.7 million, and first year operating costs, including estimated costs associated with the MDS completion, are estimated to be $2.2 million.

Based on these estimates, we believe the financial impact on swing-bed providers will be positive, with the anticipated 8 percent payment increase serving to offset the estimated start-up costs associated with MDS completion and transmission. Although the aggregate percentage increase has been adjusted downward from 9 percent to 8 percent, the reduction in MDS requirements has been even more significant. Swing-bed hospitals had expressed strong concerns that the expected increases would be eroded by their MDS costs. With the reduction in the MDS requirements, the impact of the projected 8 percent increase may represent an addition of dollars available to support swing-bed operations.

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

VII. Federalism

We have reviewed this final rule under the threshold criteria of Executive Order 13132, Federalism, and we have determined that it does not significantly affect the rights, roles, and responsibilities of States.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 413

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

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR chapter IV is amended as follows:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for part 410 continues to read as follows:

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

* * * * *

Subpart I—Payment of SMI Benefits

2. In § 410.150, the introductory text of paragraph (b) is republished, and paragraph (b)(14) is revised to read as follows:

§ 410.150 To whom payment is made.

* * * * *

(b) *Specific rules.* Subject to the conditions set forth in paragraph (a) of this section, Medicare Part B pays as follows:

* * * * *

(14) To an SNF for services (other than those described in § 411.15(p)(2) of this chapter) that it furnishes to a resident (as defined in § 411.15(p)(3) of

this chapter) of the SNF who is not in a covered Part A stay.

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

3. 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

4. In § 411.15, paragraph (p)(1) is revised, and paragraph (p)(2) introductory text, paragraph (p)(2)(i), and paragraph (p)(3) introductory text are revised to read as follows:

§ 411.15 Particular services excluded from coverage.

* * * * *

(p) *Services furnished to SNF residents.* (1) *Basic rule.* Except as provided in paragraph (p)(2) of this section, any service furnished to a resident of an SNF during a covered Part A stay by an entity other than the SNF, unless the SNF has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to the SNF's residents. Services subject to exclusion under this paragraph include, but are not limited to—

(i) Any physical, occupational, or speech-language therapy services, regardless of whether the services are furnished by (or under the supervision of) a physician or other health care professional, and regardless of whether the resident who receives the services is in a covered Part A stay; and

(ii) Services furnished as an incident to the professional services of a physician or other health care professional specified in paragraph (p)(2) of this section.

(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:

(i) Physicians' services that meet the criteria of § 415.102(a) of this chapter for payment on a fee schedule basis.

(3) *SNF resident defined.* For purposes of this paragraph, a beneficiary who is admitted to a Medicare-participating SNF is considered to be a resident of the SNF for the duration of the beneficiary's covered Part A stay. In addition, for purposes of the services described in paragraph (p)(1)(i) of this section, a beneficiary who is admitted to a Medicare-participating SNF is considered to be a resident of the SNF regardless of whether the beneficiary is in a covered Part A stay. Whenever the beneficiary leaves the facility, the beneficiary's status as an SNF resident for purposes of this paragraph (along with the SNF's responsibility to furnish or make arrangements for the services described in paragraph (p)(1) of this section) ends when one of the following events occurs—

* * * * *

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

5. The authority citation for part 413 is amended to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, 1886, and 1888 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395(f)b, 1395g, 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, 1395ww, and 1395yy).

Subpart F—Specific Categories of Costs

6. In § 413.114:

a. Paragraph (a) is revised.

b. In paragraph (c), the heading is revised.

c. In paragraph (d)(1), the introductory text is revised.

§ 413.114 Payment for posthospital SNF care furnished by a swing-bed hospital.

(a) *Purpose and basis.* This section implements section 1883 of the Act, which provides for payment for posthospital SNF care furnished by rural hospitals and CAHs having a swing-bed approval.

(1) *Services furnished in cost reporting periods beginning prior to July 1, 2002.* Posthospital SNF care furnished in general routine inpatient beds in rural hospitals and CAHs is paid in accordance with the special rules in paragraph (c) of this section for determining the reasonable cost of this care. When furnished by rural and CAH swing-bed hospitals approved after March 31, 1988 with more than 49 beds (but fewer than 100), these services must also meet the additional payment requirements set forth in paragraph (d) of this section.

