DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 409, 410, 411, 413, 424, 483, and 489

[HCFA–1913–IFC]

RIN 0938–AI47

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

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule implements provisions in section 4432 of the Balanced Budget Act of 1997 related to Medicare payment for skilled nursing facility services. These include the implementation of a Medicare prospective payment system for skilled nursing facilities, consolidated billing, and a number of related changes. The prospective payment system described in this rule replaces the retrospective reasonable cost-based system currently utilized by Medicare for payment of skilled nursing facility services under Part A of the program.

DATES: These regulations are effective July 1, 1998.

Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on July 13, 1998.

ADDRESSES: Mail an original and 3 copies of written comments to the following address:

Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1913–IFC, P.O. Box 26688, Baltimore, MD 21207–0488

If you prefer, you may deliver an original and 3 copies of your written comments to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, D.C. 20201,

or

Room C5–09–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1913–IFC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington, D.C., on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

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FOR FURTHER INFORMATION CONTACT:

Laurence Wilson, (410) 786–4603 (for general information). John Davis, (410) 786–0008 (for information related to the Federal rates).

Dana Burley, (410) 786–4547 (for information related to the case-mix classification methodology).

Steve Raitzyk, (410) 786–4599 (for information related to the facility-specific transition payment rates).

Bill Ullman, (410) 786–5667 (for information related to consolidated billing and related provisions).

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

ADLs Activities of daily living
AHEs Average Hourly Earnings
BBA 1997 Balanced Budget Act of 1997
BEA [U.S.] Bureau of Economic Analysis
BLS [U.S.] Bureau of Labor Statistics
CAH Critical access hospital
CFR Code of Federal Regulations
CPI Consumer Price Index
CPI-U Consumer Price Index for All Urban Consumers
CPT [Physicians'] Current Procedural Terminology
ECI Employment Cost Index
FI Fiscal intermediary
HCFA Health Care Financing Administration
HCPCS HCFA Common Procedure Coding System
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
MDS Minimum Data Set
MEDPAR Medicare provider analysis and review file
MSA Metropolitan Statistical Area
NECMA New England County Metropolitan Area
PCE Personal Care Expenditures
PPI Producer Price Index
PPS Prospective payment system
RAI Resident Assessment Instrument
RAPs Resident Assessment Protocol Guidelines
RUG Resource Utilization Group
SNF Skilled nursing facility
STM Staff time measure

I. Background

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

Under the present payment system, Medicare skilled nursing facility (SNF) services are paid according to a retrospective, reasonable cost-based system. Under Medicare payment principles set forth in section 1861 of the Social Security Act (the Act) and part 413 of the Code of Federal Regulations (CFR), SNFs receive payment for three major categories of costs: routine costs, ancillary costs, and capital-related costs.

In general, routine costs are the costs of those services included by the provider in a daily service charge. Routine service costs include regular room, dietary, nursing services, minor medical supplies, medical social services, psychiatric social services, and the use of certain facilities and equipment for which a separate charge is not made. Ancillary costs are costs for specialized services, such as therapy, drugs, and laboratory services, that are directly identifiable to individual patients. Capital-related costs include the costs of land, building, equipment, and the interest incurred in financing the acquisition of such items.

Under Medicare rules, the reasonable costs of ancillary services and capital-related expenses are paid in full. Routine operating costs are also paid on a reasonable cost basis, subject to per diem limits. Sections 1861(v)(1) and 1888 of the Act authorize the Secretary to set limits on the allowable routine costs incurred by an SNF.

In addition, section 1888(d) of the Act gives low Medicare volume SNFs the option of receiving a single prospectively determined payment rate for routine operating and capital-related costs in lieu of the normal reasonable cost reimbursement method. A SNF may elect this payment method only if it had fewer than 1,500 Medicare covered inpatient days in its immediately preceding cost reporting period. An SNF's prospective payment rate under section 1888(d) of the Act, excluding capital-related costs, cannot exceed its routine service cost limits. Under this payment method, ancillary costs are still a pass-through cost.

B. Requirement of the Balanced Budget Act of 1997 for a Prospective Payment System for Skilled Nursing Facilities

Section 4432(a) of the Balanced Budget Act of 1997 (BBA 1997) (Public Law 105–33), enacted on August 5, 1997, amended section 1888 of the Act by adding subsection (e). This

subsection requires implementation of a Medicare SNF prospective payment system (PPS) for all SNFs for cost reporting periods beginning on or after July 1, 1998. Under the PPS, SNFs will be paid under a PPS applicable to all covered SNF services. These payment rates will encompass all costs of furnishing covered skilled nursing services (that is, routine, ancillary, and capital-related costs) other than costs associated with operating approved educational activities. Covered SNF services include posthospital SNF services for which benefits are provided under Part A (the hospital insurance program) and all items and services (other than services excluded by statute) for which, prior to July 1, 1998, payment may be made under Part B (the supplementary medical insurance program) and which are furnished to SNF residents during a Part A covered stay.

Section 1888(e)(4) of the Act provides the basis for the establishment of the per diem Federal payment rates applied under the PPS. It sets forth the formula for establishing the rates as well as the data on which they are based. In addition, this section requires adjustments to such rates based on geographic variation and case-mix and prescribes the methodology for updating the rates in future years.

Section 1888(e)(2) sets forth a requirement applicable to most providers for a transition phase covering the first three cost reporting periods under the PPS. During this transition phase, SNFs will receive a payment rate comprised of a blend between the Federal rate and a facility-specific rate based on historical costs. Section 1888(e)(3) prescribes the methodology for computing the facility-specific rates.

In addition to the payment methodology, section 4432(a) of the BBA 1997 added several other provisions to the Act related to the implementation and administration of the PPS.

Section 1888(e)(8) prohibits judicial or administrative review on matters relating to the establishment of the Federal rates. This includes the methodology used in the computation of the Federal rates, the case-mix methodology, and the development and application of the wage index. This limitation on judicial and administrative review also extends to the establishment of the facility-specific rates, except the determinations of reasonable cost in the fiscal year 1995 cost reporting period used as the basis for these rates.

In addition, section 1888(e)(7) requires the application of the PPS to extended care services furnished in hospital swing bed units. However, this requirement is to be implemented no earlier than cost reporting periods beginning on July 1, 1999 and no later than for cost reporting periods beginning in the 12-month period starting on July 1, 2001. Accordingly, we are not revising the payment regulations for swing-bed hospitals (42 CFR 413.114) at this time, but will do so at a later date.

Finally, section 4432(c) of the BBA 1997 requires the Secretary to establish a medical review process to examine the impact of the PPS, consolidated billing, and other related changes set forth in this rule on the quality of SNF services provided to Medicare beneficiaries. This medical review process will place a particular emphasis on the quality of non-routine covered ancillary and physician services.

C. Summary of the Development of the Medicare Prospective Payment System for Skilled Nursing Facilities

The prospective payment system described in the following sections is the culmination of substantial research efforts beginning as early as the 1970s, focusing on the areas of nursing home payment and quality. In addition, it is based on a foundation of knowledge and work by a number of States that have developed and implemented similar payment methodologies for their Medicaid nursing home payment systems. Over the last 20 years, approximately 25 nursing home case-mix payment systems have been implemented by such States as New York, Ohio, West Virginia, and Texas.

Building on earlier research, the Health Care Financing Administration (HCFA) funded the development of the Multistate Nursing Home Case-Mix and Quality Demonstration in 1989. The purpose of this project was to design, implement, and evaluate a Medicare nursing home prospective payment and quality monitoring system across several States. These States were Kansas, Maine, Mississippi, New York, South Dakota, and Texas. The 3-year demonstration was implemented in 1995.

