DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

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) 2009. It also discusses our ongoing analysis of nursing home staff time measurement data collected in the Staff Time and Resource Intensity Verification (STRIVE) project. Finally, this final rule makes technical corrections in the regulations text with respect to Medicare bad debt payments to SNFs and the reference to the definition of urban and rural as applied to SNFs.

DATES: *Effective Date:* This final rule becomes effective on October 1, 2008.

FOR FURTHER INFORMATION CONTACT:

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

Table of Contents

Abbreviations

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:

AIDS Acquired Immune Deficiency Syndrome
ARD Assessment Reference Date
BBA Balanced Budget Act of 1997, Public Law 105–33
BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public Law 106–113
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106–554
CAH Critical Access Hospital
CARE Continuity Assessment Record and Evaluation
CBSA Core-Based Statistical Area
CFR Code of Federal Regulations
CMI Case-Mix Index
CMS Centers for Medicare & Medicaid Services
DRA Deficit Reduction Act of 2005, Public Law 109–171
FQHC Federally Qualified Health Center
FR **Federal Register**
FY Fiscal Year
GAO Government Accountability Office
HAC Hospital-Acquired Condition
HCPCS Healthcare Common Procedure Coding System
HIPPS Health Insurance Prospective Payment System
HIT Health Information Technology
IFC Interim Final Rule with Comment Period
IPPS Hospital Inpatient Prospective Payment System
MDS Minimum Data Set
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173
MSA Metropolitan Statistical Area
MS-DRG Medicare Severity Diagnosis-Related Group
NRST Non-Resident Specific Time
NTA Non-Therapy Ancillary
OBRA Omnibus Budget Reconciliation Act of 1987, Public Law 100–203
OIG Office of the Inspector General
OMB Office of Management and Budget
OMRA Other Medicare Required Assessment
PAC–PRD Post-Acute Care Payment Reform Demonstration
POA Present on Admission
PPS Prospective Payment System
RAI Resident Assessment Instrument
RAP Resident Assessment Protocol
RAVEN Resident Assessment Validation Entry
RFA Regulatory Flexibility Act, Public Law 96–354
RHC Rural Health Clinic
RIA Regulatory Impact Analysis
RUG–III Resource Utilization Groups, Version III
RUG–53 Refined 53–Group RUG–III Case-Mix Classification System
RST Resident Specific Time
SCHIP State Children's Health Insurance Program
SNF Skilled Nursing Facility
STM Staff Time Measurement
STRIVE Staff Time and Resource Intensity Verification
TEP Technical Expert Panel
UMRA Unfunded Mandates Reform Act, Public Law 104–4
VBP Value-Based Purchasing

I. Background

On May 7, 2008, we published a proposed rule (73 FR 25918) in the **Federal Register** (hereafter referred to as the FY 2009 proposed rule), setting forth updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2009. Annual updates to the prospective payment system rates for skilled nursing facilities are required by section 1888(e) of the Social Security Act (the Act), as added by section 4432 of the Balanced Budget Act of 1997 (BBA), and amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Our most recent annual update occurred in the August 3, 2007 final rule (72 FR 43412) that set forth updates to the SNF PPS payment rates for FY 2008. We subsequently published two correction notices (72 FR 55085, September 28, 2007, and 72 FR 67652, November 30, 2007) with respect to those payment rate updates.

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

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

• *Rates.* As discussed in section I.F.1. of this final rule, we established per diem Federal rates for urban and rural areas using allowable costs from FY 1995 cost reports. These rates also included an estimate of the cost of services that, before July 1, 1998, had been paid under Part B but were furnished to Medicare beneficiaries in a SNF during a Part A covered stay. We update the rates annually using a SNF market basket index, and we adjust them by the hospital inpatient wage index to account for geographic variation in wages. We also apply a case-mix adjustment to account for the relative resource utilization of different patient types. This adjustment utilizes a refined, 53-group version of the Resource Utilization Groups, version III (RUG-III) case-mix classification system, based on information obtained from the required resident assessments using the Minimum Data Set (MDS) 2.0. Additionally, as noted in sections I.C through I.E of this final rule, the payment rates at various times have also reflected specific legislative provisions, including section 101 of the BBRA, sections 311, 312, and 314 of the BIPA, and section 511 of the MMA.

• *Transition.* Under sections 1888(e)(1)(A) and (e)(11) of the Act, the SNF PPS included an initial, three-phase transition that blended a facility-specific rate (reflecting the individual facility's historical cost experience) with the Federal case-mix adjusted rate. The transition extended through the facility's first three cost reporting periods under the PPS, up to and including the one that began in FY 2001. Thus, the SNF PPS is no longer operating under the transition, as all facilities have been paid at the full Federal rate effective with cost reporting periods beginning in FY 2002. As we now base payments entirely on the adjusted Federal per diem rates, we no longer include adjustment factors related to facility-specific rates for the coming FY.

• *Coverage.* The establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because the RUG-III classification is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have attempted, where possible, to coordinate claims review procedures with the output of beneficiary assessment and RUG-III classifying activities. This approach includes an administrative presumption that utilizes a beneficiary's initial classification in one of the upper 35 RUGs of the refined 53-group system to assist in making certain SNF level of care determinations, as discussed in greater detail in section III.B.5 of this final rule.

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

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

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

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

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

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

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

In the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the RUG–III classification structure (see section III.B.5 of this final rule for a discussion of the relationship between the case-mix classification system and SNF level of care determinations).

Along with other revisions outlined 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 adjustments to the SNF PPS. We described these provisions in detail in the SNF PPS final rule for FY 2001 (65 FR 46770, July 31, 2001). In particular, section 101(a) of the BBRA provided for a temporary 20 percent increase in the per diem adjusted payment rates for 15 specified

RUG–III groups. In accordance with section 101(c)(2) of the BBRA, this temporary payment adjustment expired on January 1, 2006, with the implementation of case-mix refinements (see section I.F.1. of this final rule). We included further information on BBRA provisions that affected the SNF PPS in Program Memorandums A–99–53 and A–99–61 (December 1999).

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

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

The BIPA also included several provisions that resulted in adjustments to the SNF PPS. We described these provisions in detail in the SNF PPS final rule for FY 2002 (66 FR 39562, July 31, 2001). In particular:

- Section 203 of the BIPA exempted CAH swing-beds from the SNF PPS. We included further information on this provision in Program Memorandum A–01–09 (Change Request #1509), issued January 16, 2001, which is available online at *http://www.cms.hhs.gov/transmittals/downloads/a0109.pdf.*
- Section 311 of the BIPA revised the statutory update formula for the SNF market basket, and also directed us to conduct a study of alternative case-mix classification systems for the SNF PPS. In 2006, we submitted a report to the Congress on this study, which is available online at *http://www.cms.hhs.gov/SNFPPS/Downloads/RC_2006_PC-PPSSNF.pdf.*
- Section 312 of the BIPA provided for a temporary increase of 16.66 percent in the nursing component of the case-mix adjusted Federal rate for services furnished on or after April 1, 2001, and before October 1, 2002; accordingly, this add-on is no longer in effect. This section also directed the Government Accountability Office (GAO) to conduct an audit of SNF nursing staff ratios and submit a report to the Congress on whether the temporary increase in the nursing component should be continued. The report (GAO–03–176), which GAO issued in November 2002, is available online at *http://www.gao.gov/new.items/d03176.pdf.*
- Section 313 of the BIPA repealed the consolidated billing requirement for services (other than physical, occupational, and speech-language therapy) furnished to SNF residents during noncovered stays, effective January 1, 2001. (A more detailed discussion of this provision appears in section V. of this final rule.)
- Section 314 of the BIPA corrected an anomaly involving three of the RUGs that the BBRA had designated to receive the temporary payment adjustment discussed above in section I.C. of this final rule. (As noted previously, in accordance with section 101(c)(2) of the BBRA, this temporary payment adjustment expired upon the implementation of case-mix refinements on January 1, 2006.)
- Section 315 of the BIPA authorized us to establish a geographic reclassification procedure that is specific to SNFs, but only after collecting the data necessary to establish a SNF wage index that is based on wage data from nursing homes. To date, this has proven to be infeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data.

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

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

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

For the limited number of SNF residents that qualify for the AIDS add-on, implementation of this provision results in a significant increase in payment. For example, using FY 2006 data, we identified less than 2,700 SNF residents with a diagnosis code of 042 (Human Immunodeficiency Virus (HIV) Infection). For FY 2009, an urban facility with a resident with AIDS in RUG group ''SSA'' would have a case-mix adjusted payment of $259.40 (see Table 4) before the application of the MMA adjustment. After an increase of 128 percent, this urban facility would receive a case-mix adjusted payment of $591.43.

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

F. Skilled Nursing Facility Prospective Payment—General Overview

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

1. Payment Provisions—Federal Rate

The PPS uses per diem Federal payment rates based on mean SNF costs in a base year updated for inflation to the first effective period of the PPS. We

developed the Federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in FY 1995. The data used in developing the Federal rates also incorporated an estimate of the amounts that would be payable under Part B for covered SNF services furnished to individuals during the course of a covered Part A stay in a SNF.

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

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

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

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

Section 1888(e)(5) of the Act requires us to establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. We use the SNF market basket index to update the Federal rates on an annual basis. In the FY 2008 SNF PPS final rule (72 FR 43425 through 43430, August 3, 2007), we revised and rebased the market basket, which included updating the base year from FY 1997 to FY 2004. The proposed FY 2009 market basket increase was 3.1 percent. The final FY 2009 market basket increase is 3.4 percent.

In addition, as explained in the SNF PPS final rule for FY 2004 (66 FR 46058, August 4, 2003) and in section IV.B. of this final rule, the annual update of the payment rates includes, as appropriate, an adjustment to account for market basket forecast error. As described in the SNF PPS final rule for FY 2008 (72 FR 43425, August 3, 2007), the threshold percentage that serves to trigger an adjustment to account for market basket forecast error is 0.5 percentage point effective for FY 2008 and subsequent years. This adjustment takes into account the forecast error from the most recently available FY for which there is final data, and applies whenever the difference between the forecasted and actual change in the market basket exceeds a 0.5 percentage point threshold. For FY 2007 (the most recently available FY for which there is final data), the estimated increase in the market basket index was 3.1 percentage points, while the actual increase was 3.1 percentage points, resulting in no difference. Accordingly, as the difference between the estimated and actual amount of change does not exceed the 0.5 percentage point threshold, the payment rates for FY 2009 do not include a forecast error adjustment. Table 1 below shows the forecasted and actual market basket amounts for FY 2007.

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

Index	Forecasted FY 2007 increase *	Actual FY 2007 increase **	FY 2007 difference ***
SNF	3.1	3.1	0.0

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

Requirements for Issuance of Regulations

Section 902 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended section 1871(a) of the Act and requires the Secretary, in consultation with the Director of the Office of Management and Budget, to establish and publish timelines for the publication of Medicare final regulations based on the previous publication of a Medicare proposed or interim final regulation. Section 902 of the MMA also states that the timelines for these regulations may vary but shall not exceed 3 years after publication of the preceding proposed or interim final regulation except under exceptional circumstances.

This final rule finalizes provisions proposed in the May 7, 2008 proposed rule. In addition, this final rule has been published within the 3-year time limit imposed by section 902 of the MMA. Therefore, we believe that the final rule is in accordance with the Congress' intent to ensure timely publication of final regulations.

II. Summary of the Provisions of the FY 2009 Proposed Rule

In the FY 2009 proposed rule (73 FR 25918, May 7, 2008), we proposed to update the Federal payment rates used

under the SNF PPS for FY 2009. We also proposed to recalibrate the case-mix indexes so that they would more accurately reflect parity in expenditures related to the implementation of case-mix refinements in January 2006. In addition, we discussed our ongoing analysis of nursing home staff time measurement data collected in the Staff Time and Resource Intensity Verification (STRIVE) project. We also proposed to make technical corrections in the regulations text with respect to Medicare bad debt payments to SNFs and the reference to the definition of urban and rural as applied to SNFs.

III. Analysis and Response to Public Comments on the FY 2009 Proposed Rule

In response to the publication of the FY 2009 proposed rule, we received over 100 timely items of correspondence from the public. The comments originated primarily from various trade associations and major organizations, but also from individual providers, corporations, government agencies, and private citizens.

Brief summaries of each proposed provision, a summary of the public comments that we received, and our responses to the comments appear below.

A. General Comments on the FY 2009 Proposed Rule

In addition to the comments that we received on the proposed rule's discussion of specific aspects of the SNF PPS (which we address later in this final rule), commenters also submitted the following, more general observations on the payment system.

Comment: We received comments similar to those discussed previously in the SNF PPS final rule for FY 2008 (72 FR 43415 through 43416, August 3, 2007) regarding the need to address certain perceived inadequacies in payment for non-therapy ancillary (NTA) services, including those services relating to the provision of ventilator care in SNFs. We also received comments recommending that we continue to monitor ongoing research, and that we consider alternative case-mix methodologies such as the recent MedPAC proposal that appears on the MedPAC Web site (see *http://www.MedPAC.gov*.)

Response: As we noted in the August 3, 2007 FY 2008 final rule (72 FR 43416), we anticipate that the findings from our current Staff Time and Resource Intensity Verification (STRIVE) project will assist us in reviewing and addressing these types of concerns. However, as noted in our December 2006 Report to Congress, our analysis of NTA utilization has been hindered by a lack of data. All Medicare institutional providers *except* SNFs are required to submit detailed line item billing that shows each ancillary service furnished during a Part A stay. SNFs currently submit summary data that shows total dollar amounts for each ancillary service category, such as radiology and pharmacy. As we examine the data collected through the STRIVE project, we will be evaluating whether our current data requirements are sufficient to move forward with additional program enhancements. We will also consider whether collecting more detailed claims information on a regular basis will allow us to establish more accurate payment rates for NTA services.

We also believe it is important to monitor ongoing research activities, and work with all stakeholders, including MedPAC, to identify opportunities for future program enhancements. At the same time, we note that the SNF PPS reimbursement structure will be completely examined as part of the Post Acute Care Payment Reform Demonstration (PAC–PRD) project. Under this major CMS initiative, we intend to analyze the payment structure currently used for all post-acute care providers, and establish an integrated payment model centered on beneficiary needs and service utilization (including the use of non-therapy ancillaries) across settings. In considering future changes to the SNF PPS, it will be important to evaluate how shorter term enhancements contribute to our integrated post acute care strategy.

A discussion of the public comments that we received on the STRIVE project itself appears in section III.B.7.a of this final rule.

B. Annual 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, 2008. The schedule incorporates per diem Federal rates that provide Part A payment for all costs of services furnished to a beneficiary in a SNF during a Medicare-covered stay.

a. Costs and Services Covered by the Federal Rates

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

b. Methodology Used for the Calculation of the Federal Rates

The FY 2009 rates reflect an update using the full amount of the latest market basket index. The FY 2009 market basket increase factor is 3.4 percent. A complete description of the multi-step process used to calculate Federal rates initially appeared in the May 12, 1998 interim final rule (63 FR 26252), as further revised in subsequent rules. We note that in accordance with section 101(c)(2) of the BBRA, the previous temporary increases in the per diem adjusted payment rates for certain designated RUGs, as specified in section 101(a) of the BBRA and section 314 of the BIPA, are no longer in effect due to the implementation of case-mix refinements as of January 1, 2006. However, the temporary increase of 128 percent in the per diem adjusted payment rates for SNF residents with AIDS, enacted by section 511 of the MMA (and discussed previously in section I.E of this final rule), remains in effect.

We used the SNF market basket to adjust each per diem component of the Federal rates forward to reflect cost increases occurring between the midpoint of the Federal FY beginning October 1, 2007, and ending September 30, 2008, and the midpoint of the Federal FY beginning October 1, 2008, and ending September 30, 2009, to which the payment rates apply. In accordance with section 1888(e)(4)(E)(ii)(IV) of the Act, we update the payment rates for FY 2009 by a factor equal to the full market basket index percentage increase. (We note, that the FY 2009 President's Budget includes a provision that would establish a zero percent market basket update for FYs 2009 through 2011, contingent upon the enactment of legislation by the Congress to adopt that proposal.) We further adjust the rates by

a wage index budget neutrality factor, described later in this section. Tables 2 and 3 below reflect the updated components of the unadjusted Federal rates for FY 2009.

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

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per diem amount	$151.74	$114.30	$15.05	$77.44

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

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per diem amount	$144.97	$131.80	$16.08	$78.87

2. Case-Mix Adjustments

a. Background

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

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

When we introduced a new refined RUG–53 classification model in January 2006, we used our authority for establishing an appropriate case-mix structure to construct a new case-mix index for use with the RUG–53 model. We calculated the new case-mix indexes using the STM study data that were collected during the 1990s and originally used in creating the SNF PPS case-mix classification system and case-mix indexes. As explained in greater detail below, we then performed a budget neutrality analysis, and increased the RUG–53 case-mix weights so that overall payments under the two models (the original 44-group model and the refined 53-group model) could be expected to be equal.

In the following section of this final rule, we discuss the adjustments to the RUG–53 case-mix indexes structure that we proposed in our FY 2009 proposed rule.

b. Development of the Case-Mix Indexes

In the August 4, 2005 SNF PPS final rule for FY 2006 (70 FR 45032), we introduced two refinements to the SNF PPS: (1) Nine new case-mix groups to account for the care needs of beneficiaries requiring both extensive medical and rehabilitation services; and (2) an adjustment to reflect the variability in the use of non-therapy ancillaries (NTAs). We made these refinements by using the resource minute data from the original 44-group model to create a new set of relative weights, or case-mix indexes (CMIs), for the refined 53-group model. We then compared the two models to ensure that estimated total payments under the 53-group model would not be greater or less than the aggregate payments that would have been made under the 44-group model.

As explained in the FY 2009 proposed rule (73 FR 25923), in conducting this analysis for the FY 2006 final rule, we used FY 2001 claims data (the most current data available at the time) to compare estimated aggregate payments under the 44-group and 53-group models. For each model, we multiplied the estimated case-mix adjusted base rate by the number of Medicare paid days attributable to each RUG group. For the 44-group RUG model, we used the actual 2001 paid claims data to determine the distribution of paid days. For the 53-group RUG model, we did not have any actual claims data, and had to estimate the number of days that would be distributed across the 53 groups. Using our estimated distribution, we found that payments under the new 53-group model would be lower than under the original 44-group model. As the purpose of the refinement was to better allocate payment and not to reduce overall expenditures, we adjusted the new CMIs upward by applying a parity adjustment factor. In this way, we attempted to ensure that the RUG–III model was expanded in a budget-neutral manner (that is, one that would not cause any change in the overall level of expenditures). We then applied a second adjustment to the CMIs to account for the variability in the use of NTA services. These two adjustments resulted in a combined 17.9 percent increase in the CMIs that went into effect on January 1, 2006, as part of the case-mix refinement implementation. A detailed description of the methods used to make these two adjustments to the CMIs appears in the SNF PPS proposed rule for FY 2006 (70 FR 29077 through 29078, May 19, 2005).