(2) *Services furnished in cost reporting periods beginning on and after July 1, 2002.* Posthospital SNF care furnished in general routine inpatient beds in rural hospitals (other than CAHs) is paid in accordance with the provisions of the prospective payment system for SNFs described in subpart J of this part, except that for purposes of this paragraph, the requirements of § 413.343(a) must be met using the specific assessment instrument and data designated by CMS for this purpose. Posthospital SNF care furnished in general routine inpatient beds in CAHs is paid based on reasonable cost, in accordance with the provisions of subparts A through G of this part (other than paragraphs (c) and (d) of this section).

* * * * *

(c) *Special rules for determining the reasonable cost of posthospital SNF care furnished in cost reporting periods beginning prior to July 1, 2002.*

* * * * *

(d) *Additional requirements*—(1) *General rule.* For services furnished in cost reporting periods beginning prior to July 1, 2002, in order for Medicare payment to be made to a swing-bed hospital with more than 49 beds (but fewer than 100), the following payment requirements must be met:

* * * * *

7. In § 413.337, paragraph (e) is added to read as follows:

§ 413.337 Methodology for calculating the prospective payment rates.

* * * * *

(e) Pursuant to section 101 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) as revised by section 314 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), using the best available data, the Secretary will issue a new regulation with a newly refined case-mix classification system to better account for medically complex patients. Upon issuance of the new regulation, the temporary increases in payment for certain high cost patients will no longer be applicable.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

8. The authority citation for part 424 continues to read as follows:

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

9. In § 424.20(a)(2), the heading is revised to read as follows:

§ 424.20 Requirements for posthospital SNF care.

(a) * * *

(2) *Special requirement for certifications performed prior to July 1, 2002: A swing-bed hospital with more than 49 beds (but fewer than 100) that*

does not transfer a swing-bed patient to a SNF within 5 days of the availability date.

* * *

* * * * *

Subpart C—Claims for Payment

10. In § 424.32, the introductory text of paragraph (a) is republished, and paragraphs (a)(2) and (a)(5) are revised.

§ 424.32 Basic requirements for all claims.

(a) A claim must meet the following requirements:

* * * * *

(2) A claim for physician services, clinical psychologist services, or clinical social worker services must include appropriate diagnostic coding for those services using ICD–9–CM.

* * * * *

(5) All Part B claims for services furnished to SNF residents (whether filed by the SNF or by another entity) must include the SNF's Medicare provider number and appropriate HCPCS coding.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

11. 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

12. In § 489.20, the introductory text is republished, and the introductory text of paragraph (s) is revised.

§ 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 any physical, occupational, or speech-language therapy services furnished to a resident of the SNF under § 411.15(p) of this chapter (regardless of whether the resident is in a covered Part A stay), and also either to furnish directly or make arrangements for all other Medicare-covered services furnished to a resident during a covered Part A stay, except the following:

* * * * *

13. In § 489.21, the introductory text is republished, and paragraph (h) is revised to read as follows:

§ 489.21 Specific limitations on charges.

Except as specified in subpart C of this part, the provider agrees not to charge a beneficiary for any of the following:

* * * * *

(h) Items and services (other than those described in §§ 489.20(s)(1) through (15)) required to be furnished under § 489.20(s) to a resident of an SNF (defined in § 411.15(p) of this chapter), for which Medicare payment would be made if furnished by the SNF or by other providers or suppliers under arrangements made with them by the SNF. For this purpose, a charge by another provider or supplier for such an item or service is treated as a charge by the SNF for the item or service, and is also prohibited.

Note: These appendices will not appear in the Code of Federal Regulations.

Appendix A

Technical Features of the 1997 Skilled Nursing Facility Market Basket Index

As discussed in the preamble of this final rule, we have revised and rebased the SNF market basket. This appendix describes the technical aspects of the 1997-based index made final in this rule. We present this description of the market basket in three steps:

- A synopsis of the structural differences between the 1992-and the 1997-based market baskets.
- A description of the methodology used to develop the cost category weights in the 1997-based market basket.
- A description of the data sources used to measure price change for each component of the 1997-based market basket, making note of the differences, if any, from the price proxies used in the 1992-based market basket.

I. Synopsis of Structural Changes Adopted in the Revised and Rebased 1997 Skilled Nursing Facility Market Basket

We have made just one major structural change between the current 1992-based and the 1997-based SNF market baskets, which is that more recent SNF cost data were used in the revised and rebased SNF market basket.