The current focus in the development of State and Federal payment systems for nursing home care rests on explicit recognition of the differences among residents, particularly in the utilization of resources. Recognition of these differences ensures that payment levels are adequate to support quality and access to care, especially for more costly resource intensive patients. In a case-mix adjusted payment system, the amount of payment given to the nursing home for care of a resident is tied to the intensity of resource use (for example, hours of nursing or therapy time needed per day) and/or other relevant factors (for example, requirement for a ventilator). The focus of the demonstration was on the development and testing of such a case-mix PPS.

A case-mix system measures the intensity of care and services required for each resident and then translates it into a payment level. As discussed above, a number of States do have case-mix prospective payment systems for their Medicaid nursing home benefits. However, most of these payment systems were not readily transferrable to Medicare due to the relative differences in the resident populations served by each program. While naturally there is overlap, Medicare generally serves a more postacute resident population while Medicaid generally serves a longer-term custodial care population.

As a result of these differences, the development phase of the Multistate demonstration was devoted to developing a case-mix classification system appropriate for the Medicare population. The demonstration, like the national PPS set forth in this rule, utilized information from the Minimum Data Set (MDS) resident assessment instrument to classify residents into resource utilization groups (RUGs), which account for the relative resource use of different patient types. This classification system and its relationship to the MDS and the PPS are described in detail elsewhere in this rule.

D. Skilled Nursing Facility Prospective Payment—General Overview

As described above, the BBA 1997 requires implementation of a Medicare SNF PPS for cost reporting periods beginning on or after July 1, 1998. Under the PPS, SNFs are no longer paid in accordance with the present reasonable cost-based system but rather through per diem prospective case-mix adjusted payment rates applicable to all covered SNF services. These payment rates cover all the costs of furnishing covered skilled nursing services (that is, routine, ancillary, and capital-related costs) other than costs associated with operating approved educational activities. Covered SNF services include posthospital SNF services for which benefits are provided under Part A and all items and services for which, prior to July 1, 1998, payment had been made under Part B (other than physician and certain other services specifically excluded under the BBA 1997) but furnished to SNF residents during a Part A covered stay.

1. Payment Provisions—Federal Rate

The PPS utilizes per diem Federal payment rates based on mean SNF costs in a base year updated for inflation to the first effective period of the system. We develop the Federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in fiscal year 1995. The data used in developing the Federal rates also incorporate an estimate of the amounts payable under Part B for covered SNF services furnished during fiscal year 1995 to individuals who were residents of a facility and receiving Part A covered services. In developing the rates, we update costs to the first effective year of the PPS (15-month period beginning July 1, 1998) using a SNF market basket index, and standardize for facility differences in case-mix and for geographic variations in wages. Providers that received ''new provider'' exemptions from the routine cost limits are excluded from the data base used to compute the Federal payment rates. In addition, costs related to payments for exceptions to the routine cost limits are excluded from the data base used to compute the Federal payment rates. In accordance with the formula prescribed in the BBA 1997, we set the Federal rates at a level equal to a weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and a weighted mean of all SNF costs (hospital-based and freestanding) combined. We compute and apply separately payment rates for facilities located in urban and rural areas.

The Federal rate also incorporates adjustments to account for facility case-mix using a resident classification system that accounts for the relative resource utilization of different patient types. This classification system, Version III of the Resource Utilization Groups (RUGs-III), utilizes resident assessment data (from the Minimum Data Set or MDS) completed by SNFs to assign residents into one of 44 groups. SNFs complete these assessments according to an assessment schedule specifically designed for Medicare payment (that is, on the 5th, 14th, 30th, 60th, and 90th days after admission to the SNF). For Medicare billing purposes, there are revenue codes associated with each of the 44 RUG–III groups, and each assessment applies to specific days within a resident's SNF stay. SNFs that fail to perform assessments timely are paid a default payment for the days of a patient's care for which they are not in compliance with this schedule. In addition, we adjust the portion of the Federal rate attributable to wage-related costs by a wage index.

For the initial period of the PPS, beginning on July 1, 1998 and ending on September 30, 1999, the payment rates are contained in this interim final rule. For each succeeding fiscal year, we will publish the rates in the **Federal Register** before August 1 of the year preceding the affected Federal fiscal year. For fiscal years 2000 through 2002, we will increase the rates by a factor equal to the SNF market basket index amount minus 1 percentage point. For subsequent fiscal years, we will increase the rates by the applicable SNF market basket index amount.

2. Payment Provisions—Transition Period

Beginning with a provider's first cost reporting period beginning on or after July 1, 1998, there is a transition period covering three cost reporting periods. During this transition phase, SNFs receive a payment rate comprised of a blend between the Federal rate and a facility-specific rate based on each facility's fiscal year 1995 cost report. We exclude SNFs that received their first payment from Medicare on or after October 1, 1995, from the transition period, and we make payment according to the Federal rates only.

For SNFs that qualify for the transition, the composition of the blended rate varies depending on the year of the transition. For the first cost reporting period beginning on or after July 1, 1998, we make payment based on 75 percent of the facility-specific rate and 25 percent of the Federal rate. In the next cost reporting period, the rate consists of 50 percent of the facility-specific rate and 50 percent of the Federal rate. In the following cost reporting period, the rate consists of 25 percent of the facility-specific rate and 75 percent of the Federal rate. For all subsequent cost reporting periods, we base payment entirely on the Federal rate.

3. Payment Provisions—Facility-Specific Rate

We compute the facility-specific payment rate utilized for the transition using the allowable costs of SNF services for cost reporting periods beginning in fiscal year 1995 (cost reporting periods beginning on or after October 1, 1994 and before October 1, 1995). Included in the facility-specific per diem rate is an estimate of the amount payable under Part B for covered SNF services furnished during fiscal year 1995 to individuals who were residents of the facility and receiving Part A covered services. In contrast to the Federal rates, the facility-specific rate includes amounts paid to SNFs for exceptions to the routine cost limits. In addition, we also take into account ''new provider'' exemptions from the routine cost limits but only to the extent that routine costs do not exceed 150 percent of the routine cost limit.

We update the facility-specific rate for each cost reporting period after fiscal year 1995 to the first cost reporting period beginning on or after July 1, 1998 (the initial period of the PPS) by a factor equal to the SNF market basket percentage increase minus 1 percentage point. For the fiscal years 1998 and 1999, we update this rate by a factor equal to the SNF market basket index amount minus 1 percentage point, and, for each subsequent year, we update it by the applicable SNF market basket index amount.

4. Implementation of the Prospective Payment System (PPS)

As discussed above, the PPS is effective for cost reporting periods beginning on or after July 1, 1998. This is in contrast to the consolidated billing provision, which is effective for items and services furnished on or after July 1, 1998. Accordingly, we will require a number of SNFs to implement consolidated billing prior to migrating to the PPS.

E. Consolidated Billing for Skilled Nursing Facilities

Section 4432(b) of the BBA 1997 sets forth a consolidated billing requirement applicable to all SNFs providing Medicare services. SNF Consolidated Billing is a comprehensive billing requirement (similar to the one that has been in effect for inpatient hospital services for well over a decade), under which the SNF itself is responsible for billing Medicare for virtually all of the services that its residents receive. As with hospital bundling, the SNF consolidated billing requirement does not apply to the services of physicians and certain other types of medical practitioners. In a related provision, section 4432(b)(3) of the BBA 1997 requires the use of fee schedules and uniform coding specified by the Secretary for SNF Part B bills. These provisions are effective for services furnished on or after July 1, 1998.

II. Prospective Payment System for Skilled Nursing Facilities

A. Federal Payment Rates

This interim final rule with comment period sets forth a schedule of Federal prospective payment rates applicable to Medicare Part A SNF services for cost

reporting periods beginning on or after July 1, 1998. This schedule incorporates per diem Federal rates designed to provide payment for all the costs of services furnished to a Medicare resident of an SNF. This section describes the components of the Federal rates and the methodology and data used to compute them.