While we took all reasonable precautions to establish an appropriate, budget neutral conversion from the 44-group to the 53-group classification model, we recognized that the analyses we used to compute the budget neutrality adjustment were based solely on estimated data and that actual experience could be significantly different. For this reason, in the SNF PPS final rule for FY 2006 (70 FR 45031, August 4, 2005), we committed to monitoring the accuracy and effectiveness of the CMIs used in the 53-group model.

In monitoring recent claims data, we observed that actual expenditures were significantly higher than what we had projected using the 2001 data. In

particular, the proportion of dollars paid for patients who grouped in the highest paying RUG categories—combining high therapy with extensive services—greatly exceeded our projections. To determine why expenditures so greatly exceeded our projections, we repeated the budget neutrality analyses described earlier in this section (and as described in the FY 2006 SNF PPS proposed rule (70 FR 29077 through 29078, May 19, 2005)), using actual 2006 claims data to determine the distribution of paid days across the 53-group RUG model. For this analysis, we compared simulated calendar year (CY) 2006 payments (the first time period for which RUG–53 paid days data were available) to payments that would have been made under the RUG–44 model. As the introduction of the 9 new groups had not required a change to the MDS used to classify beneficiaries, we also had all of the data necessary to calculate accurately the distribution of paid days under the RUG–44 model. We found that estimated payments under the RUG–44 model were still higher than under the RUG–53 model, but that our original projections had overstated the difference. In addition, as the original budget neutrality adjustment was overestimated, the percentage adjustment made to the case-mix weights (after the budget neutrality adjustment was made) to account for NTA variability also needed to be recalibrated. Using the actual 2006 data, we found that the adjustment necessary to achieve budget neutrality was an increase of 9.68 percent rather than the 17.9 percent increase that had been in effect since January 2006. Thus, from January 2006 to the present, using the 17.9 percent adjustment to the case-mix weights resulted in overpayments far exceeding our intention of paying in a budget neutral manner. For FY 2009, we estimate the amount of overpayment at $780 million.

Although the 2001 data were the best source available at the time the FY 2006 refinements were introduced, the distribution of paid days, a key component in adjusting the RUG–53 case-mix weights, was based solely on estimated utilization. The 2006 data provide a more recent and a more accurate source of RUG–53 utilization based on actual utilization, and are an appropriate source to use for case-mix adjustment.

We received a number of comments questioning our legal authority to recalibrate the case-mix weights, as well as questions on the methodology used to make the case-mix weight adjustments. In the following discussion, we present the concerns that the commenters raised on this issue, and we also take the opportunity to address a number of misconceptions about the proposed recalibration that the comments reflected. However, in view of the potential ramifications of this proposal and the complexity of the issues involved, we believe that it would be prudent to take additional time to evaluate the proposal in order to further consider consequences that may result from it. Accordingly, we are not proceeding with the proposed recalibration at this time, pending further analysis. We note that as we continue to evaluate this issue, we fully expect to implement such an adjustment in the future. The comments that we received on this issue, and our responses, are as follows:

Comment: Several commenters stated that the need for the recalibration arose because CMS initial projections of utilization under the refined case-mix system proved to be inaccurate once actual utilization data became available. They then asserted that in view of this, the proposed recalibration represents a ''forecast error adjustment'' that is not covered under the statutory authority to provide for an appropriate adjustment to account for case mix (section 1888(e)(4)(G)(i) of the Act).

Response: It would be incorrect to characterize the proposed recalibration as a ''forecast error adjustment,'' as that term refers solely to an adjustment that compensates for an inaccurate forecast of the annual inflation factor in the SNF market basket. By contrast, the proposed recalibration would serve to ensure that the 2006 case-mix refinements are implemented as intended. As such, it would be integral to the process of providing ''* * * for an appropriate adjustment to account for case mix'' that is based upon appropriate data in accordance with section 1888(e)(4)(G)(i) of the Act.

Comment: A number of comments included references to the discussion of the 2006 case-mix refinements in the SNF PPS proposed rule for FY 2006 (70 FR 29079, May 19, 2005), in which we explained that we were ''* * * advancing these proposed changes under our authority in section 101(a) of the BBRA to establish case-mix refinements, and that the changes we are hereby proposing will represent the final adjustments made under this authority'' (emphasis added). The commenters stated that this earlier description of the 2006 case-mix refinements as ''final'' effectively precludes CMS from proceeding with a recalibration, which they characterized as representing a further refinement. Similarly, several commenters also questioned our authority to recalibrate the case-mix system prior to the completion of the STRIVE staff time measurement (STM) project. In addition, several commenters questioned whether CMS has the authority to impose a budget neutrality requirement on the introduction of a new classification model.

Response: We wish to clarify that the actual ''refinement'' that we proposed and implemented in the FY 2006 rulemaking cycle consisted of our introduction of the 9 new Rehabilitation plus Extensive Services groups at the top of the previous, 44-group RUG hierarchy, along with the adjustment recognizing the variability of NTA use, which together fulfilled the provisions of section 101(a) of the BBRA. The accompanying adjustment to the case-mix indexes (CMIs) was merely a vehicle through which we implemented that refinement. Rather than representing a new or further ''refinement'' in itself, the proposed recalibration merely serves to ensure that we correctly accomplish a revision to the CMIs that accompanied the FY 2006 case-mix refinements.

In the FY 2006 final rule (70 FR 45033, August 4, 2005), we addressed the introduction of the refinements within the broader context of ensuring payment accuracy and beneficiary access to care. We pointed out that

> * * * this incremental change is part of this ongoing process that will also include update activities such as the upcoming STM study and investigation of potential alternatives to the RUG system itself. However, the commitment to long term analysis and refinement should not preclude the introduction of more immediate methodological and policy updates.

Finally, the budget neutrality factor was applied to the unadjusted RUG 53 case-mix weights that were introduced in January 2006. As stated above, our initial analyses indicated that payments would be lower under the RUG–53 model. As the purpose of the refinement was to reallocate payments, and not to reduce expenditures, we believe that increasing the case-mix weights to equalize payments under the two models is an appropriate exercise of our broad authority to establish an appropriate case-mix system. We further note that the FY 2006 refinement to the case-mix classification system using adjusted CMIs was implemented through the rulemaking process, and we received no comments on the use of a budget neutrality adjustment at that time.

We also received a number of technical comments on the potential effects of implementing this

recalibration proposal on beneficiaries, providers, and the overall economy. These comments are summarized below.

Comment: Some commenters opposed the recalibration of the budget neutrality adjustment, believing that the change to the case-mix weights would ''take back'' payments to providers that had increased due to changes in case mix between 2001 and 2006. Specifically, several commenters expressed the belief that by proposing to recalibrate the case-mix weights put into place for the RUG–53 system, we are incorrectly identifying increased payments related to treatment of higher case-mix patients with an overpayment related to the use of an incorrect budget neutrality adjustment factor applied in January 2006. Another commenter believed that the proposed recalibration could be more accurately calculated using either 2005 data or a combination of 2005 and 2006 data.

Response: We agree that, on average, the case-mix indexes for current SNF patients are higher than they were in 2001. However, we believe this concern erroneously equates the introduction of a new classification model with the regular SNF PPS annual update process. Normally, changes in case mix are accommodated as the classification model identifies changes in case mix and assigns the appropriate RUG group. Actual payments will typically vary from projections since case-mix changes, which occur for a variety of reasons, cannot be anticipated in an impact analysis.

However, in January 2006, we did more than just update the payment rates; we introduced a new classification model, the RUG–53 case-mix system. As discussed above, the purpose of this refined model was to redistribute payments across the 53 groups while maintaining the same total expenditure level that we would have incurred had we retained the original 44-group RUG model.

In testing the two models, we used 2001 data because it was the best data we had available, and found that using the raw weights calculated for the RUG–53 model, we could expect aggregate payments to decrease as a result of introducing the refinement. To prevent this expected reduction in Medicare expenditures, we applied an adjustment to the RUG–53 case-mix weights as described in detail earlier in this section. Later analysis using actual 2006 data showed that, rather than achieving budget neutrality between the two models, expenditures were significantly higher than intended. For FY 2009, expenditures are estimated to be $780 million higher than intended.

We do not agree that updating our analysis using CY 2006 data captured payments related to increased case mix rather than establishing budget neutrality between the two models. First, by using 2006 data to estimate expenditures under both models, the same case-mix changes are incorporated into the estimated expenditure levels for RUG–44 as well as for RUG–53. Second, we believe it is appropriate to standardize the new model for the time period in which it is being introduced. The only reason we used 2001 data in the original calculation is that it was the best data available at the time. The CY 2006 data allowed us to calibrate the RUG–53 model more precisely for its first year of operation.

One commenter recommended using alternative time periods in calculating the budget neutrality adjustment. However, while it might be possible to use CY 2005 rather than CY 2006 data, using CY 2005 data still requires us to use a projection of the distributional shift to the nine new groups in the RUG–53 group model. We also looked at a second recommended alternative, which involved comparing quarterly data periods directly before and after implementation of the RUG–53 model; that is, October through December 2005 for the RUG–44 model and January through March 2006 for the RUG–53 model. Our preliminary analyses confirmed that the proposed recalibration would serve to ensure that the 2006 case-mix refinements are implemented as actually intended. However, we believe that using actual utilization data for CY 2006 is more accurate, since actual case mix during the calibration year is the basis for computing the case-mix adjustment. We have determined that using the 2006 data instead of the suggested alternatives are the most appropriate to adopt.

It is important to stress that this recalibration was not designed to adjust for aggregate payment differences that result from changes in the coding or classification of residents not reflective of real changes in case mix; that is, case-mix creep. Monitoring the changes in case mix under RUG–53 over the years since RUG–53 has been in place is part of a longer-term effort. If we find that a pattern of coding or the classification of residents does not reflect real changes in case mix over several years, we would propose a documentation and coding adjustment, pursuant to § 1888(e)(4)(F) of the Act. By contrast, the original application of a budget neutrality factor and the recalibration of that factor discussed in this final rule represented the mechanism that we used to establish the appropriate baseline for expenditures under the refined classification model (that is, the change from RUG–44 to RUG–53).

Comment: Some commenters argued against implementing the proposed recalibration, asserting that it is important to maintain Medicare SNF payments at their current levels in order to cross-subsidize what they characterized as inadequate payment rates for nursing facilities under the Medicaid program. Other commenters asserted that a shift in patients from Inpatient Rehabilitation Facilities (IRFs) to SNFs results in savings to the Medicare Trust Fund and that the current SNF spending levels are needed to treat the types of patients SNFs are now receiving.

Response: Even though we are not moving forward at this time with the proposed recalibration, we wish to be clear that it is not the appropriate role of the Medicare SNF benefit to cross-subsidize nursing home payments made under the Medicaid program. We note that MedPAC stated it is inappropriate for the Medicare program's SNF payments to cross-subsidize Medicaid nursing facility rates. Specifically, on page 152 of its March 2008 Report to the Congress on Medicare Payment Policy (which is available online at *http://medpac.gov/documents/Mar08_EntireReport.pdf*), MedPAC stated:

> There are several reasons why Medicare cross-subsidization is not advisable policy for the Medicare program. On average, Medicare payments accounted for 21 percent of revenues to freestanding SNFs in 2006. As a result, the policy would use a minority of Medicare payments to subsidize a majority of Medicaid payments. If Medicare were to pay still higher rates, facilities with high shares of Medicare payments—presumably the facilities that need revenues the least—would receive the most in subsidies from the higher Medicare payments. In other words, the subsidy would be poorly targeted. Given the variation among states in the level and method of nursing home payments, the impact of the subsidy would be highly variable; in states where Medicaid payments were adequate, it would have no positive impact. In addition, increasing Medicare's payment rates could encourage states to reduce Medicaid payments further and, in turn, result in pressure to again raise Medicare rates. It could also encourage providers to select patients based on payer source or to rehospitalize dual-eligible patients so that they qualified for a Medicare-covered, and higher payment, stay.

We agree with MedPAC and, therefore, do not agree with the commenters that cited cross-subsidizing Medicaid as a justification for maintaining Medicare SNF payments at any specific level.

Regarding the comments about a shift of patients from IRFs to SNFs producing savings to the Medicare Trust Fund, and the need to maintain current SNF spending levels to treat the types of patients SNFs are now receiving, we note that a basic principle of the SNF PPS is to pay appropriately for the services provided. CMS data are consistent with the commenters' assertions that many patients formerly being treated in IRFs are now being treated in SNFs or Home Health Agencies. In fact, the CY 2006 distribution used to recalibrate the case-mix adjustments indicates that there are more patients in the 9 new RUGs than we originally anticipated and patients shifting from IRFs could be a partial explanation.

Patients who shifted to SNFs or other settings from IRFs due to ''75 Percent Rule'' compliance percentage requirements represent a population that was not appropriate for IRF care, and CMS payments for those IRF stays would represent an overpayment to IRFs. For those former IRF patients who are appropriate for SNF care, we must pay the appropriate rate for the SNF services provided, and cannot use a reduction in IRF overpayments as a reason to increase payments under the SNF PPS. SNF patients with more intensive therapy and extensive service needs will be paid the higher amounts associated with the 9 new groups. While we are not moving forward with the proposed recalibration at this time, it is still important to understand that recalibrating CMIs would not change the relative nature of higher payments for patients using more staff resources and services.

Comment: One commenter claimed that CMS did not make the data and analysis underlying the proposed recalibration of the budget neutrality adjustment publicly available.

Response: We do not agree with the commenter's assertion. The methodology used to establish the case-mix adjustments is the same as that described in detail in the FY 2006 SNF PPS proposed rule (70 FR 29077 through 29078, May 19, 2005). In addition, the data used to calculate the adjustments are publicly available on the CMS Web site. We used the CY 2006 days of service (available in the downloads section of our Web site at *http://www.cms.hhs.gov/SNFPPS/02_Highlights.asp#TopOfPage*) for both the RUG–44 and RUG–53 systems. We multiplied the CY 2006 days of service by the FY 2008 unadjusted Federal per diem payment rate components (72 FR 43416) multiplied by the unadjusted case-mix indexes (available in the Downloads section of our Web site at *http://www.cms.hhs.gov/SNFPPS/09_RUGRefinement.asp#TopOfPage*) to establish expenditures under the RUG–44 and RUG–53 systems. The budget neutrality adjustment was determined as the percentage increase necessary for the nursing CMIs to generate estimated expenditure levels under the RUG–53 system that were equal to estimated expenditure levels under the RUG–44 system. We then calculated a second adjustment factor to increase the baseline by an amount that served to offset the variability in NTA utilization.

As discussed above, we are confident that we employed the correct methodology to evaluate the accuracy with which we implemented the 2006 refinements. However, in view of the widespread industry concern that a recalibration could potentially have adverse effects on beneficiaries and SNF clinical staff, and could negatively affect the quality of SNF care, we believe that the most prudent course is to continue to evaluate these issues carefully before proceeding. Thus, we will not proceed with the recalibration for FY 2009, but will instead continue to evaluate the data, and further consider consequences that may result from the recalibration. We note that as we continue to evaluate this issue, we fully expect to implement such an adjustment in the future. Therefore, for FY 2009, the case-mix indexes shown in Tables 4 and 5 below remain the same as those adopted in FY 2006. As always, we list the case-mix adjusted payment rates separately for urban and rural SNFs, with the corresponding case-mix values. We note that these tables do not reflect the AIDS add-on enacted by section 511 of the MMA, which we apply only after making all other adjustments (wage and case-mix).