The 1997-based market basket contains cost shares for six major cost categories that were derived from an edited set of FY 1997 Medicare Cost Reports for freestanding SNFs that had Medicare expenses. FY 1997 cost reports have cost reporting periods beginning after September 30, 1996 and before October 1, 1997. The 1992-based market basket used data from the PPS–9 Medicare Cost Reports for freestanding SNFs with Medicare expenses greater than 1 percent of total expenses. PPS–9 cost reports have cost reporting periods beginning after September 30, 1991 and before October 1, 1992. Cost allocations for the 1997-based SNF market basket within the six major cost categories use Medicare Cost Reports and two Department of Commerce data sources: the 1997 Business Expenditures Survey, Bureau of the Census, Economics and Statistics Administration, and the 1997 Bureau of Economic Analysis' Annual Input-Output tables.

II. Methodology for Developing the Cost Category Weights

Cost category weights for the 1997-based market basket were developed in two stages. First, base weights for six main categories (wages and salaries, employee benefits, contract labor, pharmaceuticals, capital-related expenses, and a residual ''all other'') were derived from the SNF Medicare Cost Reports described above. The residual ''all other'' cost category was divided into subcategories, using U.S. Department of Commerce data sources for the nursing home industry. Relationships from the 1997 Business Expenditures Survey and data from the 1997 Annual Input-Output tables were used to allocate the all other cost category.

Below we describe the source of the main category weights and their subcategories in the 1997-based market basket.

- *Wages and Salaries:* The wages and salaries cost category is derived using 1997 SNF Medicare Cost Reports. The share was determined using wages and salaries from Worksheet S–3, part II and total expenses from Worksheet B. This share represents the wage and salary share of costs for employees of the nursing home, and does not include the wages and salaries from contract labor, which is allocated to wages and salaries at a later step.

We improved the methodology for calculating the weight of contract labor, as well as that for the calculation of the fringe benefits share. Both changes result in more accurate but, in each case, lower weights in the revised market basket. The weight for wages only, as determined from the Medicare Cost Reports and excluding contract labor, increased between 1992 and 1997 (from 45.805 to 46.889). This is consistent with the rate of change of the price of wages and salaries, as represented by the ECI for wages and salaries in nursing homes, which increased at a pace faster than that of the overall market basket during the 1992–1997 period. However, when the 1997 wage share of contract labor was added to the 1997 weight for wages, the resultant weight for wages was lower than in the 1992-based index.

- *Employee Benefits:* The weight for employee benefits was determined using 1997 Medicare Cost Reports. The share was derived using wage-related costs from Worksheet S–3, part II.
- *Contract Labor:* The weight for the contract labor cost category was derived using 1997 Medicare Cost Reports. For the 1997-based SNF market basket, we used a group of cost reports edited for data entered for contract labor on Worksheet S–3, part II. This methodology differed from that of the 1992 SNF market basket (where we estimated contract labor costs using data from Worksheet A) since Worksheet S–3, part II, was not available in the 1992 Cost Reports. This methodology produces results that are similar to the contract labor share in the 1997 Business Expenditures Survey. Contract labor was not available in the 1992 Asset and Expenditure Survey. As explained in the preamble, contract labor costs were distributed between the wages and salaries and employee benefits cost categories, under the assumption that contract costs should

move at the same rate as direct labor costs even though unit labor cost levels may be different.

• *Pharmaceuticals:* The pharmaceuticals cost weight was derived from 1997 SNF Medicare Cost Reports. This share was calculated using non-salary costs from the pharmacy and drugs charged to patients' cost centers from Worksheet A.

• *Capital-Related:* The weight for the overall capital-related expenses cost category was derived using 1997 SNF Medicare Cost Report data from Worksheet B. The subcategory and vintage weights within the overall capital-related expenses were derived using additional data sources.

In determining the subcategory weights for capital, we used a combination of information from the 1997 SNF Medicare Cost Reports and the 1997 Census Business Expenditures Survey.

We estimated the depreciation expense share of capital-related expenses from the SNF Medicare Cost Reports using data from edited cost reports with data completed on Worksheet G. For the 1992-based SNF market basket, we had depreciation expenses from the 1992 Asset and Expenditure Survey. When we calculated the ratio of depreciation to wages from the 1997 SNF Medicare Cost Reports, the result was consistent with the ratio from the 1997 Business Expenditures Survey. The distribution between building and fixed equipment and movable equipment was determined from the 1997 Business Expenditures Survey. From these calculations, depreciation expenses (not including depreciation expenses implicit from leases) were estimated to be 33.2 percent of total capital-related expenditures in 1997.

The interest expense share of capital-related expenses was also derived from the same edited 1997 SNF Medicare Cost Reports. Interest expenses are not identifiable in the 1997 Business Expenditures Survey. We determined the split of interest expense between for-profit and not-for-profit facilities based on the distribution of long-term debt outstanding by type of SNF (for-profit or not-for-profit) from the 1997 SNF Medicare Cost Reports. Interest expense (not including interest expenses implicit from leases) was estimated to be 24.3 percent of total capital-related expenditures in 1997.