1. Cost and Services Covered by the Federal Rates

The Federal rates apply to all costs (that is, routine, ancillary, and capital-related costs) of covered skilled nursing services other than costs associated with operating approved educational activities as defined in 42 CFR 413.85. Under section 1888(e)(2) of the Act, covered SNF services include posthospital SNF services for which benefits are provided under Part A (the hospital insurance program) and all items and services (other than services excluded by statute) for which, prior to July 1, 1998, payment may be made under Part B (the supplementary medical insurance program) and which are furnished to SNF residents during a Part A covered stay. (These excluded service categories are discussed in greater detail in section V.B.2., in the context of the SNF Consolidated Billing provision.)

2. Data Sources Utilized for the Development of the Federal Rates

The methodology utilized by HCFA in developing the Federal rates combines a number of data sources. These sources include cost report data, claims data, case-mix indices, a wage index, and a market basket inflation index. This section describes each of these data sources while the following section describes the methodology that combines them to produce the Federal rates.

a. *Cost report data*. In accordance with sections 1888(e)(3)(A)(i) and (e)(4) of the Act, the primary data source for developing the cost basis of the Federal rates was the cost reports for hospital-based and freestanding SNFs for reporting periods beginning in fiscal year 1995 (that is, beginning on or after October 1, 1994 through September 30, 1995). Only those cost reports for periods of at least 10 months but not more than 13 months were included in the data base. We excluded shorter and longer periods on the basis that such data may not be reflective of a normal cost reporting period and, therefore, may distort the rate computation.

In accordance with section 1888(e)(4)(A) of the Act, providers that were exempted from the limits in the base year under § 413.30(e)(2) were excluded from the data base to compute the Federal rates; in addition, allowable costs related to exceptions payments were excluded. Finally, costs related to approved educational activities were excluded from the data base.

In calculating the Federal rates, we utilized fiscal year 1995 cost report data, including both settled and as-submitted cost reports. In accordance with section 1888(e)(4)(A) of the Act, adjustment factors were applied separately to routine and ancillary costs from as-submitted cost reports to make the data reflect the average adjustments that would result from the cost report settlement process. Routine costs were adjusted downward by 1.31 percent, and ancillary costs were adjusted downward by 3.26 percent.

These adjustment factors were developed through comparisons of cost data from as-submitted and settled cost reports for providers contained in the data base from 1995. The factors represent the percent change of cost elements used in the PPS rate setting methodology between submission and settlement of the cost reports. These factors were validated by examining the relationship between as-submitted and settled cost reports for SNF cost reports beginning in the three preceding Federal fiscal years (that is, 1992, 1993, and 1994) as well. This comparison showed an overall consistency in the relationship between as-submitted and settled cost reports for the SNF cost elements utilized in the PPS rate development methodology.

b. Estimate of Part B payments. Section 1888(e)(4)(A)(ii) of the Act, as added by the BBA 1997, requires that in developing the Federal rates, the Secretary estimate the amounts that would be payable under Part B for covered SNF services furnished to SNF residents. Accordingly, it was necessary to examine the Part B allowable charges (including coinsurance) associated with the SNFs contained in the cost report data base. To estimate the Part B allowable charges, we matched 100 percent of the Medicare Part B SNF claims associated with Part A covered SNF stays to the SNF cost reports described above. The matched Part B allowable charges were incorporated at a facility level by the appropriate cost report cost center (for example, laboratory services, medical supplies) with the cost report data.

c. Hospital wage index. Section 1888(e)(4) requires that we both standardize the Federal rates and provide for appropriate adjustments to account for area wage differences ''using an appropriate wage index as determined by the Secretary.'' We cannot use a wage index based on SNF wage data because the industry-specific data necessary to compute a wage index for SNFs are not yet available. However, under section 106 of the Social Security Act Amendments of 1994 (Public Law 103–432), HCFA was required to begin collecting data no later than October 31, 1995, on employee compensation and paid hours of employment in SNFs for the purpose of constructing an SNF wage index adjustment. Until this data collection effort is completed and the data are analyzed, we believe that the hospital wage data provide the best available measure of comparable wages that would also be paid by SNFs. We believe that the use of the hospital wage data results in an appropriate adjustment to the labor portion of the costs based on an appropriate wage index as required under section 1888(e) of the Act.

For the rates effective with this rule, we are using wage index values that are based on hospital wage data from cost reporting periods beginning in fiscal year 1994—the most recent hospital wage data in effect before the effective date of this rule (see Table 2.I). Accordingly, the wage index values used in this rule are based on the same wage data as used to compute the FY 1998 wage index values for the hospital PPS.

d. Case-mix indices. As discussed in section I, section 1888(e)(4) of the Act requires us to make adjustments to the Federal rates to account for the relative resource use of different patient types (that is, case-mix). In addition, the law requires us to standardize the cost data used in developing the Federal rates for case-mix.

The goal of a case-mix payment system is to measure the intensity of care and services required for each patient and translate it into an appropriate payment level. Accordingly, in making this adjustment, the Federal rates will incorporate a patient classification system based on intensity of resource use with corresponding payment weights.

As discussed previously, the patient classification system utilized under this PPS is RUG–III. RUG–III, a 44-group patient classification system, provides the basis for the case-mix payment indices used both for standardization of the Federal rates and subsequently to establish the case-mix adjustments to the rates for patients with different service use. These indices reflect the weight or value of each of the 44 RUG–III groups relative to all the groups. A full discussion of the design and structure of RUG–III is presented later in this section. These payment indices are

based on staff time measure (STM) studies conducted in 1995 and 1997 that measured the nursing and therapy staff time required to care for groups of residents. The STM is based on a 24-hour period for nursing and therapy services. Accordingly, there are separate case-mix payment indices for nursing and related services and for therapy services.

The STM studies were conducted in 12 States across 154 SNFs and 2,900 residents. These States were Kansas, Maine, Mississippi, South Dakota, Texas, California, Colorado, Maryland, Florida, Ohio, Washington, and New York. The study utilized a stratified sample of SNFs, including both freestanding and hospital-based SNFs and those with different care delivery models. The resulting indices were adjusted to account for the relative salary differences between different types of nursing staff (registered nurses, licensed practical nurses, and aides) and the different therapy disciplines (occupational therapy, physical therapy, and speech pathology). The adjustment to the nursing index for relative salary differences in nursing staff was based on data from the American Health Care Association's 1995 study of national nursing home salaries. The adjustment to the therapy index for relative salary differences among disciplines was based on data from several different sources. These sources were surveys from the American Health Care Association, the National Association for the Support of Long-Term Care, the Bureau of Labor Statistics, the American Rehabilitation Association, the University of Texas, Mutual of Omaha, and the Maryland Health Cost Review Commission. They were used in HCFA's ''best estimate'' approach in the development of rehabilitation therapy salary equivalency guidelines. The schedule detailing the national case-mix payment indices is presented later in this section (see Tables 2.E and 2.F).

e. MEDPAR case-mix analog. Section 1888(e)(4)(C) requires that the data used in developing the Federal payment rates be standardized to remove the effects of geographic variation in case-mix. Standardization ensures that the aggregate impact of the case-mix adjustments on the Federal rates does not alter the aggregate payments that would occur in the absence of such an adjustment. In order to fulfill this requirement, it is necessary to have data on the average case-mix of each SNF in our data base for its cost reporting period beginning in fiscal year 1995. Because a national source of MDS derived case-mix data does not exist for this period, it was necessary to utilize existing data sources. Accordingly, to provide national case-mix data on SNFs in our data base, we constructed a crosswalk between the RUG–III categories and the data from all Medicare claims in our Medicare Provider Analysis and Review file (MEDPAR).