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

RUG–III category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUX	1.9	2.25	288.31	257.18	.....	77.44	622.93
RUL	1.4	2.25	212.44	257.18	.....	77.44	547.06
RVX	1.54	1.41	233.68	161.16	.....	77.44	472.28
RVL	1.33	1.41	201.81	161.16	.....	77.44	440.41
RHX	1.42	0.94	215.47	107.44	.....	77.44	400.35
RHL	1.37	0.94	207.88	107.44	.....	77.44	392.76
RMX	1.93	0.77	292.86	88.01	.....	77.44	458.31
RML	1.68	0.77	254.92	88.01	.....	77.44	420.37
RLX	1.31	0.43	198.78	49.15	.....	77.44	325.37
RUC	1.28	2.25	194.23	257.18	.....	77.44	528.85
RUB	0.99	2.25	150.22	257.18	.....	77.44	484.84
RUA	0.84	2.25	127.46	257.18	.....	77.44	462.08
RVC	1.23	1.41	186.64	161.16	.....	77.44	425.24
RVB	1.09	1.41	165.40	161.16	.....	77.44	404.00
RVA	0.82	1.41	124.43	161.16	.....	77.44	363.03
RHC	1.22	0.94	185.12	107.44	.....	77.44	370.00
RHB	1.11	0.94	168.43	107.44	.....	77.44	353.31
RHA	0.94	0.94	142.64	107.44	.....	77.44	327.52
RMC	1.15	0.77	174.50	88.01	.....	77.44	339.95
RMB	1.09	0.77	165.40	88.01	.....	77.44	330.85
RMA	1.04	0.77	157.81	88.01	.....	77.44	323.26
RLB	1.14	0.43	172.98	49.15	.....	77.44	299.57
RLA	0.85	0.43	128.98	49.15	.....	77.44	255.57
SE3	1.86	.....	282.24	.....	15.05	77.44	374.73
SE2	1.49	.....	226.09	.....	15.05	77.44	318.58
SE1	1.26	.....	191.19	.....	15.05	77.44	283.68
SSC	1.23	.....	186.64	.....	15.05	77.44	279.13

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

RUG–III category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
SSB	1.13		171.47		15.05	77.44	263.96
SSA	1.1		166.91		15.05	77.44	259.40
CC2	1.22		185.12		15.05	77.44	277.61
CC1	1.06		160.84		15.05	77.44	253.33
CB2	0.98		148.71		15.05	77.44	241.20
CB1	0.91		138.08		15.05	77.44	230.57
CA2	0.9		136.57		15.05	77.44	229.06
CA1	0.8		121.39		15.05	77.44	213.88
IB2	0.74		112.29		15.05	77.44	204.78
IB1	0.72		109.25		15.05	77.44	201.74
IA2	0.61		92.56		15.05	77.44	185.05
IA1	0.56		84.97		15.05	77.44	177.46
BB2	0.73		110.77		15.05	77.44	203.26
BB1	0.69		104.70		15.05	77.44	197.19
BA2	0.6		91.04		15.05	77.44	183.53
BA1	0.52		78.90		15.05	77.44	171.39
PE2	0.85		128.98		15.05	77.44	221.47
PE1	0.82		124.43		15.05	77.44	216.92
PD2	0.78		118.36		15.05	77.44	210.85
PD1	0.76		115.32		15.05	77.44	207.81
PC2	0.71		107.74		15.05	77.44	200.23
PC1	0.69		104.70		15.05	77.44	197.19
PB2	0.55		83.46		15.05	77.44	175.95
PB1	0.54		81.94		15.05	77.44	174.43
PA2	0.53		80.42		15.05	77.44	172.91
PA1	0.5		75.87		15.05	77.44	168.36

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

RUG–III category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUX	1.9	2.25	275.44	296.55		78.87	650.86
RUL	1.4	2.25	202.96	296.55		78.87	578.38
RVX	1.54	1.41	223.25	185.84		78.87	487.96
RVL	1.33	1.41	192.81	185.84		78.87	457.52
RHX	1.42	0.94	205.86	123.89		78.87	408.62
RHL	1.37	0.94	198.61	123.89		78.87	401.37
RMX	1.93	0.77	279.79	101.49		78.87	460.15
RML	1.68	0.77	243.55	101.49		78.87	423.91
RLX	1.31	0.43	189.91	56.67		78.87	325.45
RUC	1.28	2.25	185.56	296.55		78.87	560.98
RUB	0.99	2.25	143.52	296.55		78.87	518.94
RUA	0.84	2.25	121.77	296.55		78.87	497.19
RVC	1.23	1.41	178.31	185.84		78.87	443.02
RVB	1.09	1.41	158.02	185.84		78.87	422.73
RVA	0.82	1.41	118.88	185.84		78.87	383.59
RHC	1.22	0.94	176.86	123.89		78.87	379.62
RHB	1.11	0.94	160.92	123.89		78.87	363.68
RHA	0.94	0.94	136.27	123.89		78.87	339.03
RMC	1.15	0.77	166.72	101.49		78.87	347.08
RMB	1.09	0.77	158.02	101.49		78.87	338.38
RMA	1.04	0.77	150.77	101.49		78.87	331.13
RLB	1.14	0.43	165.27	56.67		78.87	300.81
RLA	0.85	0.43	123.22	56.67		78.87	258.76
SE3	1.86		269.64		16.08	78.87	364.59
SE2	1.49		216.01		16.08	78.87	310.96
SE1	1.26		182.66		16.08	78.87	277.61
SSC	1.23		178.31		16.08	78.87	273.26
SSB	1.13		163.82		16.08	78.87	258.77
SSA	1.1		159.47		16.08	78.87	254.42
CC2	1.22		176.86		16.08	78.87	271.81
CC1	1.06		153.67		16.08	78.87	248.62
CB2	0.98		142.07		16.08	78.87	237.02
CB1	0.91		131.92		16.08	78.87	226.87
CA2	0.9		130.47		16.08	78.87	225.42
CA1	0.8		115.98		16.08	78.87	210.93
IB2	0.74		107.28		16.08	78.87	202.23
IB1	0.72		104.38		16.08	78.87	199.33
IA2	0.61		88.43		16.08	78.87	183.38

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

RUG–III category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
IA1	0.56		81.18		16.08	78.87	176.13
BB2	0.73		105.83		16.08	78.87	200.78
BB1	0.69		100.03		16.08	78.87	194.98
BA2	0.6		86.98		16.08	78.87	181.93
BA1	0.52		75.38		16.08	78.87	170.33
PE2	0.85		123.22		16.08	78.87	218.17
PE1	0.82		118.88		16.08	78.87	213.83
PD2	0.78		113.08		16.08	78.87	208.03
PD1	0.76		110.18		16.08	78.87	205.13
PC2	0.71		102.93		16.08	78.87	197.88
PC1	0.69		100.03		16.08	78.87	194.98
PB2	0.55		79.73		16.08	78.87	174.68
PB1	0.54		78.28		16.08	78.87	173.23
PA2	0.53		76.83		16.08	78.87	171.78
PA1	0.5		72.49		16.08	78.87	167.44

3. Wage Index Adjustment to Federal Rates

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

Since the implementation of the SNF PPS, as set forth in § 413.337(a)(1)(ii), a SNF's wage index is determined based on the location of the SNF in an urban or rural area as defined in § 413.333 and further defined in § 412.62(f)(1)(ii) and § 412.62(f)(1)(iii) as urban and rural areas, respectively. In the SNF PPS final rule for FY 2006 (70 FR 45041, August 4, 2005), we adopted revised labor market area definitions based on Core-Based Statistical Area (CBSAs). At the time, we noted that these were the same labor market area definitions (based on OMB's new CBSA designations) implemented under the Hospital Inpatient Prospective Payment System (IPPS) at § 412.64(b), which were effective for those hospitals beginning October 1, 2004, as discussed in the IPPS final rule for FY 2005 (69 FR at 49026 through 49034, August 11, 2004). In the FY 2006 SNF PPS final rule, we inadvertently omitted making a conforming regulation text change to § 413.333. However, this did not alter our decision to follow the IPPS definitions of urban and rural. In the FY 2009 proposed rule, we proposed to make that conforming regulation text change to revise the definitions for rural and urban areas effective for services provided on or after October 1, 2005, to reference the regulations at §§ 412.64(b)(1)(ii)(A) through (C), consistent with the revision under the IPPS.

Comments on the wage index adjustment to the Federal rates, and our responses to those comments, are as follows:

Comment: A few commenters recommended that CMS develop a SNF-specific wage index. Other commenters asked CMS to consider adopting certain wage index policies in use under the acute IPPS, because SNFs compete in a similar labor pool as acute care hospitals. The commenters indicated that adoption of these measures under the SNF PPS would allow SNFs to benefit from the IPPS geographic reclassification and/or rural floor policies. (A discussion of the IPPS reclassification and floor policies appears on our Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp.*)

Response: The regulations that govern the SNF PPS currently do not provide a mechanism for allowing providers to seek geographic reclassification. Moreover, as we have explained in the past (most recently, in the SNF PPS final rule for FY 2008 (72 FR 43420, August 3, 2007)), while section 315 of the Benefits Improvement and Protection Act of 2000 (BIPA, Pub. L. 106–554) does authorize us to establish such a reclassification methodology under the SNF PPS, it additionally stipulates that such reclassification cannot be implemented until we have collected the data necessary to establish a SNF-specific wage index. This, in turn, has proven to be infeasible due to ''* * * the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data'' (72 FR 43420, August 3, 2007). We continue to believe that these factors make it unlikely for such an approach to yield meaningful improvements in our ability to determine facility payments, or to justify the significant increase in administrative resources as well as burden on providers that this type of data collection would involve.

In addition, we reviewed the Medicare Payment Advisory Commission's (MedPAC) wage index recommendations as discussed in MedPAC's June 2007 report entitled, ''Report to Congress: Promoting Greater Efficiency in Medicare.'' Although some commenters recommend that we adopt the IPPS wage index policies such as reclassification and floor policies, we note that MedPAC's June 2007 report to Congress recommends that Congress ''repeal the existing hospital wage index statute, including reclassification and exceptions, and give the Secretary authority to establish new wage index systems.'' We believe that adopting the IPPS wage index policies (such as reclassification or floor) would not be prudent at this time, because MedPAC suggests that the reclassification and exception policies in the IPPS wage index alters the wage index values for one-third of IPPS hospitals. In addition, MedPAC found that the exceptions may

lead to anomalies in the wage index. By adopting the IPPS reclassification and exceptions at this time, the SNF PPS wage index could become vulnerable to problems similar to those that MedPAC identified in their June 2007 Report to Congress. However, we will continue to review and consider MedPAC's recommendations on a refined or alternative wage index methodology for the SNF PPS in future years.

We also note that section 106(b)(2) of the Medicare Improvements and Extension Act (MIEA) of 2006 (which is Division B of the Tax Relief and Health Care Act (TRHCA) of 2006, Pub. L. 109–432, collectively referred to as ''MIEA–TRHCA'') required the Secretary of Health and Human Services, taking into account MedPAC's recommendations on the Medicare wage index classification system, to include in the FY 2009 IPPS proposed rule one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS. To assist CMS in meeting the requirements of section 106(b)(2) of MIEA–TRHCA, in February 2008, CMS awarded a Task Order under its Expedited Research and Demonstration Contract, to Acumen, LLC. A comparison of the current IPPS wage index and MedPAC's are presented in the FY 2009 IPPS final rule. We plan to continue monitoring wage index research efforts and the impact or influence they may have for the SNF PPS wage index. Moreover, in light of all of the pending research and review of wage index issues in general, we believe that it would be premature at this time to initiate review of a SNF-specific wage index.

a. Clarification of New England Deemed Counties

As we discussed in the SNF PPS proposed rule for FY 2009 (73 FR 25926, May 7, 2008), two New England counties (Litchfield County, CT and Merrimack County, NH) are deemed to be urban areas under section 601(g) of the Social Security Amendments of 1983, yet are considered rural by OMB definitions. We proposed to clarify the treatment of these two New England counties in accordance with the FY 2008 IPPS final rule with comment period (72 FR 47337 through 47338, August 22, 2007), which revised the regulations at § 412.64(b)(1)(ii)(B) so that these counties are no longer considered urban, effective for discharges occurring on or after October 1, 2007. A more detailed discussion of this proposal appears in the SNF PPS proposed rule for FY 2009 (73 FR 24926). We note that all post-acute care payment systems are clarifying this policy to create consistency among provider types.

We received no comments on this aspect of the proposed rule, and we are proceeding with this technical clarification as proposed with no change. Therefore, we are treating these counties as rural for purposes of the SNF PPS.

b. Multi-Campus Hospital Wage Index Data

When a multi-campus hospital has campuses located in different labor market areas, wages and hours are reported in a single labor market area (CBSA) even though the hospital's staff is working at campuses in more than one labor market area. Currently, the wage data are reported in the labor market area of the hospital campus associated with the provider number. In the SNF PPS proposed rule for FY 2009 (73 FR 25926, May 7, 2008), we described a change in the way wage data for multi-campus hospitals located in different labor market areas (CBSAs) would be apportioned, consistent with a FY 2008 change in the IPPS rule. The IPPS wage data used to determine the FY 2009 SNF wage index apportion the wage data for multi-campus hospitals located in different labor market areas (CBSAs) to each CBSA where the campuses are located (72 FR 47317 through 47320, August 22, 2007). A more detailed discussion of this proposal appears in the SNF PPS proposed rule for FY 2009 (73 FR 24926). Adopting the treatment of this data is consistent with our use of the pre-floor, pre-reclassified IPPS wage data.

We received no comments on this aspect of the proposed rule and we are adopting this policy as proposed without change, consistent with our use of IPPS wage data. The wage index values for the FY 2009 SNF PPS are affected by this policy.

We also proposed to continue using the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in which there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the FY 2009 SNF PPS wage index. For rural geographic areas that do not have hospitals and, therefore, lack hospital wage data on which to base an area wage adjustment, we would use the average wage index from all contiguous CBSAs as a reasonable proxy. This methodology is used to construct the wage index for rural Massachusetts. However, as discussed in the FY 2008 SNF PPS proposed rule (72 FR 25539, May 4, 2007), we are not applying this methodology to rural Puerto Rico due to the distinct economic circumstances that exist there, but instead will continue using the most recent wage index previously available for that area. For urban areas without specific hospital wage index data, we will use the average wage indexes of all of the urban areas within the State to serve as a reasonable proxy for the wage index of that urban CBSA. The only urban area without wage index data available is CBSA (25980) Hinesville-Fort Stewart, GA. We received no comments on this issue and are finalizing our policy as proposed without change.

In summary, in the FY 2009 proposed rule, we proposed to use the FY 2009 wage index data (collected from cost reports submitted by hospitals for cost reporting periods beginning during FY 2005) to adjust SNF PPS payments beginning October 1, 2008. We also proposed to continue our policies for calculating wage indexes for areas without hospitals. We are finalizing the wage index and associated policies as proposed for the SNF PPS for FY 2009 without change. These data reflect the multi-campus and New England deemed counties policies discussed above.

To calculate the SNF PPS wage index adjustment, we apply the wage index adjustment to the labor-related portion of the Federal rate, which is 69.783 percent of the total rate. This percentage reflects the labor-related relative importance for FY 2009, using the revised and rebased FY 2004-based market basket. The labor-related relative importance for FY 2008 was 70.249, as shown in Table 11. We calculate the labor-related relative importance from the SNF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2009. The price proxies that move the different cost categories in the market basket do not necessarily change at the same rate, and the relative importance captures these changes. Accordingly, the relative importance figure more closely reflects the cost share weights for FY 2009 than the base year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2009 in four steps. First, we compute the FY 2009 price index level for the total market basket and each cost category of the market basket. Second, we calculate a ratio for each cost category by dividing the FY 2009 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2009 relative importance for each cost

category by multiplying this ratio by the base year (FY 2004) weight. Finally, we add the FY 2009 relative importance for each of the labor-related cost categories (wages and salaries, employee benefits, non-medical professional fees, labor-intensive services, and a portion of capital-related expenses) to produce the FY 2009 labor-related relative importance. Tables 6 and 7 below show the Federal rates by labor-related and non-labor-related components.

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

RUG–III category	Total rate	Labor portion	Non-labor portion
RUX	622.93	434.70	188.23
RUL	547.06	381.75	165.31
RVX	472.28	329.57	142.71
RVL	440.41	307.33	133.08
RHX	400.35	279.38	120.97
RHL	392.76	274.08	118.68
RMX	458.31	319.82	138.49
RML	420.37	293.35	127.02
RLX	325.37	227.05	98.32
RUC	528.85	369.05	159.80
RUB	484.84	338.34	146.50
RUA	462.08	322.45	139.63
RVC	425.24	296.75	128.49
RVB	404.00	281.92	122.08
RVA	363.03	253.33	109.70
RHC	370.00	258.20	111.80
RHB	353.31	246.55	106.76
RHA	327.52	228.55	98.97
RMC	339.95	237.23	102.72
RMB	330.85	230.88	99.97
RMA	323.26	225.58	97.68
RLB	299.57	209.05	90.52
RLA	255.57	178.34	77.23
SE3	374.73	261.50	113.23
SE2	318.58	222.31	96.27
SE1	283.68	197.96	85.72
SSC	279.13	194.79	84.34
SSB	263.96	184.20	79.76
SSA	259.40	181.02	78.38
CC2	277.61	193.72	83.89
CC1	253.33	176.78	76.55
CB2	241.20	168.32	72.88
CB1	230.57	160.90	69.67
CA2	229.06	159.84	69.22
CA1	213.88	149.25	64.63
IB2	204.78	142.90	61.88
IB1	201.74	140.78	60.96
IA2	185.05	129.13	55.92
IA1	177.46	123.84	53.62
BB2	203.26	141.84	61.42
BB1	197.19	137.61	59.58
BA2	183.53	128.07	55.46
BA1	171.39	119.60	51.79
PE2	221.47	154.55	66.92
PE1	216.92	151.37	65.55
PD2	210.85	147.14	63.71
PD1	207.81	145.02	62.79
PC2	200.23	139.73	60.50
PC1	197.19	137.61	59.58
PB2	175.95	122.78	53.17
PB1	174.43	121.72	52.71
PA2	172.91	120.66	52.25
PA1	168.36	117.49	50.87

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

RUG–III category	Total rate	Labor portion	Non-labor portion
RUX	650.86	454.19	196.67
RUL	578.38	403.61	174.77
RVX	487.96	340.51	147.45
RVL	457.52	319.27	138.25
RHX	408.62	285.15	123.47
RHL	401.37	280.09	121.28

TABLE 7—RUG–53 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
RMX	460.15	321.11	139.04
RML	423.91	295.82	128.09
RLX	325.45	227.11	98.34
RUC	560.98	391.47	169.51
RUB	518.94	362.13	156.81
RUA	497.19	346.95	150.24
RVC	443.02	309.15	133.87
RVB	422.73	294.99	127.74
RVA	383.59	267.68	115.91
RHC	379.62	264.91	114.71
RHB	363.68	253.79	109.89
RHA	339.03	236.59	102.44
RMC	347.08	242.20	104.88
RMB	338.38	236.13	102.25
RMA	331.13	231.07	100.06
RLB	300.81	209.91	90.90
RLA	258.76	180.57	78.19
SE3	364.59	254.42	110.17
SE2	310.96	217.00	93.96
SE1	277.61	193.72	83.89
SSC	273.26	190.69	82.57
SSB	258.77	180.58	78.19
SSA	254.42	177.54	76.88
CC2	271.81	189.68	82.13
CC1	248.62	173.49	75.13
CB2	237.02	165.40	71.62
CB1	226.87	158.32	68.55
CA2	225.42	157.30	68.12
CA1	210.93	147.19	63.74
IB2	202.23	141.12	61.11
IB1	199.33	139.10	60.23
IA2	183.38	127.97	55.41
IA1	176.13	122.91	53.22
BB2	200.78	140.11	60.67
BB1	194.98	136.06	58.92
BA2	181.93	126.96	54.97
BA1	170.33	118.86	51.47
PE2	218.17	152.25	65.92
PE1	213.83	149.22	64.61
PD2	208.03	145.17	62.86
PD1	205.13	143.15	61.98
PC2	197.88	138.09	59.79
PC1	194.98	136.06	58.92
PB2	174.68	121.90	52.78
PB1	173.23	120.89	52.34
PA2	171.78	119.87	51.91
PA1	167.44	116.84	50.60

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

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

accessed online at *http://www.whitehouse.gov/omb/bulletins/index.html.*

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

4. Updates to the Federal Rates

In accordance with section 1888(e)(4)(E) of the Act, as amended by section 311 of the BIPA, the payment rates in this final rule reflect an update equal to the full SNF market basket, estimated at 3.4 percentage points. We continue to disseminate the rates, wage index, and case-mix classification methodology through the **Federal Register** before the August 1 that precedes the start of each succeeding FY.

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

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

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

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

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

Using the hypothetical SNF XYZ described in Table 10 below, the following shows the adjustments made to the Federal per diem rate to compute the provider's actual per diem PPS payment. SNF XYZ's 12-month cost reporting period begins October 1, 2008. SNF XYZ's total PPS payment would equal $30,968. The Labor and Non-labor columns are derived from Table 6.