We used the 1997 Business Expenditures Survey to estimate the proportion of capital-related expenses attributable to leasing building and fixed and movable equipment. This share was estimated to be 34.9 percent of capital-related expenses in 1997. The split between fixed and movable lease expenses was directly available from the 1997 Business Expenditures Survey. We used this split, and the distribution of depreciation and interest calculated above to distribute leases among these cost categories.

The remaining residual after depreciation, interest, and leasing, is considered to be other capital-related expenses (insurance, taxes, other). Other capital-related expenses were estimated to be 7.7 percent of total capital-related expenditures in 1997.

Table A–1 shows the capital-related expense distribution (including expenses from leases) in the 1997 SNF PPS market basket and the 1992 SNF market basket.

TABLE A–1.—CAPITAL-RELATED EXPENSE DISTRIBUTION

	1992-based SNF capital-related expenses as a percent of total capital—related expenses	1997-based SNF capital-related expenses as a percent of total capital—related expenses
Total	100.0	100.0
Depreciation	60.5	53.3
Building and Fixed Equipment	42.1	36.5
Movable Equipment	18.4	16.8
Interest	32.6	39.0
Other capital-related expense	6.9	7.7

As explained in section I.F of the preamble, our methodology for determining the price change of capital-related expenses accounts for the vintage nature of capital, which is the acquisition and use of capital over time. In order to capture this vintage nature, the price proxies must be vintage-weighted. The determination of these vintage weights occurs in two steps. First, we must determine the expected useful life of capital and debt instruments in SNFs. Second, we must identify the proportion of expenditures within a cost category that are attributable to each individual year over the useful life of the relevant capital assets, or the vintage weights.

The derivation of useful life of capital is explained in detail in the May 12, 1998 interim final rule (63 FR 26252). The useful lives for the 1997-based SNF market basket are the same as the 1992-based SNF market basket. The data source that was previously used to develop the useful lives of capital is no longer available and a suitable replacement has not been identified. We asked for comments on any data sources that would provide the necessary information for determining useful lives of capital and debt instruments, but did not receive any suitable alternatives.

Given the expected useful life of capital and debt instruments, we must determine the proportion of capital expenditures attributable to each year of the expected useful life by cost category. These proportions represent the vintage weights. We were not able to find an historical time series of capital expenditures by SNFs. Therefore, we approximated the capital expenditure patterns of SNFs over time using alternative SNF data sources. For building and fixed equipment, we used the stock of beds in nursing homes from the CMS National Health Accounts for 1962 through 1997. We then used the change in the stock of beds each year to approximate building and fixed equipment purchases for that year. This procedure assumes that bed growth reflects the growth in capital-related costs in SNFs for building and fixed equipment. We believe this assumption is reasonable since the number of beds reflects the size of the SNF, and as the SNF adds beds, it also adds fixed capital.

Comment: Several commenters expressed concern over the use of the net changes in the number of SNF beds as an approximation of capital acquisitions over time. Commenters felt that the market basket was only reflecting changes in the number of beds and not increases in other components that are inflation sensitive.

Response: As pointed out in the proposed rule, we use the net change in the stock of beds each year to reflect the growth in real purchases of buildings and fixed capital equipment each year. This is done for use in determining the proportion of capital expenditures attributable to each year of the expected useful life of an asset or 'vintage weight'. This measure is not used to measure the inflationary increases in costs from year to year facing SNFs nor is it used to determine the actual weight of depreciation in the index. Again, the net change in the number of beds is used to establish 'vintage weights and, as such, should reflect real capital purchases as opposed to nominal purchases. Therefore, we feel that the use of the change in the number of SNF beds, while not an exact measure of purchases since it would include beds taken out of service, approximates SNF capital purchases because if the SNF is adding beds, it is most likely also adding fixed capital. We were unable to find another suitable time series of capital purchases that met our proxy selection criteria, and therefore will continue to use the stock of beds to approximate capital purchases.

For movable equipment, we used available SNF data to capture the changes in intensity of SNF services that would cause SNFs to purchase movable equipment. We estimated the change in intensity as the trend in the ratio of non-therapy ancillary costs to routine costs from the 1989 through 1997 SNF Medicare Cost Reports. For 1962 through 1988 we estimated these values using regression analysis. The time series of the ratio of non-therapy ancillary costs to routine costs for SNFs measures changes in intensity in SNF services, which are assumed to be associated with movable equipment purchase patterns. The assumption here is that as non-therapy ancillary costs increase compared with routine costs, the SNF caseload becomes more complex and would require more movable equipment. Again, the lack of direct movable equipment purchase data for SNFs over time required us to use alternative SNF data sources. The resulting two time series, determined from beds and the ratio of non-therapy ancillary to routine costs, reflect real capital purchases of building and fixed equipment and movable equipment over time, respectively.