The MEDPAR file is an analytical file created from Part A Medicare hospital and SNF claims and maintained by HCFA. These claims are the basis of the interim payments made by fiscal intermediaries and contain information on SNF stays paid for by Medicare Part A nationwide. Although Medicare claims information does not include all the data elements necessary to classify SNF patients exactly as they are in RUG–III, it does contain sufficient information to assign Medicare SNF patients to RUG–III categories at a general level. Classification into a RUG–III category is based on detailed clinical information from the patient assessment performed in the SNF. The claims in the MEDPAR file do not have the level of clinical detail required for classification into the RUG–III categories but do have basic clinical information that has been required on the claim for payment in the cost-based Medicare payment system. By using the clinical information in the MEDPAR file to crosswalk to the RUG–III grouping specifications, we were able to model how the national Medicare SNF population will classify into RUG–III categories. The model is referred to as the ''MEDPAR analog.'' The value of the MEDPAR analog is that it provides a means to use available data to examine the case-mix of Medicare SNF patients nationally.

In order to examine case-mix based on the MEDPAR file data, it was necessary to recognize certain limitations of this file, identify where crosswalks could be made between the data contained in the MEDPAR file and that needed to assign an SNF patient to a RUG–III group, and establish proxy criteria where feasible to make more case classifications possible.

One limitation of the analog results from the Medicare coverage rules for physical, occupational, and speech rehabilitation therapy services. Rehabilitation therapy provided in the SNF is covered under Part A (and thereby will have claims data in MEDPAR), unless the services are provided by an independent agency, in which case they may be billed under Part B (although our analysis of Part B supplier bills indicated relatively few rehabilitation therapy services being billed in this way). In addition, a small number of facilities do not detail rehabilitation therapy charges in their claims. For these reasons, the MEDPAR proxy may not be a complete record of all the services a patient in the SNF may receive during the course of a beneficiary's stay.

In spite of these limitations, MEDPAR is a reasonable tool to use in approximating the RUG–III categories related to Medicare SNF claims and appropriate for use in rate standardization. The file contains ICD–9–CM (International Classification of Diseases, Ninth Edition, Clinical Modification) diagnosis and procedure codes that provide a partial clinical profile of the patient supplemented by lengths of stay, revenue codes that represent types of services provided during each nursing home stay, and limited admission and discharge information. In addition, some of the facilities report rehabilitation charge information, making it possible for us to approximate frequency and duration of rehabilitation therapies, as well as to directly reproduce which discipline provided services.

The analog was first created in 1993, using the 1990 MEDPAR SNF file and an earlier version of the Minimum Data Set (MDS), the MDS+. We updated that work for the national implementation analyses, using instead the 1997 MEDPAR SNF file and the MDS 2.0. As stated above, the MDS 2.0 collects extensive patient information that includes demographic information, diagnoses, medication use, nursing rehabilitation services, activities of daily living (ADL) capabilities, and minutes per day of rehabilitative services provided. This information is the basis for assignment to a particular RUG–III group. Thus, in the creation of the MEDPAR analog, MDS+ (and now, MDS 2.0) definitions formed the key against which MEDPAR diagnosis and revenue service codes were matched.

The RUG–III classification system is a hierarchy of major patient types, organized into seven major categories. The categories are Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Function. Each of these categories is further differentiated to yield the 44 specific patient groups used for payment.

The categories and groups within them are based on the research findings of staff time measurement studies performed in 1990, 1995, and 1997, described in detail below. Through analyses of the patient characteristics recorded on the MDS and the staff time associated with caring for patients in nursing homes, clinical criteria were identified that were predictive of resource use, and categories were

formed that would group patients according to resource use. The criteria for each category were derived from the actual staff time measurement study data.

The information contained in the MEDPAR file is not adequate to enable differentiation to the 44 groups, however. Therefore, the analog classifies patients only to the category level.

There are seven RUG–III categories: Rehabilitation, Extensive Services, Special Services, Clinically Complex, Impaired Cognition, Behavior, and Physical. The Rehabilitation category has five sub-categories, based on the number of minutes therapy is provided and the number of disciplines providing service. The sub-categories are: Ultra High, Very High, High, Medium, and Low. Using the crosswalk model, we were able to classify the claims in the MEDPAR file into the five rehabilitation therapy sub-categories and four of the remaining six categories: Extensive Services, Special Services, Clinically Complex, and Impaired Cognition. There were no available data elements in the MEDPAR to crosswalk for classification into the Behavior or Physical categories.

(1) Rehabilitation category. This is the most complex RUG–III category to crosswalk using the MEDPAR data base. A patient classifies into the Rehabilitation category based on the minutes per week of rehabilitation therapy services received. We also considered whether more than one of the rehabilitation disciplines provided services. MEDPAR data do not include minutes of service, but do reflect types of service provided. We, therefore, used charges as a proxy for minutes in approximating the amounts of service each beneficiary received. Since service patterns had to be approximated using ranges of rehabilitation therapy charges, great attention was paid to developing decision rules that would yield the most accurate description possible using Medicare claims. In addition, there are five levels of intensity within the Rehabilitation category. Using research study findings (Marsteller, Jill A. and Korbin Liu, ''High End Therapy Patients: How Many and How Much?'' Washington, DC, The Urban Institute, May 1994) and consultation with rehabilitation professionals, upper and lower charge limits were set to create groupings like each of the five RUG–III Rehabilitation categories.

As previously mentioned, nursing home case-mix is not a direct function of diagnosis. Diagnosis obviously has a role in determining what services a patient receives, but it is the services themselves, with the staff time required to provide them, that determine case-mix in nursing homes. Thus, for the Rehabilitation categories, the RUG–III system uses measures of staff time and service frequency, variety, and duration to classify patients. The criteria are in the form of minimum numbers of minutes of therapy per day or per week, minimum frequencies of therapy sessions over a week, and minimum numbers of therapy disciplines used per patient. While the MEDPAR analog can directly reproduce the variety of therapy given, frequency and duration can only be approximated using Part A covered charges for skilled therapy thought to be commensurate with certain patterns of service.

The five Rehabilitation sub-categories for the MEDPAR analog were determined using ranges of covered charges per day to approximate the RUG–III criteria. The ranges of covered charges used to classify the MEDPAR cases were based on an average charge of $300 per day for rehabilitation services. This amount is based on the covered charges for rehabilitation therapy in the MEDPAR file. To group cases using the MEDPAR file, the following ranges of covered charges were used: the Low Rehabilitation sub-category ranges from $150 per day and below in any combination of types of skilled therapy; the Medium Rehabilitation sub-category ranges from $150 to $199 per day in any combination of therapies; the High Rehabilitation sub-category ranges from $200 to $299 per day in any combination of therapies; the Very High Rehabilitation sub-category ranges from $300 to $399 per day in any combination of therapies (or $400 per day and above if only one therapy); and the Ultra High Rehabilitation sub-category range encompasses any case with covered charges higher than $400 per day in at least two of the three therapies. Refer to Table 2.C for comparison of these charge ranges to the number of minutes per day and per week required by the RUG–III system.

We set a threshold at $1,000 of covered charges for rehabilitation therapy services as a minimum for classification into any of the rehabilitation sub-categories. We based this on our finding, based on claims in the National Claims History file, that $400 is a common charge for an initial evaluation and $250 is a common charge for treatment by licensed therapists. Thus, we determined this threshold amount as representative of patients who received an evaluation by a professional rehabilitative therapist but no substantial course of rehabilitative therapy. That is, claims for patients with total therapy charges less than $1,000 were identified as having received an initial evaluation to determine the need for therapy but generally received no more than 1 week of rehabilitative therapy services.

Using the MEDPAR file, there was no way to approximate the nursing rehabilitation component of the RUG–III Low Rehabilitation sub-category. It was possible, however, to model rehabilitative therapy (of less than 5 days per week) using therapy charges that parallel such a pattern of treatment.