TABLE 10—RUG–53 SNF XYZ: LOCATED IN CEDAR RAPIDS, IA (URBAN CBSA 16300) WAGE INDEX: 0.8924

RUG group	Labor	Wage index	Adj. labor	Non-labor	Adj. rate	Percent adj	Medicare days	Payment
RVX	$329.57	0.8919	$293.94	$142.71	$436.65	$436.65	14	$6,113.00
RLX	227.05	0.8919	202.51	98.32	300.83	300.83	30	9,025.00
RHA	228.55	0.8919	203.84	98.97	302.81	302.81	16	4,845.00
CC2	193.72	0.8919	172.78	83.89	256.67	*585.21	10	5,852.00
IA2	129.13	0.8919	115.17	55.92	171.09	171.09	30	5,133.00
							100	30,968.00

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

7. Other Issues

In the SNF PPS proposed rule for FY 2009 (73 FR 25930, May 7, 2008), we discussed several issues that relate to the SNF PPS for which we made no specific proposals, but solicited comments. These issues are noted below.

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

The SNF PPS proposed rule for FY 2009 (73 FR 25930, May 7, 2008) included a more detailed discussion of the current status of the STRIVE project. Specific comments on this issue, and our responses to those comments, are as follows:

Comment: Specifically referencing the STRIVE Technical Expert Panel (TEP) described in the proposed rule, one commenter expressed concern about whether registered nurses (RNs) have been adequately represented in the STRIVE process.

Response: We understand that nurses have been well represented as the STRIVE contractor has sought input from a variety of individual stakeholders. Two RNs directly representing nursing associations have attended STRIVE TEPs as observers, who not only observe the proceedings, but can also offer comments and ask questions of the STRIVE team. Other people with backgrounds as RNs constitute a significant percentage of TEP attendees overall. In fact, the STRIVE contractor has received insights from RNs attending not only as observers, but as participants, who directly interact with the STRIVE team during TEP presentations.

Comment: One commenter voiced concerns regarding whether STRIVE collected the RN staff time associated with residents separately from that of other personnel; for example, LPNs and nursing aides.

Response: STRIVE collected all nursing staff time over 2 days using personal digital assistants (PDAs). In each PDA, the name of each nursing staff member was linked to his or her

individual job title (including RN, LPN, and CNA). STRIVE does not represent the first instance in which CMS (or, rather, its predecessor, HCFA) has separately tracked different nursing staff positions as it collected time data. In the FY 2006 refinements that added nine new RUG categories, CMS calculated case-mix indexes based on nursing staff time collected in the prior time studies. That data accounted for three different disciplines: RNs, LPNs, and Aides. In fact, CMS published on its Web site a spreadsheet containing population-weighted time for each of those three positions. These data appear on the RUG refinement page of the SNF PPS Web site: *http://www.cms.hhs.gov/SNFPPS/09_RUG Refinement.asp#TopOfPage.* Under ''Downloads'' near the bottom of the page, that data can be unzipped after linking to *Unadjusted nursing weights [Zip, 15kb].*

b. Minimum Data Set (MDS) 3.0

The SNF PPS proposed rule for FY 2009 (73 FR 25931, May 7, 2008) included a more detailed discussion of the new version (3.0) of the MDS that is currently under development. Specific comments, and our responses to those comments, are as follows:

Comment: One commenter was concerned that because CMS does not currently require a resident assessment instrument to be completed at admission and at discharge, the changes in a patient's condition cannot be accurately measured and outcomes assessed, making it more difficult to tie Medicare's payments to patient outcomes.

Response: We note that the current SNF PPS is based upon the amount of resources used by a particular patient due to their unique clinical needs, and that it is not an outcome-based system. However, as noted in section III.B.7.c. of this final rule, we are currently evaluating the appropriateness of introducing certain pay for performance initiatives in the SNF setting. In the interim, although the current SNF PPS design does not provide for the completion of an assessment at admission and then again at discharge, the current Post Acute Care Payment Reform Demonstration (PAC–PRD) does provide for this. It is our intention to monitor this particular aspect of the PAC–PRD to determine both its administrative and financial impact, in order to understand the effect it could have on SNFs should it be adopted under the SNF PPS.

Comment: A commenter recommended revising the MDS to gather information solely about services furnished during the SNF stay, so that payments to SNFs are not based on services provided during the preceding hospital stay. Another stated that the draft MDS 3.0 represents an excellent modification of the current MDS, and applauded CMS for retaining the critically necessary look-back periods that, in their view, help clinicians more thoroughly evaluate and follow-up on conditions and treatments related to the hospital stay.

Response: The development of the MDS 3.0 has been and will continue to be a collaborative effort designed to maximize the quality of care provided to Medicare beneficiaries and to ensure proper payment under the SNF PPS. Under the STRIVE project, we are currently assessing each of the data elements used in the payment methodology, as well as other items that may affect resource utilization. We appreciate the commenter's concern and also recognize the role of clinicians in ensuring proper care, and will take these comments into consideration as we finalize the design of the MDS 3.0.

Comment: One commenter recommended that CMS change the look back period for therapies in section O on the MDS 3.0 from 5 days to 7 days, as it is currently on the MDS 2.0. The same commenter suggested that we continue to collect minutes for respiratory therapy on the MDS 3.0.

Response: We note that, contrary to the commenter's impression, CMS did not change the look back for therapy services on the MDS 3.0 to 5 days. In fact, the instructions for Section O4—Therapies states ''Record the *number of days each of the following therapies was administered* for at least 15 minutes a day in the last 7 Days'' (emphasis added). The January draft version of the MDS 3.0 appears at the following link: *http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30DraftVersion.pdf.* We will post the CMS Draft MDS 2.0/3.0 Crosswalk on the CMS web site. This draft version contains all of the items that potentially may appear in the final version of the MDS 3.0. We have added an item to collect the minutes of respiratory therapy services, as well as other items. The CMS Draft MDS 2.0/3.0 Crosswalk (July 2008) will be available on the MDS 3.0 Web site, which appears at the following link: *http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp.*

c. Integrated Post Acute Care Payment

In the proposed rule, we discussed our ongoing examination of possible steps toward achieving a more seamless system for the delivery and payment of post-acute care (PAC) services in various care settings. These include the PAC Payment Reform Demonstration (PAC–PRD) and its standardized patient assessment tool, the Continuity Assessment Record and Evaluation (CARE) tool. In the related area of value-based purchasing (VBP) initiatives, we described the IPPS preventable hospital-acquired conditions (HAC) payment provision, which is designed to ensure that the occurrence of selected, preventable conditions during hospitalization does not have the unintended effect of generating higher Medicare payments under the IPPS. We then discussed the potential application of this same underlying principle to other care settings in addition to IPPS hospitals. For a more detailed discussion of this issue as it pertains to the SNF setting, we refer readers to the SNF PPS proposed rule for FY 2009 (73 FR 25932, May 7, 2008).

The comments that we received, and our responses to those comments, are as follows:

Comment: We received several comments concerning the use of the CARE tool. While most of these comments acknowledged that the CARE tool holds long-term promise in terms of potentially facilitating the efficient flow of secure electronic patient information, they also cautioned that it would be far too premature at this point in time to draw any definitive conclusions about its use, given the very early stage of the research currently being conducted in this area.

Response: We agree with the commenters' observations about the CARE tool, both in terms of its significant future potential and the need to await the results of ongoing research before reaching any specific conclusions about its use. We will continue to evaluate the CARE tool closely during the remainder of the current demonstration, and we plan to keep the commenters' concerns in mind as we proceed with our research in this area.

Comment: A number of commenters stressed the need for external research in the area of PAC payment reform, as well as the importance of obtaining input from the stakeholder community.

Response: We agree with the commenters regarding the value of obtaining stakeholder input, and believe that this is, in fact, crucial to the success of our PAC payment reform efforts. We also recognize the importance of obtaining the benefit of all available findings from any research that is currently underway. We note that our own activities in this regard primarily involve applied research through our demonstration projects and internal

analysis of changes in program policy. However, we also encourage interested parties to engage in external research projects on PAC payment reform.

Comment: We received a number of comments regarding the HAC payment provision under the IPPS, and the possible adoption of a similar approach in care settings other than IPPS hospitals. The commenters recommended that CMS conduct a thorough evaluation of the HAC policy's implementation under the IPPS to determine its actual impact and efficacy before considering whether to adopt this type of approach in other care settings. Some commenters also questioned the legal authority under existing Medicare law to expand the HAC payment provision beyond the IPPS hospital setting. Other commenters raised concerns about the specific implications of applying this type of policy to the SNF setting. They cited hospital-acquired infections, dementia, and falls as examples of things that might be less appropriately characterized as ''never events'' in long-term care settings than in the acute setting. These commenters also observed that it would be unfair to penalize a SNF financially for a condition that actually developed during the preceding hospital stay but was not detected until after transfer to the SNF.

One commenter specifically noted that a SNF should not be expected to assume the financial liability for the care of a resident's decubitus ulcer if it was acquired during the preceding hospital stay. In addition, the commenters indicated that it may be difficult to differentiate a preventable healthcare-acquired complication from a normal, unavoidable aspect of a terminal illness, and also asserted that it is difficult to define the extent to which an adverse event is ''reasonably preventable.''

Response: We appreciate the commenters' thoughtful input about application of the principal embodied in the IPPS HAC payment provision to the SNF setting. While we acknowledge that infections, dementia, and falls are among the selected HACs in the IPPS acute care setting that potentially have relevance for the SNF setting as well, we agree that these and other conditions may have different implications in the SNF setting. We agree with the commenters that it would be unfair to penalize a SNF financially for a condition that developed in another care setting. We note that the IPPS HAC payment provision uses Present on Admission (POA) indicator data to exclude from payment those conditions that develop outside of the IPPS acute care stay, and a similar mechanism would be needed to apply this type of payment provision to the SNF setting should such an approach be adopted there. Regarding the commenters' concerns about the difficulty of determining which adverse events are ''reasonably preventable,'' we would expect to work closely with stakeholders to determine which conditions could reasonably be prevented through the application of evidence-based guidelines. With regard to the comments that questioned the existing legal authority for expanding the HAC payment provision beyond the IPPS hospital setting, we note that in this final rule, we are not establishing any new Medicare policies in this area. However, we will keep the commenters' concerns in mind as our implementation of VBP for all Medicare payment systems proceeds. We look forward to working with stakeholders in continuing to explore possible ways to reduce the occurrence of these preventable conditions in various care settings. Finally, we note that in addition to the comments on those aspects of PAC payment reform and VBP that we discussed in the proposed rule, we also received some comments on the current Nursing Home VBP Demonstration (referenced previously in the SNF PPS update notice for FY 2007 (71 FR 43172, July 31, 2006); however, those comments, which offered specific suggestions about the design and conduct of the demonstration, are beyond the scope of this rulemaking.

8. Miscellaneous Technical Corrections and Clarifications

In the FY 2009 proposed rule, we set forth certain technical corrections and clarifications, as discussed below.

a. Bad Debt Payments

In the SNF PPS proposed rule for FY 2009 (73 FR 25932, May 7, 2008), we proposed to make a technical revision in the regulations text at § 413.335(b), in order to reflect our longstanding policy regarding Medicare bad debt payments to SNFs.

We received no comments on this aspect of the proposed rule. We are proceeding with this technical correction as proposed with no change.

b. Additional Clarifications

In the FY 2009 proposed rule (73 FR 25932 through 25933, May 7, 2008), we also discussed the following clarifications in two other areas:

- The circumstances under which a SNF is paid at the ''default rate,'' a reduced payment made in lieu of the full SNF PPS rate that would have been payable had the SNF's resident been assessed in a timely manner; and
- The role of rehabilitation services evaluations in SNFs.

The comments that we received, and our responses, are as follows:

Comment: One commenter asserted that in some of the circumstances that we specified as triggering payment of the default rate (for example, when the SNF does not receive timely notification of a Medicare Secondary Payer denial, or of the revocation of a payment ban), the SNF is not at fault and, accordingly, should be permitted to complete an assessment retroactively.

Response: We note that SNFs are not permitted to backdate any portion of the medical record, including the resident assessment. It is for precisely this reason that we strongly encourage SNFs to follow the Medicare-required assessment schedule in any instance where there is even a possibility of Medicare payment; otherwise, the SNF risks being paid at the default rate. We also note that if a SNF has performed an ''OBRA'' assessment (that is, one conducted to meet the basic assessment schedule prescribed in the nursing home reform provisions of OBRA 1987 rather than the supplemental SNF PPS schedule for Medicare-required assessments) during this period which also happens to fall within the window for a Medicare-required assessment, the OBRA assessment can be used for Medicare payment purposes as well.

Comment: One commenter was concerned that CMS did not allow the billing of the default code when a SNF PPS assessment is inadvertently omitted, referring to an instruction in the Resident Assessment Instrument (RAI) regarding the use of the default code when an assessment was not completed. The commenter also asked whether there is a time limit on the filing of a late assessment.

Response: To bill for Part A services provided under the SNF PPS, the SNF is required to submit a HIPPS rate code and the assessment reference date (ARD) associated with the applicable RAI on the claim, except as provided in the five specific circumstances described in the FY 2009 proposed rule (73 FR 25933), under which payment is available at the default rate. In order to obtain the HIPPS code, the SNF is required to submit the RAI to the State RAI database, and to receive a Final Validation Report prior to filing the claim in order to establish the correct RUG code for billing purposes. For these reasons, the SNF cannot simply bill the default code if it misses a Medicare-required assessment. Instead, we have always provided for payment at the

default rate for what is referred to as a ''late assessment.'' A late assessment occurs when the ARD for the Medicare-required assessment is set outside of the prescribed assessment window. In order to bill the default code, the SNF must prepare a late assessment that is completed prior to the date of discharge from Medicare Part A. If no assessment is completed prior to discharge from Medicare Part A, no payment is made. The statement in the RAI that the commenter cited is more fully described in the situations set forth in Chapter 2, Section 2.9 of the RAI. We are currently in the process of revising the RAI instructions to ensure greater clarity.

Comment: One commenter expressed the belief that CMS was further penalizing SNFs for not completing Medicare-required assessments by having the SNF absorb all of the liability for SNF-level care provided to their beneficiaries, by limiting the use of the default code (outside of a late assessment) to the following situations:

- When the stay is less than 8 days within a spell of illness (that is, benefit period);
- The SNF is notified on an untimely basis or is unaware of a Medicare Secondary Payer denial;
- The SNF is notified on an untimely basis of the revocation of a payment ban;
- The beneficiary requests a demand bill; or,
- The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage program.

Response: As we stated in the FY 2009 proposed rule (73 FR 25933), program instructions have been issued through the Provider Reimbursement Manual and the Medicare Claims Processing Manual since the inception of the SNF PPS to allow for the use of the default code in the first four situations described above. The proposed rule simply reiterated these policies in order to remind providers of the procedures on the use of the default code in circumstances other than that of a late assessment. We also took this opportunity to clarify that in those situations where a beneficiary was enrolled in a Medicare Advantage (MA) plan and the SNF was subsequently unaware or notified untimely of a beneficiary's disenrollment from an MA plan, the SNF could use the default code to receive payment for services provided.

Comment: One commenter asked that CMS explain why the default code is allowed to be billed when the stay is less than 8 days within a spell of illness (that is, benefit period) when the beneficiary dies or is discharged.

Response: In those situations where the beneficiary dies or is discharged before day 8 of the covered stay upon initial admission to the SNF following the qualifying three-day hospital stay, CMS has instructed SNFs either to complete an assessment to the best of their ability or to submit a claim using the default rate without the necessity of completing an assessment. The decision to allow for payment at the default rate without the completion of an assessment in this case is predicated on the administrative presumption that the beneficiary meets the SNF level of care requirements through the ARD on the Medicare-required 5-day assessment completed upon initial admission following the qualifying three-day hospital stay. The ARD on a Medicare-required 5-day assessment must be set no later than the eighth day of the covered stay.

Comment: A commenter asked that CMS explain why the default code is allowed to be billed when a beneficiary requests that the SNF submit a demand bill.

Response: As stated above, a HIPPS rate code must be present on the claim in order to receive payment under the SNF PPS. However, a SNF is not required to assess a beneficiary to classify that beneficiary into a RUG using the RAI when the SNF determines that the care is noncovered, or where the beneficiary has not met the technical requirements for a SNF stay. Therefore, a SNF may submit a claim using the default code in order to ensure payment in the event that the SNF's determination of noncoverage is subsequently reversed.

Comment: A commenter requested clarification of the term ''most recent clinical assessment,'' in the context of current program instructions that provide for payment at other than the default rate when the SNF is notified untimely or is unaware of a Medicare secondary payer (MSP) denial or the revocation of a payment ban. The commenter also requested guidance on how to handle an untimely notification of a beneficiary's disenrollment from a Medicare Advantage program. The commenter additionally requested clear instructions on the proper way to use clinical assessments in place of Medicare PPS assessments when the ''most recent clinical assessment'' does not accurately represent the level of resources currently being utilized by the beneficiary (including the number of days that can be billed using the ''most recent clinical assessment'').

Response: A SNF that finds itself in these circumstances had no reason to expect payment under the SNF PPS and is generally not required to perform Medicare-required assessments; as a result, the SNF is left without a HIPPS code that would be required to bill for payment under the SNF PPS. Instructions relating to MSP denials in the Provider Reimbursement Manual and revocation of payment bans in the Medicare Claims Processing Manual have allowed SNFs to use the most recent assessment that was completed in accordance with the schedule outlined in 42 CFR 483.20(b)(4) in order to receive payment under the Medicare program. However, the commenter makes a valid point in asking whether it is proper to submit an MDS that does not reflect the level of resources currently being utilized by beneficiaries.

After careful consideration of this question, we are revising our policy to allow the 14-day assessment required under 42 CFR 483.20(b)(4) to be used to bill for all days of covered care associated with a Medicare-required 5-day and 14-day assessment. This is the case even if the beneficiary is no longer receiving therapy services that were identified under the most recent clinical assessment. For covered days associated with the Medicare-required 30-, 60-, or 90-day assessment, the SNF must have an assessment that falls within the window of the Medicare-required assessment in order to receive full payment at the RUG level in which the resident grouped. If no assessment was completed, the SNF may submit a claim requesting payment at the default rate.

This revision recognizes that the level of resources used by a resident changes throughout the stay, and that the 14-day assessment required under § 483.20(b)(4) is less likely to represent the beneficiary's clinical status later in the stay.

We will also apply this policy to situations where the SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage program.

Comment: A commenter asked if guidance involving the ''special payment modifiers'' was forthcoming, noting that it was overdue.

Response: Instructions are currently being revised to provide for the proper use of the ''special payment modifiers.''