To obtain nominal purchases, which are used to determine the vintage weights for interest, we converted the two real capital purchase series from 1963 through 1997 determined above to nominal capital purchase series using their respective price proxies (Boeckh institutional construction index and PPI for machinery and equipment). We then combined the two nominal series into one nominal capital purchase series for 1963 through 1997. Nominal capital purchases are needed for interest vintage weights to capture the value of the debt instrument.

Once these capital purchase time series were created for 1963 through 1997, we averaged different periods to obtain an average capital purchase pattern over time. For building and fixed equipment we averaged thirteen 23-year periods, for movable equipment we averaged twenty-six 10-year periods, and for interest we averaged fourteen 22-year periods. The vintage weight for a given year is calculated by dividing the capital purchase amount in any given year by the total amount of purchases during the expected useful life of the equipment or debt instrument. This methodology was described in full in the May 12, 1998 **Federal Register** (63 FR 26252). The resulting vintage weights for each of these cost categories are shown in Table A–2.

TABLE A–2.—VINTAGE WEIGHTS FOR 1997-BASED SNF PPS CAPITAL-RELATED PRICE PROXIES

Year	Building and fixed equipment	Movable equipment	Interest
1	0.082	0.083	0.025
2	0.086	0.088	0.028
3	0.085	0.089	0.031
4	0.083	0.090	0.034
5	0.077	0.091	0.038
6	0.069	0.097	0.042
7	0.063	0.106	0.046
8	0.060	0.111	0.049
9	0.050	0.116	0.051
10	0.040	0.128	0.051
11	0.040	.....	0.052
12	0.036	.....	0.053
13	0.030	.....	0.051
14	0.020	.....	0.050
15	0.016	.....	0.049
16	0.014	.....	0.048
17	0.012	.....	0.049
18	0.017	.....	0.050
19	0.018	.....	0.051
20	0.023	.....	0.051
21	0.025	.....	0.049
22	0.027	.....	0.051
23	0.029	.....	.....
Total	1.000	1.000	1.000

Sources: 1997 SNF Medicare Cost Reports; CMS, National Health Accounts.
Note: Totals may not sum to 1.000 due to rounding.

• *All Other:* Subcategory weights for the All Other category were derived using information from two U.S. Department of Commerce data sources. Weights for the three utilities cost categories, as well as that for telephone services, were derived from the 1997 Business Expenditure Survey. Weights for other cost categories were derived from the 1997 Annual Input-Output tables.

III. Price Proxies Used To Measure Cost Category Growth

A. Wages and Salaries

For measuring price growth in the wages and salaries cost component of the 1997-based SNF market basket, we use the percentage change in the ECI for wages and salaries for private nursing homes.

Comment: Commenters questioned the ability of the ECI for nursing home wages and salaries to capture trends in wages in SNFs. The commenters were specifically concerned that the ECI was not capturing the wage increases shown by other data sources, that the difference in skill mix between SNFs and nursing homes was not being reflected, and that the fixed weights in the ECI was not representative of the current SNF skill mix.

Response: We believe that the ECI for wages and salaries in nursing homes is the best price proxy for measuring wage changes facing SNFs. This wage series reflects actual wage data reported by nursing homes to BLS. This proxy meets our criteria of relevance, reliability, timeliness, and time-series length. The commenters expressed concern that the ECI for nursing homes was not capturing the wage increases shown by other data sources, including other BLS surveys. Two BLS surveys, other than the ECI, that measure wages for nursing homes, the Average Hourly Earnings (AHE) and the Employer Cost for Employee Compensation (ECEC), reflect both changes in hourly wage and changes in skill mix. As we stated in the proposed rule, change in occupational mix does not represent a price change and, as such, should not be included in an input price index. Otherwise, changes in prices are confounded with shifts among occupations. In addition, the AHE includes only earnings for nonsupervisory workers, and the ECEC is only published annually for March of each year. Thus neither of these wage measures meet our criteria for use in the SNF market basket. Although referenced in the comments we received, we have not been provided other data sources measuring wages for SNF

employees and, as such, cannot make a determination of the relevance, reliability, timeliness, or time-series length of the data.