The Ultra High Rehabilitation sub-category is intended to apply only to the most complex cases requiring rehabilitative therapy well above the average amount of service time. This translates into higher charges for therapy services, both because treatment is more frequent and complex, and because length of stay is longer than for other skilled rehabilitation groups. In line with the intended complexity of this classification group, the lowest charge that the Ultra High sub-category includes is $400 per day in at least two of the three therapies.

The RUG–III criteria for Ultra High Rehabilitation are:

- Two of the three rehabilitation therapy disciplines are represented.
- At least 720 minutes of treatment per week across the three disciplines.
- One discipline providing services at least 5 days per week.

The remaining three sub-categories, Very High, High, and Medium Rehabilitation are not driven by a specific number of disciplines represented. All three require at least 5 days per week of skilled rehabilitative therapy, but they are split according to weekly treatment time. The Very High cases must be receiving 500 minutes per week and must be receiving at least one of the disciplines all 5 days; any additional disciplines will count toward the total time, but no other disciplines are required for assignment to this sub-category. Similarly, those in the High sub-category must be receiving a minimum of 325 minutes per week and this time must include one of the rehabilitation disciplines being provided daily (at least 5 days per week). Cases in the Medium sub-category must be receiving at least 150 minutes of skilled rehabilitation in any combination of disciplines over the minimum 5 days (or five 30-minute sessions).

(2) Non-rehabilitation categories. As stated above, MEDPAR contains ICD–9–CM codes as the variables describing patient diagnoses and procedures. This numerical coding system is used by hospitals to report patient information,

and nursing homes use these codes on a more limited basis for reporting. The MDS 2.0 has many of the most prevalent diagnoses found in this patient population listed for check-off by the nurse performing the assessment, with a section elsewhere on the form available to write in any relevant additional ICD–9–CM codes. The analog for the non-rehabilitation categories was created by matching the ICD–9–CM codes in the MEDPAR file to as much of the specific clinical criteria on the MDS 2.0 used to classify residents into the Extensive Services, Special Care, Clinically Complex, and Impaired Cognition categories.

Certain RUG–III criteria could not be satisfactorily coded by an ICD–9–CM code. Although we could capture the clinical characteristics of the patients, many of the items used to assign patients to specific RUG–III groups are not included in the ICD–9–CM coding scheme. In the Clinically Complex category, for example, the number of physician visits or order changes is a qualifying factor that cannot be captured by an ICD–9–CM code, and will not be reported in the MEDPAR file. Similarly, we could not capture the patient's ADL capabilities.

For the lower categories, Impaired Cognition, Behavior Only, and Physical Function Reduced, our ability to match the MDS 2.0 items to those likely to be reported on the MEDPAR was greatly diminished. We were able to identify a few codes with which to group some of the cases that would fall into the Cognitively Impaired category, but there were no ICD–9–CM codes that describe the patients who meet the criteria for the remaining two categories. Therefore, the analog only groups patients into the top five categories, leaving all other cases as unclassified.

(3) Case-mix using the analog. As explained above, in the RUG–III system, the case-mix index is a function of the distribution of residents in each of the categories, further detailed across the ADL index, and then by service counts, depression, or nursing rehabilitation services. ADLs, nursing rehabilitation, depression, and service counts could not be modeled using MEDPAR. For the analog, the nursing and nursing/therapy weights could not be applied to the second and third levels of the RUG–III system. In the Rehabilitation category, weights for the five sub-categories were combined.

f. Skilled Nursing Facility market basket index. Section 1888(e)(4) of the Act requires the Secretary to establish an 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. The SNF market basket index is used to develop the Federal rates and also to update the Federal rates on an annual basis beginning in fiscal year 2000. We have developed an SNF market basket index that consists of the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses. A complete discussion concerning the design and application of the SNF market basket index and the factors used in developing the payment rates is presented in section IV of this rule.

3. Methodology Used for the Calculation of the Federal Rates

The methodology used to compute the per diem standardized Federal rates was a multi-step process combining each of the data sources described above. This section details each of these steps. The schedule of Federal rates (Tables 2.G and 2.H) that results from this methodology is presented later in this section.

a. Per diem costs. In developing the per diem costs of SNFs, the cost data (including the estimate of Part B costs) for each facility are separated in components based on their relationship to the case-mix indices described above. This facilitates both the standardization of costs for case-mix and, similarly, the application of appropriate case-mix adjustment to the Federal rates. Costs related to nursing (excluding nurse management) and social services salaries (including benefits) and total costs (after allocation) of non-therapy ancillary services are grouped in the component related to the nursing index. Our analysis of patient level charges for these non-therapy ancillary services indicates a correlation between the RUG–III classification system and these services.

Occupational, physical, and speech therapy costs (after allocation) are grouped in the component related to the therapy index. The majority of SNF therapy costs are included in this therapy component of the per diem rate. As can be seen in the schedule of rates presented in Tables 2.E and 2.F, the therapy component of the per diem rates is only applicable to the 14 RUG–III therapy groups. However, through our analysis of Medicare claims and other data, we observed a low level of therapy services being utilized by patients that would not be classified into a RUG–III therapy group. These therapy services would include evaluations for rehabilitation in one or more of the therapy disciplines. Therefore, in order to provide more appropriate payment levels in the non-therapy RUG–III groups, we estimated therapy costs in our data base associated with non-therapy RUG–III groups. These costs were grouped into the non-case-mix component of costs but, as can be seen in the rate schedule, are only applicable to the non-therapy RUG III groups.

This estimate was determined using the percentage of therapy charges by discipline for each facility in our data base associated with the non-therapy RUG–III RUG categories as determined by the MEDPAR Analog. This percentage was applied by discipline to the therapy costs in each facility's cost report data. The results of this calculation are presented in Tables 2.A and 2.B. All other costs are grouped in the non-case-mix related component.

For each facility in the data base, components are converted to a per diem by dividing the costs by Medicare days. For the therapy component, costs are divided by the number of Medicare days related to patients receiving therapy. For the remaining components, costs are divided by total Medicare days. For each component of cost, an outlier elimination process is performed to eliminate aberrant values. Facilities with per diem amounts greater than three standard deviations from the geometric mean are determined to be outliers and are eliminated from the calculation of the per diem cost for that component.

As required by section 1888(e)(4)(E)(i) of the Act, all costs are updated from the base year to the initial period of the PPS (that is, the 15-month period beginning July 1, 1998 and ending September 30, 1999) using the SNF market basket index described in section IV of this rule (see Tables 4.D. and 4.E). As required by the statute, this update is determined using the annual SNF market basket percentage minus 1 percentage point.

b. Updating the data. The SNF market basket index is used to adjust each per diem amount forward to reflect cost increases occurring between the midpoint of the cost reporting period represented in the data and the midpoint of the initial period (beginning July 1, 1998 and ending September 30, 1999) to which the payment rates apply. In accordance with section 1888(e)(4)(B) of the Act, the cost data are updated for each year between the cost reporting period and the initial period by a factor equivalent to the annual market basket index percentage minus 1 percentage point.

c. Standardization of cost data. Section 1888(e)(4)(C) of the Act requires that the Secretary standardize the updated cost data for each facility for the effects of case-mix and geographic

differences in wage levels. In order to standardize for wage differences, the proportion of labor related and non-labor related components of SNF costs must be identified. These proportions are based on the relative importance of the different components of the SNF market basket index (see Table 4.C). Accordingly, the labor-related portion of costs is 75.888 percent of costs while the non-labor portion is 24.112 percent. Costs are standardized for geographic differences in wage levels using the hospital wage index (described earlier in this section).