Comment: One commenter wanted to know, if a SNF can demonstrate that an ARD was determined on a document other than the MDS, whether the SNF could use such documentation to ''set'' the ARD in order to avoid payment at the default rate.

Response: It is not acceptable to backdate an MDS or to use any documentation other than the MDS itself to establish the ARD.

Comment: In a situation where the SNF receives no payment under Part A because it fails to do Medicare-required assessment before the date of discharge from Medicare Part A, a commenter questioned whether the SNF could bill Medicare Part B for services rendered, as the SNF would receive no Part A reimbursement.

Response: In situations where the SNF fails to assess the beneficiary and fails to issue the proper Notification of Non-Coverage, the SNF is liable for all services normally covered under the Medicare Part A benefit. Since the beneficiary is receiving benefits, the days will be considered Part A days and charged against the beneficiary's benefit period. The SNF may collect any applicable copayment amounts. Services that would have been payable to the SNF as Part A benefits cannot be billed to either the FI or the carrier as Part B services.

Comment: A commenter questioned why CMS was issuing a technical clarification regarding the requirement for a therapy evaluation before therapy minutes can be counted in Section P and Section T of the MDS. The commenter was concerned that while the proposed change appears to be consistent with the practices of its therapy members, questions have been raised as to whether in making this clarification, CMS inadvertently may be changing the instructions for Subpart T as they relate to projected therapy services.

Response: Due to several recent inquiries on the need for therapy evaluations, we sought to ensure that SNFs and other non-therapy ancillary providers are clear as to the requirement for a therapy evaluation for each discipline before minutes can be included on the MDS on Section P and Section T. Moreover, in the case of Section T, the projection must be based upon the evaluation performed for each discipline that reflects the needs of the patient.

IV. The Skilled Nursing Facility Market Basket Index

Section 1888(e)(5)(A) of the Act requires us to establish a SNF market basket index (input price index) that reflects changes over time in the prices of an appropriate mix of goods and services included in the SNF PPS. In the FY 2009 proposed rule, we stated that the proposed rule incorporated the latest available projections of the SNF market basket index. In this final rule, we are updating projections based on the latest available projections at the time of publication. Accordingly, we have developed a SNF market basket index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses.

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

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

	Relative importance, labor-related, FY 2008 (04 index) 07:2 forecast	Relative importance, labor-related, FY 2009 (04 index) 08:2 forecast
Wages and salaries	51.218	51.003
Employee benefits	11.720	11.547
Nonmedical professional fees	1.333	1.331
Labor-intensive services	3.456	3.434
Capital-related (.391)	2.522	2.468
Total	70.249	69.783

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

A. Use of the Skilled Nursing Facility Market Basket Percentage

Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage as the percentage change in the SNF market basket index from the average of the previous FY to the average of the current FY. For the Federal rates established in this final rule, we use the percentage increase in the SNF market basket index to compute the update factor for FY 2009. We use the Global Insight, Inc. (GII, formerly DRI–WEFA), 2nd quarter 2008 (2008q2) forecasted percentage increase in the FY 2004-based SNF market basket index for routine, ancillary, and capital-related expenses, described in the previous section, to compute the update factor. Finally, as discussed previously in section I.A. of this final rule, we no longer compute update factors to adjust a facility-specific portion of the SNF PPS rates because the initial three-phase transition period from facility-specific to full Federal rates that started with cost reporting periods beginning in July 1998 has expired.

B. Market Basket Forecast Error Adjustment

As discussed in the FY 2004 supplemental proposed rule (68 FR 34768, June 10, 2003) and finalized in the FY 2004 final rule (68 FR 46067, August 4, 2003), regulations at § 413.337(d)(2) provide for an adjustment to account for market basket forecast error. The initial adjustment applied to the update of the FY 2003 rate for FY 2004, and took into account the cumulative forecast error for the period from FY 2000 through FY 2002. Subsequent adjustments in succeeding FYs take into account the forecast error from the most recently available FY for which there is final data, and apply whenever the difference between the forecasted and actual change in the market basket exceeds a specified threshold. We originally used a 0.25 percentage point threshold for this purpose; however, for the reasons specified in the FY 2008 SNF PPS final rule (72 FR 43425, August 3, 2007), we adopted a 0.5 percentage point threshold effective with FY 2008. As discussed previously in section I.F.2. of this final rule, as the difference between the estimated and actual amounts of increase in the market basket index for FY 2007 (the most recently available FY for which there is final data) does not exceed the 0.5 percentage point threshold, the payment rates for FY 2009 do not include a forecast error adjustment.

The following is a specific comment that we received on the market basket forecast error adjustment, and our response:

Comment: A few commenters suggested that CMS apply a cumulative forecast error to account for all of the variations in the market basket forecasts since FY 2004 (that is, as of when CMS implemented the market basket forecast error correction policy.)

Response: For FY 2004, CMS applied a one-time, cumulative forecast error correction of 3.26 percent (68 FR 46036). Since that time, the forecast errors have been relatively small and clustered near zero. We believe the forecast error correction should be applied only when the forecast error in any given year reflects a percentage such that the SNF PPS base payment rate does not adequately reflect the historical price changes faced by SNFs. We continue to believe that the forecast error adjustment mechanism should appropriately be reserved for the type of major, unexpected change that initially gave rise to this policy, rather than the minor variances that are a routine and inherent aspect of this type of statistical measurement.

C. Federal Rate Update Factor

Section 1888(e)(4)(E)(ii)(IV) of the Act requires that the update factor used to establish the FY 2009 Federal rates be at a level equal to the full market basket percentage change. Accordingly, to establish the update factor, we determined the total growth from the average market basket level for the period of October 1, 2007 through September 30, 2008 to the average market basket level for the period of October 1, 2008 through September 30, 2009. Using this process, the market basket update factor for FY 2009 SNF Federal rates is 3.4 percent. We used this update factor to compute the Federal portion of the SNF PPS rate shown in Tables 2 and 3.

We received one comment expressing support for our proposed full market basket increase for FY 2009. We thank the commenter and again note that the final update factor for FY 2009 is 3.4 percent.

V. Consolidated Billing

Section 4432(b) of the BBA established a consolidated billing requirement that places with the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive, except for a small number of services that the statute specifically identifies as being excluded from this provision. Section 103 of the BBRA amended this provision by further excluding a number of individual ''high-cost, low-probability'' services, identified by the Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy and its administration, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA amendment in greater detail in the FY 2001 SNF PPS proposed rule (65 FR 19231 through 19232, April 10, 2000), and the FY 2001 SNF PPS final rule (65 FR 46790 through 46795, July 31, 2000), as well as in Program Memorandum AB–00–18 (Change Request #1070), issued March 2000, which is available online at *http://www.cms.hhs.gov/transmittals/downloads/ab001860.pdf*.

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

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

To date, the Congress has enacted no further legislation affecting the consolidated billing provision. However, as noted above and explained in the FY 2001 SNF PPS proposed rule (65 FR 19232, April 10, 2000), the amendments enacted in section 103 of the BBRA not only identified for exclusion from this provision a number of particular service codes within four specified categories (that is, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices), but also gave the Secretary ''* * * the authority to designate additional, individual services for exclusion within each of the specified service categories.'' In the FY 2001 SNF PPS proposed rule, we also noted that the BBRA Conference report (H.R. Rep. No. 106–479 at 854 (1999) (Conf. Rep.)) characterizes the individual services that this legislation targets for exclusion as, ''* * * high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment [SNFs] receive under the prospective payment system* * *.'' According to the conferees, section 103(a) ''* * * is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs * * * For example, * * * chemotherapy drugs [that] are not typically administered in a SNF, or are exceptionally expensive, or are given as infusions, thus requiring special staff expertise to administer.'' By contrast, we noted that the Congress declined to designate for exclusion any of the remaining services within those four categories (thus leaving all of those services subject to SNF consolidated billing), because they ''* * * are relatively inexpensive and are administered routinely in SNFs''.

As we further explained in the FY 2001 SNF PPS final rule (65 FR 46790, July 31, 2000), any additional service codes that we might designate for exclusion under our discretionary authority must meet the same criteria that the Congress used in identifying the original codes excluded from consolidated billing under section 103(a) of the BBRA: Our longstanding policy is that they must fall within one of the four service categories specified in the BBRA, and they also must meet the same standards of high cost and low probability in the SNF setting. Accordingly, we characterized this statutory authority to identify additional service codes for exclusion '' * * * as essentially affording the flexibility to revise the list of excluded codes in response to changes of major significance that may occur over time (for example, the development of new medical technologies or other advances in the state of medical practice)'' (65 FR 46791). In the FY 2009 proposed rule (73 FR 25934, May 7, 2008), we specifically invited public comments identifying codes in any of these four service categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) representing recent medical advances that might meet our criteria for exclusion from SNF consolidated billing.

Specific comments on this issue and our responses to those comments are as follows:

Comment: Several commenters submitted additional chemotherapy codes that they recommended for exclusion from consolidated billing.

Response: We note that the law (at section 1888(e)(2)(A)(iii)(II) of the Act) describes the chemotherapy code ranges that the BBRA identified for exclusion in terms of the version of the HCPCS codes that was in existence ''as of July 1, 1999.'' In the SNF PPS final rule for FY 2006 (70 FR 45048, August 4, 2005), we reiterated our belief that the authority granted by the BBRA to identify additional codes for exclusion within this category was ''* * * essentially affording the flexibility to revise the list of excluded codes in response to changes of major significance *that may occur over time* (for example, the development of new medical technologies or other advances in the state of medical practice)'' (emphasis added). Accordingly, we view this discretionary authority as applying *only* to codes that were created subsequent to that point, and not to those codes that were in existence as of July 1, 1999.

A review of the particular chemotherapy codes that commenters submitted in response to the proposed rule's solicitation for comment revealed that many of them were codes that had already been submitted for consideration in previous years, and that we had previously decided not to exclude. Other codes that commenters submitted were themselves already in existence as of July 1, 1999, but did not fall within the specific code ranges statutorily designated for exclusion in the BBRA. As the statute does not specifically exclude these already-existing codes, we are not adding them to the exclusion list. Most of the other codes submitted represent services that, for various reasons, do not meet the statutory criteria for exclusion. For example, some represent oral medications that can be administered routinely in SNFs and are not reasonably characterized as ''requiring special staff expertise to administer.'' Others represent drugs that are administered *in conjunction with* chemotherapy to address side effects such as nausea; however, as such drugs are not in themselves inherently chemotherapeutic in nature, they do not fall within the excluded chemotherapy category designated in the BBRA. Finally, some other codes that were submitted represent services that, in fact, are *already excluded* from consolidated billing under existing instructions.

Comment: Although the FY 2008 SNF PPS proposed rule specifically invited comments on possible exclusions within the particular service categories identified in the BBRA legislation, a number of commenters took this opportunity to reiterate concerns about other aspects of consolidated billing. For example, some commenters reiterated past suggestions that CMS unbundle additional service categories such as specialized wound care procedures (including hyperbaric oxygen therapy) and ambulance services. Another commenter advocated the exclusion of custom fabricated orthotics, stating that in the absence of such an exclusion SNFs might deny access to needed orthotic treatments during the Medicare-covered portion of the stay.

Response: As we have consistently stated (most recently, in the SNF PPS final rule for FY 2008 (72 FR 43431, August 3, 2007)), the BBRA authorizes us to identify additional services for exclusion *only within* those particular service categories—chemotherapy and its administration; radioisotope services; and, customized prosthetic devices (a term which *does not* encompass orthotics)—that it has designated for this purpose, and does not give us the authority to create additional categories of excluded services beyond those specified in the law. Accordingly, as the particular services that these commenters recommended for exclusion do not fall within one of the specific service categories designated for this purpose in the statute itself, these services remain subject to consolidated billing. Regarding the concern about the possibility of a SNF withholding access to a needed item or service during the covered portion of a stay because it is bundled, we note that the requirements for program participation at § 483.25 require participating SNFs to provide the necessary care and services to attain or maintain each resident's ''* * * highest practicable state of physical, mental, and psychosocial well-being * * *.'' Thus, a SNF which delays or denies access to needed care could jeopardize its Medicare program certification.

Comment: One commenter stated that the existing exclusion of certain customized prosthetic devices should be expanded to encompass *all* prosthetics that are designated by an L code.

Response: When the Congress enacted the selective consolidated billing exclusion (by HCPCS code) of certain customized prosthetic devices in section 103 of the BBRA, it specifically identified certain designated L codes for exclusion, while omitting others from the exclusion list. Accordingly, we believe it is clear that the assignment of an L code to a particular prosthetic does not, in itself, automatically serve to qualify that item for exclusion from consolidated billing.

Comment: Several commenters took this opportunity to revisit the existing set of administrative exclusions for certain high-intensity outpatient hospital services under the regulations in 42 CFR § 411.15(p)(3)(iii), and expressed the view that these exclusions should not be limited to only those services that actually occur in the hospital setting, but rather, should also encompass services performed in other, non-hospital settings as well. As examples, they cited services such as magnetic resonance imaging (MRIs) and computerized axial tomography (CT) scans furnished in freestanding imaging centers, and radiation therapy furnished in physicians' clinics or ambulatory care centers, all of which may be less expensive and more accessible in certain particular localities (such as rural areas) than those furnished by hospitals.

Response: We believe the comments that reflect previous suggestions for expanding this administrative exclusion to encompass services furnished in non-hospital settings indicate a continued misunderstanding of the underlying purpose of this provision. As we have consistently noted in response to comments on this issue in previous years (most recently, in the SNF PPS final rule for FY 2008 (72 FR 43431, August 3, 2007), and as also explained in Medicare Learning Network (MLN) Matters article SE0432 (available online at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0432.pdf*), the rationale for establishing this exclusion was to address those types of services that are so far beyond the normal scope of SNF care that they *require the intensity of the hospital setting* in order to be furnished safely and effectively.

Moreover, we note that when the Congress enacted the consolidated billing exclusion for certain RHC and FQHC services in section 410 of the MMA, the accompanying legislative history's description of present law acknowledged that the existing exclusions for exceptionally intensive outpatient services are specifically limited to ''* * * certain outpatient services *from a Medicare-participating hospital or critical access hospital* * * *'' (emphasis added). (See the House Ways and Means Committee Report (H. Rep. No. 108–178, Part 2 at 209), and the Conference Report (H. Conf. Rep. No. 108–391 at 641).) Therefore, these services are excluded from SNF consolidated billing *only* when furnished in the outpatient hospital or CAH setting, and not when furnished in other, freestanding (non-hospital or non-CAH) settings.

Accordingly, establishing a categorical exclusion for these services that would apply irrespective of the setting in which they are furnished would require the enactment of legislation by the Congress to amend the law itself.

Comment: Other commenters reiterated previous suggestions on expanding the existing chemotherapy exclusion to encompass related drugs that are commonly administered in conjunction with chemotherapy in order to treat the side effects of the chemotherapy drugs. The commenters cited examples such as anti-emetics (anti-nausea drugs), erythropoietin (EPO), and Reclast, an osteoporosis drug administered via a once-yearly infusion.

Response: As we have noted previously in this final rule and in response to comments on this issue in the past (most recently, in the SNF PPS final rule for FY 2008 (72 FR 43432, August 3, 2007), the BBRA authorizes us to identify additional services for exclusion *only within* those particular service categories—chemotherapy and its administration; radioisotope services; and, customized prosthetic devices—that it has designated for this purpose, and does not give us the authority to exclude other services which, though they may be related, fall outside of the specified service categories themselves. Thus, while anti-emetics, for example, are commonly administered *in conjunction with* chemotherapy, they are not themselves inherently chemotherapeutic in nature and, consequently, do not fall within the excluded chemotherapy category designated in the BBRA. In the case of Reclast, in the FY 2008 SNF PPS final rule (72 FR 43432, August 3, 2007), we discussed the specific rationale for our decision not to exclude this particular drug, explaining that such an exclusion could not be accomplished administratively under our existing authority. We also explained in the FY 2008 final rule that the existing statutory exclusion from consolidated billing for EPO is effectively defined by the scope of coverage under the Part B EPO benefit at section 1861(s)(2)(O) of the Act; that benefit, in turn, specifically limits EPO coverage to dialysis patients, and does not provide for such coverage in any other, non-dialysis situations such as chemotherapy (72 FR 43432).

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

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

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

We received no comments on this aspect of the proposed rule and are making no changes in this final rule.

VII. Provisions of the Final Rule

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

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

VIII. Collection of Information Requirements

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

IX. Regulatory Impact Analysis

A. Overall Impact

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

Executive Order 12866, as amended, directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This final rule is a major rule, as defined in Title 5, United States Code, section 804(2), because we estimate the FY 2009 impact of the standard update will be to increase payments to SNFS by approximately $780 million dollars. We are also considering this an economically significant rule under Executive Order 12866.

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

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

This final rule updates the SNF PPS rates published in the FY 2008 SNF PPS final rule (72 FR 43412, August 3, 2007) and the associated correction notices published on September 28, 2007 (72 FR 55085) and on November 30, 2007 (72 FR 67652), resulting in a net change in payments of an estimated $780 million for FY 2009. As indicated in Table 12, the effect on facilities will be a net positive impact of 3.4 percent. We note that while all providers will experience

an overall net increase in payments, some providers may experience larger increases than others due to the distributional impact of the FY 2009 wage indexes and the degree of Medicare utilization.

The Department of Health and Human Services generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. While this final rule is considered major, its relative impact on SNFs overall is positive due to the application of the 3.4 percent market basket adjustment. Thus, while the overall impact is positive on the industry as a whole, and on small entities specifically, it is highly variable, with the majority of SNFs having significantly lower Medicare utilization. Therefore, for most facilities, the impact on total facility revenues, considering all payers, should be substantially less than those shown in Table 12. However, in view of the potential economic impact on small entities, we have considered regulatory alternatives.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. This final rule affects small rural hospitals that furnish SNF services under a swing-bed agreement, or that have a hospital-based SNF. We anticipate that the impact on small rural hospitals will be similar to the impact on SNF providers overall.

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

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

B. Anticipated Effects

This final rule sets forth updates of the SNF PPS rates contained in the FY 2008 final rule (72 FR 43412, August 3, 2007) and the associated correction notices published on September 28, 2007 (72 FR 55085) and on November 30, 2008 (72 FR 67652). Based on the above, we estimate the FY 2009 impact would be a net increase of $780 million in payments to SNFs. The impact analysis of this final rule represents the projected effects of the changes in the SNF PPS from FY 2008 to FY 2009. We estimate the effects by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to these changes, and we do not make adjustments for future changes in such variables as days or case-mix.

We note that certain events may combine to limit the scope or accuracy of our impact analysis, because an analysis is future-oriented and, thus, very susceptible to changes in provider behavior related to such events as newly-legislated general Medicare program funding changes by the Congress. Although these changes may not be specific to the SNF PPS, the nature of the Medicare program is that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon SNFs.