For our purposes, the ECI appropriately keeps the occupational mix constant. Currently, the ECI reflects the 1990 distribution of occupations as measured by the BLS Occupational Employment Survey. The BLS periodically updates this distribution to reflect a more recent occupational mix. When the BLS updates the occupational distribution it will be reflected in the ECI for wages and salaries in nursing homes and, therefore, will be reflected in the SNF market basket. However, it is appropriate that the SNF market basket currently reflect the wage increases associated with a fixed occupational mix rather than confound changes in wages with changes in skill mix.

The commenters were concerned that the ECI reflected wages in nursing homes and not just for SNFs, which they feel have a different skill mix. The ECI for nursing homes captures wages for SNFs and other types of nursing and personal care facilities as defined by the Standard Industrial Classification (SIC). Employment in skilled nursing care facilities, as measured by the Current Employment Survey, includes skilled nursing homes, convalescent homes, extended care facilities, and mental retardation hospitals. Skilled nursing care facilities, as defined by SIC, represent a significant portion (at least 70 percent) of total nursing home employment. The BLS does not publish data, nor are we aware of any available data that meet our criteria, at a more detailed level than total nursing homes. As such, we feel that while the ECI for nursing homes does include more than SNFs, the wage trends and skill mix in SNFs are adequately represented by this proxy.

B. Employee Benefits

For measuring employee benefits price growth in the 1997-based market basket, the percentage change in the ECI for benefits for private nursing homes is used. The ECI for benefits for private nursing homes is also a fixed-weight index that measures pure price change and is not affected by shifts in occupation. Again, we believe that the ECI for nursing homes is the most acceptable and appropriate benefit series available from reliable, timely, and relevant statistical sources.

C. All Other Expenses

• *Nonmedical professional fees:* The ECI for compensation for Private Industry Professional, Technical, and Specialty Workers is used to measure price changes in nonmedical professional fees.

• *Electricity:* For measuring price change in the electricity cost category, the PPI for Commercial Electric Power is used.

• *Fuels, nonhighway:* For measuring price change in the Fuels, Nonhighway cost category, the PPI for Commercial Natural Gas is used.

• *Water and Sewerage:* For measuring price change in the Water and Sewerage cost category, the CPI–U (Consumer Price Index for All Urban Consumers) for Water and Sewerage is used.

• *Food-wholesale purchases:* For measuring price change in the Food-wholesale purchases cost category, the PPI for Processed Foods is used.

• *Food-retail purchases:* For measuring price change in the Food-retail purchases cost category, the CPI–U for Food Away From Home is used. This reflects the use of contract food service by some SNFs.

• *Pharmaceuticals:* For measuring price change in the Pharmaceuticals cost category, the PPI for Prescription Drugs is used.

Comment: Some commenters were concerned that the price proxy used for pharmaceuticals is inappropriate, since the PPI for prescription drugs may have a different distribution of drugs included than SNFs use.

Response: The PPI commodity grouping for ethical preparations (prescription drugs) is a combined index. The weights for each product included in this PPI are based on the gross value of shipments (domestic products only) across all industries engaged in the production of ethical preparations. The weights include all prescription drugs that are made in the U.S. and do not include proprietary or biological preparations. The weighting of all ethical preparations according to the value of shipments means that pharmaceuticals used by SNFs are included. While there may not be quite the same proportions of pharmaceuticals used in SNFs as in the PPI, there is no evidence provided by the commenters or that we have found suggesting a different price change than reported by the PPI. There does not exist an alternative proxy for SNF pharmaceuticals that meets our criteria for inclusion in the index. Based on this, we feel the PPI for prescription drugs does provide an accurate representation of the pure price change of pharmaceuticals faced by SNFs, and thus is an appropriate price proxy.

• *Chemicals:* For measuring price change in the Chemicals cost category, the PPI for Industrial Chemicals is used.

• *Rubber and Plastics:* For measuring price change in the Rubber and Plastics cost category, the PPI for Rubber and Plastic Products is used.

• *Paper Products:* For measuring price change in the Paper Products cost category, the PPI for Converted Paper and Paperboard is used.

• *Miscellaneous Products:* For measuring price change in the Miscellaneous Products cost category, the PPI for Finished Goods less Food and Energy is used. This represents a change from the 1992 SNF market basket, in which the PPI for Finished Goods is used. Both food and energy are already adequately represented in separate cost categories and should not also be reflected in this cost category.

• *Telephone Services:* The percentage change in the price of Telephone Services as measured by the CPI–U is applied to this component.

• *Labor-Intensive Services:* For measuring price change in the Labor-Intensive Services cost category, the ECI for Compensation for Private Service Occupations is used.