To standardize the cost data for the effects of case-mix, we used the MEDPAR Analog on claims data applicable to the fiscal year 1995 cost reporting periods in the data base. This allowed us to classify each SNF's residents into one of 10 RUG–III categories produced by the analog. By applying the case mix indices applicable to the RUG–III categories assigned by the analog, we were able to develop average case-mix index values (nursing and therapy) for each facility. As described below, these index values were used in standardizing SNF costs for case-mix.

As discussed earlier in this rule, a MEDPAR Analog is used to standardize for case-mix because actual MDS data are not available on a national level. However, in order to correct for systematic differences between the case-mix estimates produced by the analog method and the method that will be used under this PPS (that is, based on MDS data), a sensitivity analysis of the analog was performed. This analysis involved a comparison of case-mix values (based on the application of the case-mix indices) generated by the analog and corresponding values generated from actual MDS resident assessments for a sample of SNFs and patients. While the availability of such comparative data is limited, we were able to draw a sample from the States participating in the Multistate Nursing Home Demonstration that included patients from approximately 100 SNFs in five States. The sample contained 13,354 Medicare claims covering 139,766 days of care. On average, case-mix values based on MDS data are 3 percent higher than analog-based values for the nursing index and 28 percent higher for the therapy index. This variance produced by the analog in the assignment of case-mix values is factored into the standardization methodology to ensure the rates are set at the appropriate level.

Each urban and rural component of per diem cost is standardized for differences in wage levels and case-mix by dividing total unstandardized cost by a standardization factor that reflects each facility's wage level and case-mix. This factor is based in part on each facility's wage adjustment (.7588 times its wage index plus .2412) multiplied by the appropriate case-mix value and number of days of care. These facility values are summed to obtain the standardization factor. The standardized cost is divided by the appropriate total days to obtain the standardized per diem cost.

This process equates per diem standardized cost (per diem cost adjusted for individual facility wage and case-mix differences) to per diem unstandardized cost. In this manner, standardization accounts for the application of individual facility wage index and case-mix adjustments to the per diem payment rates without altering the aggregates of the per diem cost data used to construct the per diem payment rates.

d. Computation of national standardized payment rates. Section 1888(e)(4)(D)(iii) of the Act authorizes the Secretary to compute separate payment rates for SNFs in urban and rural areas as defined in section 1886(d)(2)(D). Under the statute, urban areas are those defined by the Office of Management and Budget as metropolitan statistical areas (MSAs) or New England County Metropolitan Areas (NECMAs). All other areas are considered rural areas. Table 2.I showing the wage index indicates all areas considered urban for purposes of establishing these rates.

Using the data described above and the formula prescribed in section 1888(e)(4)(E) of the Act, we calculated the national average per diem standardized payment rates separately for urban and rural SNFs using the following steps. The unadjusted Federal rates resulting from this calculation are presented in Tables 2.A and 2.B below.

(1) As required by section 1888(e)(4)(D)(ii) of the Act, for each of the four components of cost, we computed the mean based on data from freestanding SNFs only. This mean was weighted by the total number of Medicare days of the facility.

(2) As required by section 1888(e)(4)(D)(i) of the Act, for each of the four components of cost, we computed the mean based on data from both hospital-based and freestanding SNFs. Again, this mean was weighted by the total number of Medicare days of the facility.

(3) As required by section 1888(e)(4)(E)(i) of the Act, for each of the four components of cost, we calculated arithmetic mean of the amounts determined under steps (1) and (2) above.

(4) The unadjusted Federal rate for the initial period is calculated differently depending on the RUG–III case-mix grouping. For the 14 RUG–III therapy groups, the unadjusted Federal rate is the sum of the nursing case-mix, non-case-mix and therapy case-mix components. For other RUG–III groups, the unadjusted Federal rate is the sum of the nursing case-mix, non-case-mix and therapy non-case-mix components.

TABLE 2.A.—UNADJUSTED FEDERAL RATE PER DIEM

[Urban]

Rate component	Nursing—case mix	Therapy—case mix	Therapy—non-case mix	Non-case mix
Per Diem Amount	$109.48	$82.67	$10.91	$55.88

TABLE 2.B.—UNADJUSTED FEDERAL RATE PER DIEM

[Rural]

Rate Component	Nursing—case mix	Therapy—case mix	Therapy—non-case mix	Non-case mix
Per Diem Amount	$104.88	$95.51	$11.66	$56.95

B. Design and Methodology for Case-Mix Adjustment of Federal Rates

As indicated earlier, section 1888(e)(4)(G) of the Act requires that the Federal rates be adjusted for case-mix (the relative resource utilization of patients). The RUG-III classification is a patient classification system that accounts for the relative resource utilization of different patient types. To adjust for case-mix, care provided directly to, or for, a patient is represented by an index score (case-mix index) that is based on the amount of staff time, weighted by salary levels, associated with each group. That is, each RUG-III group is assigned an index score that represents the amount of nursing time and rehabilitation treatment time associated with caring for the patients who qualify for the group. The nursing weight includes both patient-specific time spent daily on behalf of each patient type by registered nurses, licensed practical nurses, and aides, as well as patient non-specific time spent by these staff members on other necessary functions such as staff education, administrative duties, and other tasks associated with maintenance of the care giving environment.

The case-mix indices are applied to the unadjusted rates presented above resulting in 44 separate rates, each corresponding with one of the 44 RUG–III classification groups. To determine the appropriate payment rate, SNFs are required to classify patients into a RUG–III group based on assessment data from the MDS 2.0. The design and structure of RUG–III and the methodology and Federal policy associated with the classification of patients into RUG–III groups, including the completion of assessments (MDS 2.0) for Medicare patients, under this PPS, are described in the following pages.

1. Background on the Resource Utilization Groups (RUGs) Patient Classification System

As part of the Nursing Home Case-Mix and Quality demonstration project, Version III of the Resource Utilization Groups (RUG–III) case-mix classification system was developed to capture resource use of nursing home patients and to provide an improved method of tracking the quality of their care.

RUG–III is a 44-group model for classifying nursing home patients into homogeneous groups according to the amount and type of resources they use. The RUG–III groups are the basis for the payment indices used to establish equitable prospective payment levels for patients with different service use. Care provided directly to, or for, a patient is represented by an index score that is based on the amount of staff time, weighted by salary levels, associated with each group. That is, each RUG–III group is assigned an index score that represents the amount of nursing time and rehabilitation treatment time associated with caring for the patients who qualify for the group. The nursing weight includes both patient-specific time spent daily on behalf of each patient type by registered nurses, licensed practical nurses, and aides, as well as patient non-specific time spent by these staff members on other necessary functions such as staff education, administrative duties, and other tasks associated with maintenance of the care giving environment.

The principal goal of case-mix measurement is to identify patient characteristics associated with measured resource use. In nursing homes, no adequate models have been found for using length of stay or episode cost to explain resource use. Thus, the RUG–III nursing home case-mix system explains patient resource use on a daily basis.

The classification system was designed using resident characteristic information and measures of wage-weighted staff time. Information regarding a patient's characteristics and care needs is derived from the MDS, a set of core screening and assessment items and item definitions. The MDS is part of a standardized, comprehensive patient assessment instrument (the Resident Assessment Instrument or RAI) that all long term care facilities that are certified to participate in Medicare or Medicaid are required to use to develop individualized plans of care for each individual in the facility. The staff time measure (STM) study captured the amount of nursing staff time required to care for groups of residents over a 24-hour period and over the span of a week for therapy services.

Patient assessment and staff time data used to develop the initial version of the RUG–III classification system were collected from March to December 1990 for 7,648 patients in 202 nursing facilities in Kansas, Maine, Mississippi, South Dakota, Nebraska, Texas, and New York. Since then, two more staff time data collections have been performed on 154 Medicare certified units of hospital and freestanding facilities in 12 States (California, Colorado, Florida, Kansas, Maine, Maryland, Mississippi, New York, Ohio, South Dakota, Texas, and Washington). Only units that were judged to be providing adequate care were considered for participation in the study. Of these, States were asked to select facilities that included 35 percent Medicare certified units, 25 percent hospital units, and two Alzheimer's units. ''Unit'' was defined as a nursing center such as a corridor or a floor, controlled from one nursing station. The remainder of the sample was selected by the State's demonstration project staff to represent the characteristics of the State's nursing homes.