In accordance with section 1888(e)(4)(E) of the Act, we update the payment rates for FY 2008 by a factor equal to the full market basket index percentage increase plus the FY 2007 forecast error adjustment to determine the payment rates for FY 2009. The special AIDS add-on established by section 511 of the MMA remains in effect until ''* * * such date as the Secretary certifies that there is an appropriate adjustment in the case mix * * *.'' We have not provided a separate impact analysis for this MMA provision. Our latest estimates indicate that there are less than 2,700 beneficiaries who qualify for the AIDS add-on payment. The impact on Medicare is included in the ''total'' column of Table 12. In updating the rates for FY 2009, we made a number of standard annual revisions and clarifications mentioned elsewhere in this final rule (for example, the update to the wage and market basket indexes used for adjusting the Federal rates). These revisions would increase payments to SNFs by approximately $780 million for FY 2009.

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

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

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

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

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

The fourth column shows the effect of all of the changes on the FY 2009 payments. The market basket increase of 3.4 percentage points is constant for all providers and, though not shown individually, is included in the total column. It is projected that aggregate payments will increase by 3.4 percent, assuming facilities do not change their care delivery and billing practices in response.

As can be seen from this table, the effects of the changes vary by specific types of providers and by location. For example, all facilities experience payment increases, however, some providers (for example, those in the urban Pacific region) show a greater increase. In fact, payment increases for facilities in the urban and rural Pacific areas of the country are the highest for any of the provider categories at 4.9 percent and 4.5 percent, respectively.

TABLE 12—PROJECTED IMPACT TO THE SNF PPS FOR FY 2009

	Number of facilities	Updated wage data (percent)	Total FY 2009 change (percent)
Total	15,373	0.0	3.4
Urban	10,497	0.0	3.4
Rural	4,876	0.0	3.4
Hospital based urban	1,528	−0.1	3.3
Freestanding urban	8,969	0.0	3.4
Hospital based rural	1,154	0.0	3.4
Freestanding rural	3,722	0.0	3.4
Urban by region:			
New England	840	0.2	3.6
Middle Atlantic	1,490	−0.5	2.9
South Atlantic	1,734	−0.3	3.1
East North Central	2,010	−0.5	2.9
East South Central	530	0.0	3.4
West North Central	827	0.6	4.0
West South Central	1,166	0.2	3.6
Mountain	472	0.0	3.4
Pacific	1,420	1.5	4.9
Outlying	8	0.6	4.0
Rural by region:			
New England	150	−1.8	1.6
Middle Atlantic	257	−0.2	3.2
South Atlantic	603	0.0	3.4
East North Central	940	−0.6	2.8
East South Central	552	0.3	3.7
West North Central	1,144	0.5	4.0
West South Central	821	0.5	3.9
Mountain	259	−0.1	3.3
Pacific	148	1.1	4.5
Outlying	2	0.4	3.9
Ownership:			
Government	665	−0.1	3.3
Proprietary	11,286	0.0	3.4
Voluntary	3,422	−0.1	3.3

We received one comment on the regulatory impact section. The comment and our response to the comment is as follows:

Comment: One commenter asserted that the regulatory impact analysis understates the effects of the policy changes associated with the proposed recalibration of the case-mix weights (as discussed in the FY 2009 SNF PPS proposed rule) on state and local governments, as well as small entities. The commenter stated that the loss of tax revenues for State and local governments will be substantial.

Response: As we have decided not to pursue the recalibration of the case-mix weights at this time, SNFs will see an increase of approximately 3.4 percent in their payments. However, should we decide to recalibrate the case-mix weights in the future, we wish to make clear that the law and regulations that govern SNF payment rate updates do not provide for considering indirect effects, induced effects, or ripple effects on economic activity. Moreover, as such secondary effects, if any, would occur within the context of a dynamic, market-based economy, we expect that the market would properly adjust its economic resources in reaction to the appropriately recalibrated SNF PPS payments. For these reasons, we believe that the regulatory impact analysis adequately estimates the proposed rule's economic impact.

C. Alternatives Considered

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

In finalizing our decision on the proposed FY 2009 recalibration of the case-mix adjustment, we reviewed the options considered in the proposed rule and took into consideration comments received during the public comment period as discussed in the preamble.

Although the 2001 data were the best source available at the time the FY 2006 refinements were introduced, the distribution of paid days, a key component in adjusting the RUG–53 case-mix weights, was based solely on estimated utilization. The 2006 data provide a more recent and a more accurate source of RUG–53 utilization based on actual utilization, and are an appropriate source to use for case-mix adjustment. However, in light of the potential ramifications of this proposal

and the complexity of the issues involved, we believe that it would be prudent to take additional time to evaluate the proposal in order to further consider consequences that may result from it. Accordingly, we are not proceeding with the proposed recalibration at this time, pending further analysis. We note that as we continue to evaluate this issue, we fully expect to implement such an adjustment in the future.

D. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 13 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. This table provides our best estimate of the change in Medicare payments under the SNF PPS as a result of the policies in this final rule based on the data for 15,373 SNFs in our database. All expenditures are classified as transfers to Medicare providers (that is, SNFs).

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

[In millions]

Category	Transfers
Annualized Monetized Transfers.	$780 million.
From Whom to Whom?	Federal Government to SNF Medicare Providers.

E. Conclusion

Overall estimated payments for SNFs in FY 2009 are projected to increase by $780 million dollars compared with those in FY 2008. We estimate that SNFs in urban areas will experience a positive change of 3.4 percent in estimated payments compared with FY 2008. We estimate that SNFs in rural areas will experience a 3.4 percent increase in estimated payments compared with FY 2008. Providers in the urban Pacific region and the rural Pacific region show the greatest increases in payments of 4.9 percent and 4.5 percent, respectively.

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

List of Subjects in 42 CFR Part 413

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

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

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

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

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

Subpart J—Prospective Payment for Skilled Nursing Facilities

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

§ 413.333 Definitions.

* * * * *

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

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

§ 413.335 [Amended]

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

§ 413.335 Basis of payment.

* * * * *

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

(2) In addition to the Federal per diem payment amounts, SNFs receive payment for bad debts of Medicare beneficiaries, as specified in § 413.89 of this part.

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

Dated: July 18, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: July 31, 2008.

Michael O. Leavitt,

Secretary.

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

Addendum—FY 2009 CBSA Wage Index Tables

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

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

CBSA code	Urban area (constituent counties)	Wage index
10180	Abilene, TX	0.8097
	Callahan County, TX	
	Jones County, TX	
	Taylor County, TX	
10380	Aguadilla-Isabela-San Sebastián, PR	0.3399
	Aguada Municipio, PR	
	Aguadilla Municipio, PR	
	Añasco Municipio, PR	
	Isabela Municipio, PR	
	Lares Municipio, PR	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Moca Municipio, PR	
	Rincón Municipio, PR	
	San Sebastián Municipio, PR	
10420	Akron, OH	0.8917
	Portage County, OH	
	Summit County, OH	
10500	Albany, GA	0.8703
	Baker County, GA	
	Dougherty County, GA	
	Lee County, GA	
	Terrell County, GA	
	Worth County, GA	
10580	Albany-Schenectady-Troy, NY	0.8707
	Albany County, NY	
	Rensselaer County, NY	
	Saratoga County, NY	
	Schenectady County, NY	
	Schoharie County, NY	
10740	Albuquerque, NM	0.9210
	Bernalillo County, NM	
	Sandoval County, NM	
	Torrance County, NM	
	Valencia County, NM	
10780	Alexandria, LA	0.8130
	Grant Parish, LA	
	Rapides Parish, LA	
10900	Allentown-Bethlehem-Easton, PA-NJ	0.9499
	Warren County, NJ	
	Carbon County, PA	
	Lehigh County, PA	
	Northampton County, PA	
11020	Altoona, PA	0.8521
	Blair County, PA	
11100	Amarillo, TX	0.8927
	Armstrong County, TX	
	Carson County, TX	
	Potter County, TX	
	Randall County, TX	
11180	Ames, IA	0.9487
	Story County, IA	
11260	Anchorage, AK	1.1931
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	
11300	Anderson, IN	0.8760
	Madison County, IN	
11340	Anderson, SC	0.9570
	Anderson County, SC	
11460	Ann Arbor, MI	1.0445
	Washtenaw County, MI	
11500	Anniston-Oxford, AL	0.7927
	Calhoun County, AL	
11540	Appleton, WI	0.9440
	Calumet County, WI	
	Outagamie County, WI	
11700	Asheville, NC	0.9142
	Buncombe County, NC	
	Haywood County, NC	
	Henderson County, NC	
	Madison County, NC	
12020	Athens-Clarke County, GA	0.9591
	Clarke County, GA	
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	
12060	Atlanta-Sandy Springs-Marietta, GA	0.9754
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	
12100	Atlantic City-Hammonton, NJ	1.1973
	Atlantic County, NJ	
12220	Auburn-Opelika, AL	0.7544
	Lee County, AL	
12260	Augusta-Richmond County, GA-SC	0.9615
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	
12420	Austin-Round Rock, TX	0.9536
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
	Williamson County, TX	
12540	Bakersfield, CA	1.1189
	Kern County, CA	
12580	Baltimore-Towson, MD	1.0055
	Anne Arundel County, MD	
	Baltimore County, MD	
	Carroll County, MD	
	Harford County, MD	
	Howard County, MD	
	Queen Anne's County, MD	
	Baltimore City, MD	
12620	Bangor, ME	1.0174
	Penobscot County, ME	
12700	Barnstable Town, MA	1.2643
	Barnstable County, MA	
12940	Baton Rouge, LA	0.8163
	Ascension Parish, LA	
	East Baton Rouge Parish, LA	
	East Feliciana Parish, LA	
	Iberville Parish, LA	
	Livingston Parish, LA	
	Pointe Coupee Parish, LA	
	St. Helena Parish, LA	
	West Baton Rouge Parish, LA	
	West Feliciana Parish, LA	
12980	Battle Creek, MI	1.0120
	Calhoun County, MI	
13020	Bay City, MI	0.9248
	Bay County, MI	
13140	Beaumont-Port Arthur, TX	0.8479
	Hardin County, TX	
	Jefferson County, TX	
	Orange County, TX	
13380	Bellingham, WA	1.1640
	Whatcom County, WA	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
13460	Bend, OR	1.1375
	Deschutes County, OR	
13644	Bethesda-Frederick-Gaithersburg, MD	1.0548
	Frederick County, MD	
	Montgomery County, MD	
13740	Billings, MT	0.8805
	Carbon County, MT	
	Yellowstone County, MT	
13780	Binghamton, NY	0.8574
	Broome County, NY	
	Tioga County, NY	
13820	Birmingham-Hoover, AL	0.8792
	Bibb County, AL	
	Blount County, AL	
	Chilton County, AL	
	Jefferson County, AL	
	St. Clair County, AL	
	Shelby County, AL	
	Walker County, AL	
13900	Bismarck, ND	0.7148
	Burleigh County, ND	
	Morton County, ND	
13980	Blacksburg-Christiansburg-Radford, VA	0.8155
	Giles County, VA	
	Montgomery County, VA	
	Pulaski County, VA	
	Radford City, VA	
14020	Bloomington, IN	0.8979
	Greene County, IN	
	Monroe County, IN	
	Owen County, IN	
14060	Bloomington-Normal, IL	0.9323
	McLean County, IL	
14260	Boise City-Nampa, ID	0.9268
	Ada County, ID	
	Boise County, ID	
	Canyon County, ID	
	Gem County, ID	
	Owyhee County, ID	
14484	Boston-Quincy, MA	1.1897
	Norfolk County, MA	
	Plymouth County, MA	
	Suffolk County, MA	
14500	Boulder, CO	1.0302
	Boulder County, CO	
14540	Bowling Green, KY	0.8388
	Edmonson County, KY	
	Warren County, KY	
14600	Bradenton-Sarasota-Venice, FL	0.9900
	Manatee County, FL	
	Sarasota County, FL	
14740	Bremerton-Silverdale, WA	1.0770
	Kitsap County, WA	
14860	Bridgeport-Stamford-Norwalk, CT	1.2868
	Fairfield County, CT	
15180	Brownsville-Harlingen, TX	0.8916
	Cameron County, TX	
15260	Brunswick, GA	0.9567
	Brantley County, GA	
	Glynn County, GA	
	McIntosh County, GA	
15380	Buffalo-Niagara Falls, NY	0.9537
	Erie County, NY	
	Niagara County, NY	
15500	Burlington, NC	0.8736
	Alamance County, NC	
15540	Burlington-South Burlington, VT	0.9254
	Chittenden County, VT	
	Franklin County, VT	
	Grand Isle County, VT	
15764	Cambridge-Newton-Framingham, MA	1.1086
	Middlesex County, MA	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
15804	Camden, NJ	1.0346
	Burlington County, NJ	
	Camden County, NJ	
	Gloucester County, NJ	
15940	Canton-Massillon, OH	0.8841
	Carroll County, OH	
	Stark County, OH	
15980	Cape Coral-Fort Myers, FL	0.9396
	Lee County, FL	
16180	Carson City, NV	1.0128
	Carson City, NV	
16220	Casper, WY	0.9579
	Natrona County, WY	
16300	Cedar Rapids, IA	0.8919
	Benton County, IA	
	Jones County, IA	
	Linn County, IA	
16580	Champaign-Urbana, IL	0.9461
	Champaign County, IL	
	Ford County, IL	
	Piatt County, IL	
16620	Charleston, WV	0.8275
	Boone County, WV	
	Clay County, WV	
	Kanawha County, WV	
	Lincoln County, WV	
	Putnam County, WV	
16700	Charleston-North Charleston-Summerville, SC	0.9209
	Berkeley County, SC	
	Charleston County, SC	
	Dorchester County, SC	
16740	Charlotte-Gastonia-Concord, NC-SC	0.9595
	Anson County, NC	
	Cabarrus County, NC	
	Gaston County, NC	
	Mecklenburg County, NC	
	Union County, NC	
	York County, SC	
16820	Charlottesville, VA	0.9816
	Albemarle County, VA	
	Fluvanna County, VA	
	Greene County, VA	
	Nelson County, VA	
	Charlottesville City, VA	
16860	Chattanooga, TN-GA	0.8878
	Catoosa County, GA	
	Dade County, GA	
	Walker County, GA	
	Hamilton County, TN	
	Marion County, TN	
	Sequatchie County, TN	
16940	Cheyenne, WY	0.9276
	Laramie County, WY	
16974	Chicago-Naperville-Joliet, IL	1.0399
	Cook County, IL	
	DeKalb County, IL	
	DuPage County, IL	
	Grundy County, IL	
	Kane County, IL	
	Kendall County, IL	
	McHenry County, IL	
	Will County, IL	
17020	Chico, CA	1.0897
	Butte County, CA	
17140	Cincinnati-Middletown, OH-KY-IN	0.9687
	Dearborn County, IN	
	Franklin County, IN	
	Ohio County, IN	
	Boone County, KY	
	Bracken County, KY	
	Campbell County, KY	
	Gallatin County, KY	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Grant County, KY	
	Kenton County, KY	
	Pendleton County, KY	
	Brown County, OH	
	Butler County, OH	
	Clermont County, OH	
	Hamilton County, OH	
	Warren County, OH	
17300	Clarksville, TN-KY	0.8298
	Christian County, KY	
	Trigg County, KY	
	Montgomery County, TN	
	Stewart County, TN	
17420	Cleveland, TN	0.8010
	Bradley County, TN	
	Polk County, TN	
17460	Cleveland-Elyria-Mentor, OH	0.9241
	Cuyahoga County, OH	
	Geauga County, OH	
	Lake County, OH	
	Lorain County, OH	
	Medina County, OH	
17660	Coeur d'Alene, ID	0.9322
	Kootenai County, ID	
17780	College Station-Bryan, TX	0.9346
	Brazos County, TX	
	Burleson County, TX	
	Robertson County, TX	
17820	Colorado Springs, CO	0.9977
	El Paso County, CO	
	Teller County, CO	
17860	Columbia, MO	0.8540
	Boone County, MO	
	Howard County, MO	
17900	Columbia, SC	0.8933
	Calhoun County, SC	
	Fairfield County, SC	
	Kershaw County, SC	
	Lexington County, SC	
	Richland County, SC	
	Saluda County, SC	
17980	Columbus, GA-AL	0.8739
	Russell County, AL	
	Chattahoochee County, GA	
	Harris County, GA	
	Marion County, GA	
	Muscogee County, GA	
18020	Columbus, IN	0.9739
	Bartholomew County, IN	
18140	Columbus, OH	0.9943
	Delaware County, OH	
	Fairfield County, OH	
	Franklin County, OH	
	Licking County, OH	
	Madison County, OH	
	Morrow County, OH	
	Pickaway County, OH	
	Union County, OH	
18580	Corpus Christi, TX	0.8598
	Aransas County, TX	
	Nueces County, TX	
	San Patricio County, TX	
18700	Corvallis, OR	1.1304
	Benton County, OR	
19060	Cumberland, MD-WV	0.7816
	Allegany County, MD	
	Mineral County, WV	
19124	Dallas-Plano-Irving, TX	0.9945
	Collin County, TX	
	Dallas County, TX	
	Delta County, TX	
	Denton County, TX	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Ellis County, TX	
	Hunt County, TX	
	Kaufman County, TX	
	Rockwall County, TX	
19140	Dalton, GA	0.8705
	Murray County, GA	
	Whitfield County, GA	
19180	Danville, IL	0.9374
	Vermilion County, IL	
19260	Danville, VA	0.8395
	Pittsylvania County, VA	
	Danville City, VA	
19340	Davenport-Moline-Rock Island, IA-IL	0.8435
	Henry County, IL	
	Mercer County, IL	
	Rock Island County, IL	
	Scott County, IA	
19380	Dayton, OH	0.9203
	Greene County, OH	
	Miami County, OH	
	Montgomery County, OH	
	Preble County, OH	
19460	Decatur, AL	0.7803
	Lawrence County, AL	
	Morgan County, AL	
19500	Decatur, IL	0.8145
	Macon County, IL	
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.8890
	Volusia County, FL	
19740	Denver-Aurora, CO	1.0818
	Adams County, CO	
	Arapahoe County, CO	
	Broomfield County, CO	
	Clear Creek County, CO	
	Denver County, CO	
	Douglas County, CO	
	Elbert County, CO	
	Gilpin County, CO	
	Jefferson County, CO	
	Park County, CO	
19780	Des Moines-West Des Moines, IA	0.9535
	Dallas County, IA	
	Guthrie County, IA	
	Madison County, IA	
	Polk County, IA	
	Warren County, IA	
19804	Detroit-Livonia-Dearborn, MI	0.9958
	Wayne County, MI	
20020	Dothan, AL	0.7613
	Geneva County, AL	
	Henry County, AL	
	Houston County, AL	
20100	Dover, DE	1.0325
	Kent County, DE	
20220	Dubuque, IA	0.8380
	Dubuque County, IA	
20260	Duluth, MN-WI	1.0363
	Carlton County, MN	
	St. Louis County, MN	
	Douglas County, WI	
20500	Durham, NC	0.9732
	Chatham County, NC	
	Durham County, NC	
	Orange County, NC	
	Person County, NC	
20740	Eau Claire, WI	0.9668
	Chippewa County, WI	
	Eau Claire County, WI	
20764	Edison-New Brunswick, NJ	1.1283
	Middlesex County, NJ	
	Monmouth County, NJ	
	Ocean County, NJ	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Somerset County, NJ	
20940	El Centro, CA	0.8746
	Imperial County, CA	
21060	Elizabethtown, KY	0.8525
	Hardin County, KY	
	Larue County, KY	
21140	Elkhart-Goshen, IN	0.9568
	Elkhart County, IN	
21300	Elmira, NY	0.8247
	Chemung County, NY	
21340	El Paso, TX	0.8694
	El Paso County, TX	
21500	Erie, PA	0.8713
	Erie County, PA	
21660	Eugene-Springfield, OR	1.1061
	Lane County, OR	
21780	Evansville, IN-KY	0.8690
	Gibson County, IN	
	Posey County, IN	
	Vanderburgh County, IN	
	Warrick County, IN	
	Henderson County, KY	
	Webster County, KY	
21820	Fairbanks, AK	1.1297
	Fairbanks North Star Borough, AK	
21940	Fajardo, PR	0.4061
	Ceiba Municipio, PR	
	Fajardo Municipio, PR	
	Luquillo Municipio, PR	
22020	Fargo, ND-MN	0.8166
	Cass County, ND	
	Clay County, MN	
22140	Farmington, NM	0.8051
	San Juan County, NM	
22180	Fayetteville, NC	0.9340
	Cumberland County, NC	
	Hoke County, NC	
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8970
	Benton County, AR	
	Madison County, AR	
	Washington County, AR	
	McDonald County, MO	
22380	Flagstaff, AZ	1.1743
	Coconino County, AZ	
22420	Flint, MI	1.1425
	Genesee County, MI	
22500	Florence, SC	0.8130
	Darlington County, SC	
	Florence County, SC	
22520	Florence-Muscle Shoals, AL	0.7871
	Colbert County, AL	
	Lauderdale County, AL	
22540	Fond du Lac, WI	0.9293
	Fond du Lac County, WI	
22660	Fort Collins-Loveland, CO	0.9867
	Larimer County, CO	
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	0.9946
	Broward County, FL	
22900	Fort Smith, AR-OK	0.7697
	Crawford County, AR	
	Franklin County, AR	
	Sebastian County, AR	
	Le Flore County, OK	
	Sequoyah County, OK	
23020	Fort Walton Beach-Crestview-Destin, FL	0.8769
	Okaloosa County, FL	
23060	Fort Wayne, IN	0.9176
	Allen County, IN	
	Wells County, IN	
	Whitley County, IN	
23104	Fort Worth-Arlington, TX	0.9709
	Johnson County, TX	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Parker County, TX	
	Tarrant County, TX	
	Wise County, TX	
23420	Fresno, CA	1.1009
	Fresno County, CA	
23460	Gadsden, AL	0.7983
	Etowah County, AL	
23540	Gainesville, FL	0.9312
	Alachua County, FL	
	Gilchrist County, FL	
23580	Gainesville, GA	0.9109
	Hall County, GA	
23844	Gary, IN	0.9250
	Jasper County, IN	
	Lake County, IN	
	Newton County, IN	
	Porter County, IN	
24020	Glens Falls, NY	0.8473
	Warren County, NY	
	Washington County, NY	
24140	Goldsboro, NC	0.9143
	Wayne County, NC	
24220	Grand Forks, ND-MN	0.7565
	Polk County, MN	
	Grand Forks County, ND	
24300	Grand Junction, CO	0.9812
	Mesa County, CO	
24340	Grand Rapids-Wyoming, MI	0.9184
	Barry County, MI	
	Ionia County, MI	
	Kent County, MI	
	Newaygo County, MI	
24500	Great Falls, MT	0.8784
	Cascade County, MT	
24540	Greeley, CO	0.9684
	Weld County, CO	
24580	Green Bay, WI	0.9709
	Brown County, WI	
	Kewaunee County, WI	
	Oconto County, WI	
24660	Greensboro-High Point, NC	0.9011
	Guilford County, NC	
	Randolph County, NC	
	Rockingham County, NC	
24780	Greenville, NC	0.9448
	Greene County, NC	
	Pitt County, NC	
24860	Greenville-Mauldin-Easley, SC	0.9961
	Greenville County, SC	
	Laurens County, SC	
	Pickens County, SC	
25020	Guayama, PR	0.3249
	Arroyo Municipio, PR	
	Guayama Municipio, PR	
	Patillas Municipio, PR	
25060	Gulfport-Biloxi, MS	0.9029
	Hancock County, MS	
	Harrison County, MS	
	Stone County, MS	
25180	Hagerstown-Martinsburg, MD-WV	0.8997
	Washington County, MD	
	Berkeley County, WV	
	Morgan County, WV	
25260	Hanford-Corcoran, CA	1.0870
	Kings County, CA	
25420	Harrisburg-Carlisle, PA	0.9153
	Cumberland County, PA	
	Dauphin County, PA	
	Perry County, PA	
25500	Harrisonburg, VA	0.8894
	Rockingham County, VA	
	Harrisonburg City, VA	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
25540	Hartford-West Hartford-East Hartford, CT	1.1069
	Hartford County, CT	
	Middlesex County, CT	
	Tolland County, CT	
25620	Hattiesburg, MS	0.7337
	Forrest County, MS	
	Lamar County, MS	
	Perry County, MS	
25860	Hickory-Lenoir-Morganton, NC	0.8976
	Alexander County, NC	
	Burke County, NC	
	Caldwell County, NC	
	Catawba County, NC	
25980	Hinesville-Fort Stewart, GA [1]	0.9110
	Liberty County, GA	
	Long County, GA	
26100	Holland-Grand Haven, MI	0.9008
	Ottawa County, MI	
26180	Honolulu, HI	1.1811
	Honolulu County, HI	
26300	Hot Springs, AR	0.9113
	Garland County, AR	
26380	Houma-Bayou Cane-Thibodaux, LA	0.7758
	Lafourche Parish, LA	
	Terrebonne Parish, LA	
26420	Houston-Sugar Land-Baytown, TX	0.9838
	Austin County, TX	
	Brazoria County, TX	
	Chambers County, TX	
	Fort Bend County, TX	
	Galveston County, TX	
	Harris County, TX	
	Liberty County, TX	
	Montgomery County, TX	
	San Jacinto County, TX	
	Waller County, TX	
26580	Huntington-Ashland, WV-KY-OH	0.9254
	Boyd County, KY	
	Greenup County, KY	
	Lawrence County, OH	
	Cabell County, WV	
	Wayne County, WV	
26620	Huntsville, AL	0.9082
	Limestone County, AL	
	Madison County, AL	
26820	Idaho Falls, ID	0.9080
	Bonneville County, ID	
	Jefferson County, ID	
26900	Indianapolis-Carmel, IN	0.9908
	Boone County, IN	
	Brown County, IN	
	Hamilton County, IN	
	Hancock County, IN	
	Hendricks County, IN	
	Johnson County, IN	
	Marion County, IN	
	Morgan County, IN	
	Putnam County, IN	
	Shelby County, IN	
26980	Iowa City, IA	0.9483
	Johnson County, IA	
	Washington County, IA	
27060	Ithaca, NY	0.9614
	Tompkins County, NY	
27100	Jackson, MI	0.9309
	Jackson County, MI	
27140	Jackson, MS	0.8067
	Copiah County, MS	
	Hinds County, MS	
	Madison County, MS	
	Rankin County, MS	
	Simpson County, MS	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
27180	Jackson, TN	0.8523
	Chester County, TN	
	Madison County, TN	
27260	Jacksonville, FL	0.8999
	Baker County, FL	
	Clay County, FL	
	Duval County, FL	
	Nassau County, FL	
	St. Johns County, FL	
27340	Jacksonville, NC	0.8177
	Onslow County, NC	
27500	Janesville, WI	0.9662
	Rock County, WI	
27620	Jefferson City, MO	0.8775
	Callaway County, MO	
	Cole County, MO	
	Moniteau County, MO	
	Osage County, MO	
27740	Johnson City, TN	0.7971
	Carter County, TN	
	Unicoi County, TN	
	Washington County, TN	
27780	Johnstown, PA	0.7920
	Cambria County, PA	
27860	Jonesboro, AR	0.7916
	Craighead County, AR	
	Poinsett County, AR	
27900	Joplin, MO	0.9406
	Jasper County, MO	
	Newton County, MO	
28020	Kalamazoo-Portage, MI	1.0801
	Kalamazoo County, MI	
	Van Buren County, MI	
28100	Kankakee-Bradley, IL	1.0485
	Kankakee County, IL	
28140	Kansas City, MO-KS	0.9610
	Franklin County, KS	
	Johnson County, KS	
	Leavenworth County, KS	
	Linn County, KS	
	Miami County, KS	
	Wyandotte County, KS	
	Bates County, MO	
	Caldwell County, MO	
	Cass County, MO	
	Clay County, MO	
	Clinton County, MO	
	Jackson County, MO	
	Lafayette County, MO	
	Platte County, MO	
	Ray County, MO	
28420	Kennewick-Pasco-Richland, WA	0.9911
	Benton County, WA	
	Franklin County, WA	
28660	Killeen-Temple-Fort Hood, TX	0.8765
	Bell County, TX	
	Coryell County, TX	
	Lampasas County, TX	
28700	Kingsport-Bristol-Bristol, TN-VA	0.7743
	Hawkins County, TN	
	Sullivan County, TN	
	Bristol City, VA	
	Scott County, VA	
	Washington County, VA	
28740	Kingston, NY	0.9375
	Ulster County, NY	
28940	Knoxville, TN	0.7881
	Anderson County, TN	
	Blount County, TN	
	Knox County, TN	
	Loudon County, TN	
	Union County, TN	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9349
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9758
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9221
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8374
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7556
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0389
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	0.9797
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8530
29540	Lancaster, PA Lancaster County, PA	0.9363
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	0.9931
29700	Laredo, TX Webb County, TX	0.8366
29740	Las Cruces, NM Dona Ana County, NM	0.8929
29820	Las Vegas-Paradise, NV Clark County, NV	1.1971
29940	Lawrence, KS Douglas County, KS	0.8343
30020	Lawton, OK Comanche County, OK	0.8211
30140	Lebanon, PA Lebanon County, PA	0.8954
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9465
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9200
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9110
30620	Lima, OH Allen County, OH	0.9427
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9759
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.8672
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8765
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8370