• *Non Labor-Intensive Services:* For measuring price change in the Non Labor-Intensive Services cost category, the CPI–U for All Items is used.

D. Capital-Related Expenses

All capital-related expense categories have the same price proxies as those used in the 1992-based SNF PPS market basket described in the May 12, 1998 **Federal Register** (63 FR 26252). The price proxies for the SNF capital-related expenses are described below:

• *Depreciation—Building and Fixed Equipment:* The Boeckh Institutional Construction Index for unit prices of fixed assets.

• *Depreciation—Movable Equipment:* The PPI for Machinery and Equipment.

• *Interest—Government and Nonprofit SNFs:* The Average Yield for Municipal Bonds from the Bond Buyer Index of 20 bonds. CMS input price indexes, including this rebased SNF index, appropriately reflect the rate of change in the price proxy and not the level of the price proxy. While SNFs may face different interest rate levels than those included in the Bond Buyer Index, the rate of change between the two is not significantly different.]

• *Interest—For-profit SNFs:* The Average Yield for Moody's AAA Corporate Bonds. Again, the final rebased SNF index focuses on the rate of change in this interest rate and not the level of the interest rate.

Comment: One commenter indicated that the AAA corporate bond proxy is not appropriate for SNFs.

Response: We feel that the yield on Moody's AAA corporate bond rating is an appropriate proxy to use to measure the interest costs faced by SNFs. While the interest rate levels may not be equal for differently rated bonds, over the long term on which vintage weighting is based, the growth rates of the bond yields move similarly.

• *Other Capital-related Expenses:* The CPI–U for Residential Rent.

TABLE A–3.—A COMPARISON OF PRICE PROXIES USED IN THE 1992-BASED AND 1997-BASED SKILLED NURSING FACILITY MARKET BASKETS

Cost category	1992-based price proxy	1997-based price proxy
Wages and Salaries	ECI for Wages and Salaries for Private Nursing Homes.	Same
Employee Benefits	ECI for Benefits for Private Nursing Homes	Same

TABLE A–3.—A COMPARISON OF PRICE PROXIES USED IN THE 1992-BASED AND 1997-BASED SKILLED NURSING FACILITY MARKET BASKETS—Continued

Cost category	1992-based price proxy	1997-based price proxy
Nonmedical professional fees	ECI for Compensation for Private Professional and Technical Workers.	Same
Electricity	PPI for Commercial Electric Power	Same
Fuels	PPI for Commercial Natural Gas	Same
Water and sewerage	CPI-U for Water and Sewerage	Same
Food—Wholesale purchases	PPI—Processed Foods	Same
Food—Retail purchases	CPI-U—Food Away From Home	Same
Pharmaceuticals	PPI for Prescription Drugs	Same
Chemicals	PPI for Industrial Chemicals	Same
Rubber and plastics	PPI for Rubber and Plastic Products	Same
Paper products	PPI for Converted Paper and Paperboard	Same
Miscellaneous products	PPI for Finished Goods	PPI for Finished Goods less Food And Energy
Telephone services	CPI-U for Telephone Services	Same
Labor-intensive services	ECI for Compensation for private service occupations.	Same
Non labor-intensive services	CPI-U for All Items	Same
Depreciation: Building and Fixed Equipment	Boeckh Institutional Construction Index	Same
Depreciation: Movable Equipment	PPI for Machinery and Equipment	Same
Interest: Government and Nonprofit SNFs	Average Yield Municipal Bonds (Bond Buyer Index—20 bonds).	Same
Interest: For-profit SNFs	Average Yield Moody's AAA Bonds	Same
Other Capital-related Expenses	CPI-U for Residential Rent	Same