The sample was purposefully targeted toward residents needing complex care and/or with cognitive impairments. This assured that sufficient numbers of patients with rare types of complex care needs were included in the sample. Facilities with special care units (for example, Alzheimer's or Rehabilitation units) that participated in the study were also asked to provide data from a non-specialized unit.

During the data collection, personnel on the study units electronically recorded all of the time in their work days: time providing services directly to patients; in activities related to specific patients, such as charting or consultation with family members or other members of the patient care team; as well as time that is not attributable to any particular patient, like that spent in meetings, in training, on breaks, etc. The time was allocated according to whether or not it was directly related to a particular patient, and was categorized as either patient specific time or non-patient specific time.

Those data have been used to modify the classification system to create the current RUG–III and establish updated average staff times to be salary-weighted. Analyses of the staff time data in conjunction with the patient MDS information identified three main predictors of a patient's resource utilization: (1) clinical characteristics; (2) limitations in the activities of daily living (ADLs); and (3) skilled services received. The RUG–III classification system uses these three types of variables to describe SNF patients for the purposes of determining the relative cost of caring for different types of patients (case-mix).

Analysis of the data indicated that patients with serious clinical conditions such as dehydration and respiratory infections, as well as patients who were very dependent in ADLs, require more nursing time than patients without complicating conditions. The RUG–III classification system resulting from the analyses is hierarchical. The clinical characteristics of patients, as identified by the MDS, that were associated with the greatest utilization of nursing time and rehabilitative therapy time, were used to categorize patients into the highest case-mix classification groups.

Similarly, the clinical characteristics associated with the lowest utilization of nursing time were used to categorize patients into the lowest case-mix classification group. Not all clinical characteristics are recognized separately by the classification system. Only those characteristics that were predictive of resource use and that would not introduce incentives that are considered to be negative, or not compatible with high quality patient care, are used to classify patients into RUG–III groups.

Table 2.C shows the mutually exclusive, layered categories of the RUG–III classification system. The table describes which patient clinical characteristics, levels of assistance used in performing ADLs, and services are used to assign the patient to a RUGs group. Clinical characteristics include the patient diagnoses, conditions, and comorbidities. ADLs include bed mobility, toilet use, transfer from bed to chair, and eating. Patients receive a single RUG–III ADL score that measures the patient's ability to perform these activities (scores range from 4–18; higher scores represent greater functional dependence and a need for more assistance). Finally, treatments and services include respiratory therapy, amount of rehabilitation received, and treatments such as suctioning and intravenous medication administration.

TABLE 2.C.—CROSSWALK OF MDS 2.0 ITEMS AND RUG III GROUPS

Category	ADL index	End splits	MDS RUG III codes
REHABILITATION			
ULTRA HIGH	16–18	Not Used	RUC
Rx 720 minutes/week minimum	9–15	Not Used	RUB
At least 2 disciplines, one at least 5 days/week	4–8	Not Used	RUA
VERY HIGH	16–18	Not Used	RVC
Rx 500 mins. a wk. minimum	9–15	Not Used	RVB
At least 1 discipline—5 days	4–8	Not Used	RVA
HIGH	13–18	Not Used	RHC
Rx 325 mins. a wk. minimum	8–12	Not Used	RHB
1 discipline 5 days a week	4–7	Not Used	RHA
MEDIUM	15–18	Not Used	RMC
Rx 150 mins. a wk. minimum	8–14	Not Used	RMB
5 days across 3 disciplines	4–7	Not Used	RMA
LOW—Rx 45 minutes/week over at least 3 days	14–18	Not Used	RLB
Nursing rehabilitation 6 days/week, 2 activities	4–13	Not Used	RLA
EXTENSIVE SERVICES—(Adlsum <7 Special)			
IV Feeding in last 7 days	7–18	count of other categories code	SE3
In last 14 days, IV medications, suctioning	7–18	into plus IV	SE2
Tracheostomy care, ventilator/respirator	7–18	Meds +Feed	SE1
SPECIAL CARE—(ADLSUM <7 Clin. Complex)			
MS, Quad, or CP with ADLsum >=10, Resp. Ther.=7 days	17–18	Not Used	SSC
Tube fed and aphasic; Radiation tx; Rec'g tx for surgical wnds/lesions or ulcers (2=sites, any stg; 1 site stg 3 or 4).	15–16	Not Used	SSB
Fever with Dehy., Pneu., Vomit., Weight Loss, or Tube Fed	7–14	Not Used (Extensive <7 ADL)	SSA
CLINICALLY COMPLEX—Burns, Coma, Septicemia, Pneumonia, Footwnds, Internal Bld, Dehyd, Tube fed (minimum.	17–18D	Signs of depression	CC2
501 ml. fl, 26% cals), Oxygen, Transfusions	17–18		CC1
Hemiplegia with ADL sum >=10, Chemotherapy, Dialysis	12–16D	Signs of depression	CB2
No. of Days in last 14—Phys. Visits/makes order changes:	12–16		CB1
visits>=1 and chng.>=4; or visits>=2 and chng.>=2	4–11D	Signs of depression	CA2
Diabetes with injection 7 days/wk and order chng.>=2 days	4–11	(Special <7 ADL)	CA1
IMPAIRED COGNITION:			
Score on MDS2.0 Cognitive	6–10	Nursing rehabilitation not receiving	IB2
Performance Scale >=3	6–10		IB1
(Score of ''6'' will be Clin. Comp. or PE2–PD1)	4–5	Nursing rehabilitation not receiving	IA2 IA1
BEHAVIOR ONLY:			
Code on MDS 2.0 items	6–10	Nursing rehabilitation not receiving	BB2
4+ days a week	6–10		BB1
wandering, physical or verbal abuse	4–5		BB2
inappropriate behavior or resists care	4–5		BA1
or hallucinations, or delusions	4–5		BA1
PHYSICAL FUNCTION REDUCED:			
No clinical variables used	16–18 16–18 11–15	Nursing rehabilitation not receiving	PE2 PE1
Nursing Rehab. Activities >=2, at least 6 days a wk	11–15	Nursing rehabilitation not receiving	PD2 PD1
Passive or Active ROM, amputation care, splint care	9–10	Nursing rehabilitation	PC2
Training in dressing or grooming, eating or swallowing	9–10	not receiving	PC1
transfer, bed mobility or walking, communication, scheduled toileting program or bladder retraining.	6–8 6–8 4–5 4–5	Nursing rehabilitation not receiving Nursing rehabilitation not receiving	PB2 PB1 PA2 PA1

TABLE 2.C.—CROSSWALK OF MDS 2.0 ITEMS AND RUG III GROUPS—Continued

Category	ADL index	End splits	MDS RUG III codes
			Default

Source: Analysis of the 1995 Medicare Units Staff Time.
Study: Update of RUG III Classification MDS.

2. The RUG–III Classification System

In the RUG–III classification system, patient characteristic and health status information from the MDS, such as ''diagnoses,'' ''ability to perform ADLs,'' and ''treatments received,'' will be used to assign the patient to a resource group for payment. The RUG–III system is a hierarchy of major patient types. RUG–III consists of seven major categories that are the first level of patient classification. The major categories, in hierarchical order, are Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Function. These major categories are further differentiated into 44 more specific patient groupings. Except for Rehabilitation and Extensive Services, these categories are first subdivided into groups based on the patient's ADL score. The next level of subdivision is based on nursing rehabilitation services and signs of depression.