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
31020	Longview, WA	1.1207
	Cowlitz County, WA	
31084	Los Angeles-Long Beach-Santa Ana, CA	1.2208
	Los Angeles County, CA	
31140	Louisville-Jefferson County, KY-IN	0.9249
	Clark County, IN	
	Floyd County, IN	
	Harrison County, IN	
	Washington County, IN	
	Bullitt County, KY	
	Henry County, KY	
	Meade County, KY	
	Nelson County, KY	
	Oldham County, KY	
	Shelby County, KY	
	Spencer County, KY	
	Trimble County, KY	
31180	Lubbock, TX	0.8731
	Crosby County, TX	
	Lubbock County, TX	
31340	Lynchburg, VA	0.8774
	Amherst County, VA	
	Appomattox County, VA	
	Bedford County, VA	
	Campbell County, VA	
	Bedford City, VA	
	Lynchburg City, VA	
31420	Macon, GA	0.9570
	Bibb County, GA	
	Crawford County, GA	
	Jones County, GA	
	Monroe County, GA	
	Twiggs County, GA	
31460	Madera, CA	0.7939
	Madera County, CA	
31540	Madison, WI	1.0967
	Columbia County, WI	
	Dane County, WI	
	Iowa County, WI	
31700	Manchester-Nashua, NH	1.0359
	Hillsborough County, NH	
31900	Mansfield, OH	0.9330
	Richland County, OH	
32420	Mayagüez, PR	0.3940
	Hormigueros Municipio, PR	
	Mayagüez Municipio, PR	
32580	McAllen-Edinburg-Mission, TX	0.9009
	Hidalgo County, TX	
32780	Medford, OR	1.0244
	Jackson County, OR	
32820	Memphis, TN-MS-AR	0.9232
	Crittenden County, AR	
	DeSoto County, MS	
	Marshall County, MS	
	Tate County, MS	
	Tunica County, MS	
	Fayette County, TN	
	Shelby County, TN	
	Tipton County, TN	
32900	Merced, CA	1.2243
	Merced County, CA	
33124	Miami-Miami Beach-Kendall, FL	0.9830
	Miami-Dade County, FL	
33140	Michigan City-La Porte, IN	0.9159
	LaPorte County, IN	
33260	Midland, TX	0.9827
	Midland County, TX	
33340	Milwaukee-Waukesha-West Allis, WI	1.0080
	Milwaukee County, WI	
	Ozaukee County, WI	
	Washington County, WI	
	Waukesha County, WI	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
33460	Minneapolis-St. Paul—Bloomington, MN-WI	1.1150
	Anoka County, MN	
	Carver County, MN	
	Chisago County, MN	
	Dakota County, MN	
	Hennepin County, MN	
	Isanti County, MN	
	Ramsey County, MN	
	Scott County, MN	
	Sherburne County, MN	
	Washington County, MN	
	Wright County, MN	
	Pierce County, WI	
	St. Croix County, WI	
33540	Missoula, MT	0.8973
	Missoula County, MT	
33660	Mobile, AL	0.7908
	Mobile County, AL	
33700	Modesto, CA	1.2194
	Stanislaus County, CA	
33740	Monroe, LA	0.7900
	Ouachita Parish, LA	
	Union Parish, LA	
33780	Monroe, MI	0.8941
	Monroe County, MI	
33860	Montgomery, AL	0.8283
	Autauga County, AL	
	Elmore County, AL	
	Lowndes County, AL	
	Montgomery County, AL	
34060	Morgantown, WV	0.8528
	Monongalia County, WV	
	Preston County, WV	
34100	Morristown, TN	0.7254
	Grainger County, TN	
	Hamblen County, TN	
	Jefferson County, TN	
34580	Mount Vernon-Anacortes, WA	1.0292
	Skagit County, WA	
34620	Muncie, IN	0.8489
	Delaware County, IN	
34740	Muskegon-Norton Shores, MI	1.0055
	Muskegon County, MI	
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	0.8652
	Horry County, SC	
34900	Napa, CA	1.4520
	Napa County, CA	
34940	Naples-Marco Island, FL	0.9672
	Collier County, FL	
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	0.9504
	Cannon County, TN	
	Cheatham County, TN	
	Davidson County, TN	
	Dickson County, TN	
	Hickman County, TN	
	Macon County, TN	
	Robertson County, TN	
	Rutherford County, TN	
	Smith County, TN	
	Sumner County, TN	
	Trousdale County, TN	
	Williamson County, TN	
	Wilson County, TN	
35004	Nassau-Suffolk, NY	1.2453
	Nassau County, NY	
	Suffolk County, NY	
35084	Newark-Union, NJ-PA	1.1731
	Essex County, NJ	
	Hunterdon County, NJ	
	Morris County, NJ	
	Sussex County, NJ	
	Union County, NJ	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Pike County, PA	
35300	New Haven-Milford, CT	1.1742
	New Haven County, CT	
35380	New Orleans-Metairie-Kenner, LA	0.9103
	Jefferson Parish, LA	
	Orleans Parish, LA	
	Plaquemines Parish, LA	
	St. Bernard Parish, LA	
	St. Charles Parish, LA	
	St. John the Baptist Parish, LA	
	St. Tammany Parish, LA	
35644	New York-White Plains-Wayne, NY-NJ	1.2885
	Bergen County, NJ	
	Hudson County, NJ	
	Passaic County, NJ	
	Bronx County, NY	
	Kings County, NY	
	New York County, NY	
	Putnam County, NY	
	Queens County, NY	
	Richmond County, NY	
	Rockland County, NY	
	Westchester County, NY	
35660	Niles-Benton Harbor, MI	0.9066
	Berrien County, MI	
35980	Norwich-New London, CT	1.1398
	New London County, CT	
36084	Oakland-Fremont-Hayward, CA	1.6092
	Alameda County, CA	
	Contra Costa County, CA	
36100	Ocala, FL	0.8512
	Marion County, FL	
36140	Ocean City, NJ	1.1496
	Cape May County, NJ	
36220	Odessa, TX	0.9475
	Ector County, TX	
36260	Ogden-Clearfield, UT	0.9153
	Davis County, UT	
	Morgan County, UT	
	Weber County, UT	
36420	Oklahoma City, OK	0.8724
	Canadian County, OK	
	Cleveland County, OK	
	Grady County, OK	
	Lincoln County, OK	
	Logan County, OK	
	McClain County, OK	
	Oklahoma County, OK	
36500	Olympia, WA	1.1537
	Thurston County, WA	
36540	Omaha-Council Bluffs, NE-IA	0.9441
	Harrison County, IA	
	Mills County, IA	
	Pottawattamie County, IA	
	Cass County, NE	
	Douglas County, NE	
	Sarpy County, NE	
	Saunders County, NE	
	Washington County, NE	
36740	Orlando-Kissimmee, FL	0.9111
	Lake County, FL	
	Orange County, FL	
	Osceola County, FL	
	Seminole County, FL	
36780	Oshkosh-Neenah, WI	0.9474
	Winnebago County, WI	
36980	Owensboro, KY	0.8685
	Daviess County, KY	
	Hancock County, KY	
	McLean County, KY	
37100	Oxnard-Thousand Oaks-Ventura, CA	1.1951
	Ventura County, CA	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
37340	Palm Bay-Melbourne-Titusville, FL	0.9332
	Brevard County, FL	
37380	Palm Coast, FL	0.8963
	Flagler County, FL	
37460	Panama City-Lynn Haven, FL	0.8360
	Bay County, FL	
37620	Parkersburg-Marietta-Vienna, WV-OH	0.7867
	Washington County, OH	
	Pleasants County, WV	
	Wirt County, WV	
	Wood County, WV	
37700	Pascagoula, MS	0.8102
	George County, MS	
	Jackson County, MS	
37764	Peabody, MA	1.0747
	Essex County, MA	
37860	Pensacola-Ferry Pass-Brent, FL	0.8242
	Escambia County, FL	
	Santa Rosa County, FL	
37900	Peoria, IL	0.9038
	Marshall County, IL	
	Peoria County, IL	
	Stark County, IL	
	Tazewell County, IL	
	Woodford County, IL	
37964	Philadelphia, PA	1.0979
	Bucks County, PA	
	Chester County, PA	
	Delaware County, PA	
	Montgomery County, PA	
	Philadelphia County, PA	
38060	Phoenix-Mesa-Scottsdale, AZ	1.0379
	Maricopa County, AZ	
	Pinal County, AZ	
38220	Pine Bluff, AR	0.7926
	Cleveland County, AR	
	Jefferson County, AR	
	Lincoln County, AR	
38300	Pittsburgh, PA	0.8678
	Allegheny County, PA	
	Armstrong County, PA	
	Beaver County, PA	
	Butler County, PA	
	Fayette County, PA	
	Washington County, PA	
	Westmoreland County, PA	
38340	Pittsfield, MA	1.0445
	Berkshire County, MA	
38540	Pocatello, ID	0.9343
	Bannock County, ID	
	Power County, ID	
38660	Ponce, PR	0.4289
	Juana Díaz Municipio, PR	
	Ponce Municipio, PR	
	Villalba Municipio, PR	
38860	Portland-South Portland-Biddeford, ME	0.9942
	Cumberland County, ME	
	Sagadahoc County, ME	
	York County, ME	
38900	Portland-Vancouver-Beaverton, OR-WA	1.1456
	Clackamas County, OR	
	Columbia County, OR	
	Multnomah County, OR	
	Washington County, OR	
	Yamhill County, OR	
	Clark County, WA	
	Skamania County, WA	
38940	Port St. Lucie, FL	0.9870
	Martin County, FL	
	St. Lucie County, FL	
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0920
	Dutchess County, NY	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Orange County, NY	
39140	Prescott, AZ	1.0221
	Yavapai County, AZ	
39300	Providence-New Bedford-Fall River, RI-MA	1.0696
	Bristol County, MA	
	Bristol County, RI	
	Kent County, RI	
	Newport County, RI	
	Providence County, RI	
	Washington County, RI	
39340	Provo-Orem, UT	0.9381
	Juab County, UT	
	Utah County, UT	
39380	Pueblo, CO	0.8713
	Pueblo County, CO	
39460	Punta Gorda, FL	0.8976
	Charlotte County, FL	
39540	Racine, WI	0.9054
	Racine County, WI	
39580	Raleigh-Cary, NC	0.9817
	Franklin County, NC	
	Johnston County, NC	
	Wake County, NC	
39660	Rapid City, SD	0.9598
	Meade County, SD	
	Pennington County, SD	
39740	Reading, PA	0.9242
	Berks County, PA	
39820	Redding, CA	1.3731
	Shasta County, CA	
39900	Reno-Sparks, NV	1.0317
	Storey County, NV	
	Washoe County, NV	
40060	Richmond, VA	0.9363
	Amelia County, VA	
	Caroline County, VA	
	Charles City County, VA	
	Chesterfield County, VA	
	Cumberland County, VA	
	Dinwiddie County, VA	
	Goochland County, VA	
	Hanover County, VA	
	Henrico County, VA	
	King and Queen County, VA	
	King William County, VA	
	Louisa County, VA	
	New Kent County, VA	
	Powhatan County, VA	
	Prince George County, VA	
	Sussex County, VA	
	Colonial Heights City, VA	
	Hopewell City, VA	
	Petersburg City, VA	
	Richmond City, VA	
40140	Riverside-San Bernardino-Ontario, CA	1.1468
	Riverside County, CA	
	San Bernardino County, CA	
40220	Roanoke, VA	0.8660
	Botetourt County, VA	
	Craig County, VA	
	Franklin County, VA	
	Roanoke County, VA	
	Roanoke City, VA	
	Salem City, VA	
40340	Rochester, MN	1.1214
	Dodge County, MN	
	Olmsted County, MN	
	Wabasha County, MN	
40380	Rochester, NY	0.8811
	Livingston County, NY	
	Monroe County, NY	
	Ontario County, NY	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Orleans County, NY	
	Wayne County, NY	
40420	Rockford, IL	0.9835
	Boone County, IL	
	Winnebago County, IL	
40484	Rockingham County, NH	0.9926
	Strafford County, NH	
40580	Rocky Mount, NC	0.9031
	Edgecombe County, NC	
	Nash County, NC	
40660	Rome, GA	0.9134
	Floyd County, GA	
40900	Sacramento—Arden-Arcade—Roseville, CA	1.3572
	El Dorado County, CA	
	Placer County, CA	
	Sacramento County, CA	
	Yolo County, CA	
40980	Saginaw-Saginaw Township North, MI	0.8702
	Saginaw County, MI	
41060	St. Cloud, MN	1.0976
	Benton County, MN	
	Stearns County, MN	
41100	St. George, UT	0.9021
	Washington County, UT	
41140	St. Joseph, MO-KS	1.0380
	Doniphan County, KS	
	Andrew County, MO	
	Buchanan County, MO	
	DeKalb County, MO	
41180	St. Louis, MO-IL	0.9006
	Bond County, IL	
	Calhoun County, IL	
	Clinton County, IL	
	Jersey County, IL	
	Macoupin County, IL	
	Madison County, IL	
	Monroe County, IL	
	St. Clair County, IL	
	Crawford County, MO	
	Franklin County, MO	
	Jefferson County, MO	
	Lincoln County, MO	
	St. Charles County, MO	
	St. Louis County, MO	
	Warren County, MO	
	Washington County, MO	
	St. Louis City, MO	
41420	Salem, OR	1.0884
	Marion County, OR	
	Polk County, OR	
41500	Salinas, CA	1.4987
	Monterey County, CA	
41540	Salisbury, MD	0.9246
	Somerset County, MD	
	Wicomico County, MD	
41620	Salt Lake City, UT	0.9158
	Salt Lake County, UT	
	Summit County, UT	
	Tooele County, UT	
41660	San Angelo, TX	0.8424
	Irion County, TX	
	Tom Green County, TX	
41700	San Antonio, TX	0.8856
	Atascosa County, TX	
	Bandera County, TX	
	Bexar County, TX	
	Comal County, TX	
	Guadalupe County, TX	
	Kendall County, TX	
	Medina County, TX	
	Wilson County, TX	
41740	San Diego-Carlsbad-San Marcos, CA	1.1538