APPENDIX B.—SWING-BED DATA ELEMENTS

MDS item description	MDS2.0 item
First Name, Middle Initial, Last Name	AA1a, 1b, 1c
Gender	AA2
Birth Date	AA3
Marital Status	A5
Ethnicity/Race	AA4
Zip Code	AB4
Resident SSN	AA5a
Resident Medicare Number	AA5b
Resident Medicaid Number	AA7
Secondary Payer Source	A7
Facility Medicare Provider Number	AA6b
Facility Medicaid Provider Number	AA6a
Admitted From at Entry to Swing-Bed Extended Care Services	Similar to AB2
Prior Acute Care Admission Date	New Item
Admission Date	AB1
Readmission Date	A4
Assessment Reference Date	A3
Reason for Assessment	Similar to AA8
Discharge Status	R3
Discharge Date	R4
Comatose	B1
Short Term Memory	B2a
Cognitive skills/Daily Decision-Making	B4
Making Self Understood	C4
Negative Statements	E1a
Repetitive Statements	E1b
Repetitive Verbalizations	E1c
Persistent Anger with Others	E1d
Self Deprecation	E1e
Expression of Unrealistic Fears	E1f
Recurrent Statements of Fears for the Future	E1g
Repetitive Health Complaints	E1h
Repetitive Anxious Complaints/Concerns	E1i
Unpleasant mood in morning	E1j
Insomniac/Change in Sleeping Patterns	E1k
Sad/Pained/Worried Facial Expression	E1l
Crying/tearfulness	E1m
Repetitive physical movements	E1n
Withdrawal from activities of interest	E1o
Reduced Social Interaction	E1p
Behavior symptom—Wandering frequency	E4aa
Behavior symptom—Verbally Abusive frequency	E4ba

APPENDIX B.—SWING-BED DATA ELEMENTS—Continued

MDS item description	MDS2.0 item
Behavior symptom—Physically Abusive frequency	E4ca
Behavior symptom—Socially Inappropriate/disruption frequency	E4da
Behavior symptom—Resists care frequency	E4ea
ADL-Self Performance—Bed Mobility	G1aa
ADL Support—Bed Mobility	G1ab
ADL—Self Performance—Transfer	G1ba
ADL Support—Transfer	G1bb
ADL—Self Performance—Eating	G1ha
ADL—Support—Eating	G1hb
ADL Self-Performance—Toileting	G1ia
ADL Support—Toileting	G1ib
Any scheduled toileting plan	H3a
Bladder retraining plan	H3b
Diabetes mellitus	I1a
Aphasia	I1r
Cerebral Palsy	I1s
Hemiplegia/hemiparesis	I1v
Multiple Sclerosis	I1w
Quadriplegia	I1z
Pneumonia	I2e
Septicemia	I2g
Dehydrated—output exceeds input	J1c
Delusions	J1e
Fever	J1h
Hallucinations	J1i
Internal bleeding	J1j
Vomiting	J1o
Weight loss	K3a
Parenteral IV	K5a
Feeding Tube	K5b
Total calories by IV	K6a
Average fluid intake by IV	K6b
Ulcers—Stage 1	M1a
Ulcers—Stage 2	M1b
Ulcers—Stage 3	M1c
Ulcers—Stage 4	M1d
Pressure Ulcer	M2a
Burns	M4b
Open lesions	M4c
Surgical Wounds	M4g
Pressure relieving device for chair	M5a
Pressure relieving device for bed	M5b
Turning/Repositioning program	M5c
Nutrition/hydration program	M5d
Ulcer Care	M5e
Surgical wound care	M5f
Application of dressings	M5g
Application of ointments/medications	M5h
Infection of foot	M6b
Open lesions on foot	M6c
Application of dressings	M6f
Time Awake—Morning	N1a
Time Awake Afternoon	N1b
Time Awake—Evening	N1c
Time Awake—None of the Above	N1d
Injections	O3
Chemotherapy	P1aa
Dialysis	P1ab
IV Meds	P1ac
Oxygen Therapy	P1ag
Radiation	P1ah
Suctioning	P1ai
Trach Care	P1aj
Transfusions	P1ak
Ventilator/respirator	P1al
Therapy Days—Speech	P1baa
Therapy Minutes—Speech	P1bab
Therapy Days OT	P1bba
Therapy Minutes—OT	P1bbb
Therapy Days—PT	P1bca
Therapy Minutes—PT	P1bcb
Therapy Days Respiratory	P1bda

APPENDIX B.—SWING-BED DATA ELEMENTS—Continued

MDS item description	MDS2.0 item
Therapy Minutes—Respiratory	P1bdb
Range of Motion—Passive	P3a
Range of Motion—Active	P3b
Splint or brace assistance	P3c
Bed Mobility	P3d
Transfer	P3e
Walking	P3f
Dressing or grooming	P3g
Eating or swallowing	P3h
Amputation/prosthesis care	P3i
Communication	P3j
Physician Visits	P7
Physician Orders	P8
Ordered Therapies	T1b
Estimated Therapy days	T1c
Estimated Therapy Minutes	T1d
Medicare Case-Mix Group	T3a
Medicaid Case-Mix Group, if Applicable	T3b
HIPPS Assessment Indicator	New Item (software generated)
RN Signature	R2a
Date of RN Signature	R2b

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

Dated: July 23, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 24, 2001.

Tommy G. Thompson,

Secretary.

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