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	San Diego County, CA	
41780	Sandusky, OH	0.8870
	Erie County, OH	
41884	San Francisco-San Mateo-Redwood City, CA	1.5529
	Marin County, CA	
	San Francisco County, CA	
	San Mateo County, CA	
41900	San Germán-Cabo Rojo, PR	0.4756
	Cabo Rojo Municipio, PR	
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
	San Germán Municipio, PR	
41940	San Jose-Sunnyvale-Santa Clara, CA	1.6141
	San Benito County, CA	
	Santa Clara County, CA	
41980	San Juan-Caguas-Guaynabo, PR	0.4393
	Aguas Buenas Municipio, PR	
	Aibonito Municipio, PR	
	Arecibo Municipio, PR	
	Barceloneta Municipio, PR	
	Barranquitas Municipio, PR	
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Canóvanas Municipio, PR	
	Carolina Municipio, PR	
	Cataño Municipio, PR	
	Cayey Municipio, PR	
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Comerío Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Guaynabo Municipio, PR	
	Gurabo Municipio, PR	
	Hatillo Municipio, PR	
	Humacao Municipio, PR	
	Juncos Municipio, PR	
	Las Piedras Municipio, PR	
	Loíza Municipio, PR	
	Manatí Municipio, PR	
	Maunabo Municipio, PR	
	Morovis Municipio, PR	
	Naguabo Municipio, PR	
	Naranjito Municipio, PR	
	Orocovis Municipio, PR	
	Quebradillas Municipio, PR	
	Río Grande Municipio, PR	
	San Juan Municipio, PR	
	San Lorenzo Municipio, PR	
	Toa Alta Municipio, PR	
	Toa Baja Municipio, PR	
	Trujillo Alto Municipio, PR	
	Vega Alta Municipio, PR	
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	
42020	San Luis Obispo-Paso Robles, CA	1.2441
	San Luis Obispo County, CA	
42044	Santa Ana-Anaheim-Irvine, CA	1.1993
	Orange County, CA	
42060	Santa Barbara-Santa Maria-Goleta, CA	1.1909
	Santa Barbara County, CA	
42100	Santa Cruz-Watsonville, CA	1.6429
	Santa Cruz County, CA	
42140	Santa Fe, NM	1.0610
	Santa Fe County, NM	
42220	Santa Rosa-Petaluma, CA	1.5528
	Sonoma County, CA	
42340	Savannah, GA	0.9152
	Bryan County, GA	
	Chatham County, GA	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Effingham County, GA	
42540	Scranton—Wilkes-Barre, PA	0.8333
	Lackawanna County, PA	
	Luzerne County, PA	
	Wyoming County, PA	
42644	Seattle-Bellevue-Everett, WA	1.1755
	King County, WA	
	Snohomish County, WA	
42680	Sebastian-Vero Beach, FL	0.9217
	Indian River County, FL	
43100	Sheboygan, WI	0.8920
	Sheboygan County, WI	
43300	Sherman-Denison, TX	0.9024
	Grayson County, TX	
43340	Shreveport-Bossier City, LA	0.8442
	Bossier Parish, LA	
	Caddo Parish, LA	
	De Soto Parish, LA	
43580	Sioux City, IA-NE-SD	0.8915
	Woodbury County, IA	
	Dakota County, NE	
	Dixon County, NE	
	Union County, SD	
43620	Sioux Falls, SD	0.9354
	Lincoln County, SD	
	McCook County, SD	
	Minnehaha County, SD	
	Turner County, SD	
43780	South Bend-Mishawaka, IN-MI	0.9761
	St. Joseph County, IN	
	Cass County, MI	
43900	Spartanburg, SC	0.9025
	Spartanburg County, SC	
44060	Spokane, WA	1.0559
	Spokane County, WA	
44100	Springfield, IL	0.9102
	Menard County, IL	
	Sangamon County, IL	
44140	Springfield, MA	1.0405
	Franklin County, MA	
	Hampden County, MA	
	Hampshire County, MA	
44180	Springfield, MO	0.8424
	Christian County, MO	
	Dallas County, MO	
	Greene County, MO	
	Polk County, MO	
	Webster County, MO	
44220	Springfield, OH	0.8876
	Clark County, OH	
44300	State College, PA	0.8937
	Centre County, PA	
44700	Stockton, CA	1.2015
	San Joaquin County, CA	
44940	Sumter, SC	0.8257
	Sumter County, SC	
45060	Syracuse, NY	0.9787
	Madison County, NY	
	Onondaga County, NY	
	Oswego County, NY	
45104	Tacoma, WA	1.1241
	Pierce County, WA	
45220	Tallahassee, FL	0.8964
	Gadsden County, FL	
	Jefferson County, FL	
	Leon County, FL	
	Wakulla County, FL	
45300	Tampa-St. Petersburg-Clearwater, FL	0.8852
	Hernando County, FL	
	Hillsborough County, FL	
	Pasco County, FL	
	Pinellas County, FL	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
45460	Terre Haute, IN	0.9085
	Clay County, IN	
	Sullivan County, IN	
	Vermillion County, IN	
	Vigo County, IN	
45500	Texarkana, TX-Texarkana, AR	0.8144
	Miller County, AR	
	Bowie County, TX	
45780	Toledo, OH	0.9407
	Fulton County, OH	
	Lucas County, OH	
	Ottawa County, OH	
	Wood County, OH	
45820	Topeka, KS	0.8756
	Jackson County, KS	
	Jefferson County, KS	
	Osage County, KS	
	Shawnee County, KS	
	Wabaunsee County, KS	
45940	Trenton-Ewing, NJ	1.0604
	Mercer County, NJ	
46060	Tucson, AZ	0.9229
	Pima County, AZ	
46140	Tulsa, OK	0.8445
	Creek County, OK	
	Okmulgee County, OK	
	Osage County, OK	
	Pawnee County, OK	
	Rogers County, OK	
	Tulsa County, OK	
	Wagoner County, OK	
46220	Tuscaloosa, AL	0.8496
	Greene County, AL	
	Hale County, AL	
	Tuscaloosa County, AL	
46340	Tyler, TX	0.8804
	Smith County, TX	
46540	Utica-Rome, NY	0.8404
	Herkimer County, NY	
	Oneida County, NY	
46660	Valdosta, GA	0.8027
	Brooks County, GA	
	Echols County, GA	
	Lanier County, GA	
	Lowndes County, GA	
46700	Vallejo-Fairfield, CA	1.4359
	Solano County, CA	
47020	Victoria, TX	0.8124
	Calhoun County, TX	
	Goliad County, TX	
	Victoria County, TX	
47220	Vineland-Millville-Bridgeton, NJ	1.0366
	Cumberland County, NJ	
47260	Virginia Beach-Norfolk-Newport News, VA-NC	0.8884
	Currituck County, NC	
	Gloucester County, VA	
	Isle of Wight County, VA	
	James City County, VA	
	Mathews County, VA	
	Surry County, VA	
	York County, VA	
	Chesapeake City, VA	
	Hampton City, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
47300	Visalia-Porterville, CA	1.0144
	Tulare County, CA	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
47380	Waco, TX	0.8596
	McLennan County, TX	
47580	Warner Robins, GA	0.8989
	Houston County, GA	
47644	Warren-Troy-Farmington Hills, MI	0.9904
	Lapeer County, MI	
	Livingston County, MI	
	Macomb County, MI	
	Oakland County, MI	
	St. Clair County, MI	
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	1.0827
	District of Columbia, DC	
	Calvert County, MD	
	Charles County, MD	
	Prince George's County, MD	
	Arlington County, VA	
	Clarke County, VA	
	Fairfax County, VA	
	Fauquier County, VA	
	Loudoun County, VA	
	Prince William County, VA	
	Spotsylvania County, VA	
	Stafford County, VA	
	Warren County, VA	
	Alexandria City, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fredericksburg City, VA	
	Manassas City, VA	
	Manassas Park City, VA	
	Jefferson County, WV	
47940	Waterloo-Cedar Falls, IA	0.8490
	Black Hawk County, IA	
	Bremer County, IA	
	Grundy County, IA	
48140	Wausau, WI	0.9615
	Marathon County, WI	
48260	Weirton-Steubenville, WV-OH	0.8079
	Jefferson County, OH	
	Brooke County, WV	
	Hancock County, WV	
48300	Wenatchee, WA	0.9544
	Chelan County, WA	
	Douglas County, WA	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	0.9757
	Palm Beach County, FL	
48540	Wheeling, WV-OH	0.6955
	Belmont County, OH	
	Marshall County, WV	
	Ohio County, WV	
48620	Wichita, KS	0.9069
	Butler County, KS	
	Harvey County, KS	
	Sedgwick County, KS	
	Sumner County, KS	
48660	Wichita Falls, TX	0.8832
	Archer County, TX	
	Clay County, TX	
	Wichita County, TX	
48700	Williamsport, PA	0.8096
	Lycoming County, PA	
48864	Wilmington, DE-MD-NJ	1.0696
	New Castle County, DE	
	Cecil County, MD	
	Salem County, NJ	
48900	Wilmington, NC	0.9089
	Brunswick County, NC	
	New Hanover County, NC	
	Pender County, NC	
49020	Winchester, VA-WV	0.9801
	Frederick County, VA	
	Winchester City, VA	

TABLE 8—FY 2009 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Hampshire County, WV	
49180	Winston-Salem, NC	0.9016
	Davie County, NC	
	Forsyth County, NC	
	Stokes County, NC	
	Yadkin County, NC	
49340	Worcester, MA	1.0836
	Worcester County, MA	
49420	Yakima, WA	0.9948
	Yakima County, WA	
49500	Yauco, PR	0.3432
	Guánica Municipio, PR	
	Guayanilla Municipio, PR	
	Peñuelas Municipio, PR	
	Yauco Municipio, PR	
49620	York-Hanover, PA	0.9518
	York County, PA	
49660	Youngstown-Warren-Boardman, OH-PA	0.8915
	Mahoning County, OH	
	Trumbull County, OH	
	Mercer County, PA	
49700	Yuba City, CA	1.1137
	Sutter County, CA	
	Yuba County, CA	
49740	Yuma, AZ	0.9281
	Yuma County, AZ	

[1] At this time, there are no hospitals located in this urban area on which to base a wage index. We use the average wage index of all of the urban areas within the State to serve as a reasonable proxy.

TABLE 9—FY 2009 WAGE INDEX BASED ON CBSA LABOR MARKET AREAS FOR RURAL AREAS

State code	Nonurban area	Wage index
1	Alabama	0.7587
2	Alaska	1.1898
3	Arizona	0.8453
4	Arkansas	0.7473
5	California	1.2275
6	Colorado	0.9570
7	Connecticut	1.1016
8	Delaware	0.9962
10	Florida	0.8504
11	Georgia	0.7612
12	Hawaii	1.0999
13	Idaho	0.7651
14	Illinois	0.8386
15	Indiana	0.8473
16	Iowa	0.8804
17	Kansas	0.8052
18	Kentucky	0.7803
19	Louisiana	0.7447
20	Maine	0.8644
21	Maryland	0.8883
22	Massachusetts [1]	1.1670
23	Michigan	0.8887
24	Minnesota	0.9059
25	Mississippi	0.7584
26	Missouri	0.7982
27	Montana	0.8658
28	Nebraska	0.8730
29	Nevada	0.9382
30	New Hampshire	1.0182
31	New Jersey [1]	.....
32	New Mexico	0.8812
33	New York	0.8145
34	North Carolina	0.8576
35	North Dakota	0.7205
36	Ohio	0.8588
37	Oklahoma	0.7732
38	Oregon	1.0218
39	Pennsylvania	0.8365
40	Puerto Rico [1]	0.4047
41	Rhode Island [1]	.....
42	South Carolina	0.8538
43	South Dakota	0.8603
44	Tennessee	0.7789
45	Texas	0.7894
46	Utah	0.8267
47	Vermont	1.0079
48	Virgin Islands	0.6971
49	Virginia	0.7861
50	Washington	1.0181
51	West Virginia	0.7503
52	Wisconsin	0.9373
53	Wyoming	0.9315
65	Guam	0.9611

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

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