The initial subdivision of the Rehabilitation category is based on minutes per week of rehabilitative therapy services. The second level of subdivision uses ADL score. The Extensive Services category does not use ADL limitations except as a threshold for assignment into the category. Rather, services that require more technical clinical knowledge and skill are the variables used for assignment of patients into this category. Examples of these services are intravenous feeding or medications and tracheostomy care.

For example, the Special Care category includes patients with quadriplegia, multiple sclerosis, surgical wound(s), open lesions, fever with vomiting, dehydration, pneumonia, tube feedings, or weight loss, those who are aphasic and need to be tube fed, those receiving treatment for 2 or more skin ulcers, and patients who are receiving radiation therapy. Any patient with one or more of these conditions, who is not receiving rehabilitation services, will be assigned to this category. The patient's assignment to one of the three groups within this category is dependent on the patient's ADL score.

The Rehabilitation category is organized differently than the clinical categories that follow in the hierarchy. Within this category, there are five sub-categories (Ultra High, Very High, High, Medium, and Low) that are then further split into the individual groups for payment. The sub-categories are defined by minutes per week of rehabilitation received by the patient, number of rehabilitation disciplines providing service, and the number of days per week on which rehabilitation services were provided. Assignment into a specific payment group is based on the patient's ability to perform certain of the activities of daily living as represented by his ADL score. As stated elsewhere, the patient is assessed on his ability to perform independently all of the activities of daily living and is assigned an ADL sum score that represents performance of the four ''late loss'' ADLs. The ''late loss'' ADLs used in the MDS ADL sum score are: eating; toileting; bed mobility; and transferring.

A brief description of the respective RUG–III categories follows.

Rehabilitation: This category includes patients who, if they were not receiving rehabilitation therapy, would qualify for one of the other RUG–III skilled care categories. This category is divided into subcategories based on the number of minutes of rehabilitative services received in a week, combinations of rehabilitation disciplines providing services, receipt of nursing rehabilitative services, and the patient ADL scores. The range of rehabilitation therapy minutes per day represented in the Rehabilitation category varies from a low of 45 minutes per week to a high of more than 720 minutes per week. Patients who qualify for assignment to the Ultra High Rehabilitation sub-category receive at least 720 minutes per week of rehabilitation therapies. At least two disciplines must be providing services: one of the disciplines must provide services 5 days each week, and the other must provide services at least 3 days each week. In contrast, patients assigned to the lowest rehabilitation sub-category, Low Rehabilitation, must receive at least 45 minutes of rehabilitative therapy services across at least 3 days each week, in addition to 6 days per week of nursing rehabilitation in two activities.

Extensive Services: To qualify for this category, patients must have, in the past 14 days, received intravenous medications, tracheostomy care, required a ventilator/respirator, required suctioning, or must have, in the past 7 days, received intravenous feeding. In addition, the patients assigned to this category will have an ADL score that is at least 7.

Each patient in the extensive services category is assigned a score of 0–5 based on five criteria. The score is used to classify the patient to one of the three RUG–III groups in this category—0 or 1 will classify into the SE1 group, those with scores of 2 or 3 will go to SE2, and those with 4 or 5 will group to SE3.

For the following five criteria, the patient receives one point for each criterion that applies to him or her. The first three criteria are presence of a clinical condition that qualifies the patient for classification to the Special Care category, Clinically Complex category, or the Cognitively Impaired category. The fourth and fifth criteria are whether the patient is receiving intravenous feeding or whether the patient is receiving intravenous medication.

For example, a person who qualifies for both the Cognitively Impaired and Special Care categories will be assigned a score of 2 and will be classified into the SE2 group. Similarly, a patient who is ventilator dependent and requires suctioning will be assigned a score of 0 and will be classified into SE1.

Special Care: Patients who are assigned to this category have at least one of the following: multiple sclerosis, cerebral palsy, quadriplegia with an ADL score of 10 or more, or receive respiratory therapy 7 days per week; have, and receive treatment for, pressure or stasis ulcers on 2 or more body sites; have a surgical wound(s) or open lesions; be tube fed with at least 26 percent of daily calorie requirements and at least 501 ml of fluid through the tube per day, and aphasic; receive radiation therapy; or have a fever in combination with dehydration, pneumonia, vomiting, weight loss, or tube feedings.

Clinically Complex: Patients qualify for this category if they are comatose, have burns, septicemia, pneumonia, internal bleeding, dehydration, dialysis, hemiplegia in combination with an ADL

score of 10 or more, receive chemotherapy, tube feedings that comprise at least 26 percent of daily calorie requirements and at least 501 ml of fluid through the tube per day, treatments for foot wounds, or transfusions. Also included in this category are diabetics who receive injections 7 days per week and who have two or more physician order changes in the past 14 days as well as patients who have received oxygen therapy in the past 14 days. In order to assure inclusion of patients with unstable conditions, we also use a combination of physician visits and order changes as qualifying criteria for this category. This is a proxy measure for the amounts of skilled nursing observation, care planning, and monitoring usually required by this type of patient. The qualifying combinations of physician visit/order changes that must occur within the 14-day observation period to qualify for this category are: one or more visits with at least four order changes, or two or more visits with two or more order changes.

Impaired Cognition: Patients in this category and the following two categories frequently will not qualify for Medicare coverage although some may, due to specific circumstances. The patients in this category will have scores on the MDS 2.0 Cognition Performance Scale of 3, 4, or 5, and for two of the groups in this category will be receiving nursing rehabilitation services 6 days per week. Some patients with Alzheimer's disease or other types of dementia who have been acutely ill will classify to this category for Medicare. Under the SNF coverage guidelines, these patients could qualify based on the need for skilled nursing rehabilitation.

Behavior Only: These are patients who, in 4 of the last 7 days, exhibited behaviors that include resisting care, being combative, being physically and/or verbally abusive, wandering, and who have hallucinations or delusions.

Physical Function Reduced: The patients in this category are those who do not have any of the conditions or characteristics identified above. However, some have been documented as receiving ''skilled nursing'' and have been covered by Medicare in the past. With proper documentation and justification regarding the need for skilled care, Medicare may continue to cover SNF services.

3. Use of RUG–III ''Grouper'' Software

As discussed at the beginning of this section, all data necessary to classify a patient to one of the RUG–III categories is contained on the MDS 2.0. Under this PPS, SNFs are required to use the MDS 2.0 as the data source for classification of patients for case-mix. The software programs that use the MDS 2.0 to assign patients to the appropriate groups, called groupers, are available from many software vendors. The version we use is available at no cost from our web site at: http://www.hcfa.gov/medicare/ hsqb/ mds20.

The logic used in the groupers is based on the hierarchical nature of the RUG–III system. This means that the patient is first assigned to the highest category for which the patient qualifies, and then, using relevant additional criteria, as explained above (ADL score, nursing rehabilitation, etc.), the patient is assigned to one of the groups within that category.

The grouper assigns patients to the highest-weighted group rather than to the highest group in the hierarchy. This is important because there may be rare instances in which a case would qualify for a group that, although higher in the hierarchy, has a lower payment index than a group that is lower in the hierarchy.

4. Determining the Case-Mix Indices

Care provided directly to, or for, a patient is represented by an index score that is based on the amount of staff time, weighted by salary levels, associated with each group. That is, each RUG–III group is assigned an index score that represents the amount of nursing time and rehabilitation treatment time associated with caring for the patients who qualify for the group. The nursing weight includes both patient-specific time spent daily on behalf of each patient type by registered nurses, licensed practical nurses, and aides, as well as patient non-specific time spent by these staff members on other necessary functions such as staff education, administrative duties, and other tasks associated with maintenance of the care giving environment.

As explained above (in section II.B.1), measures of the staff time required to care for nursing home patients were collected and used to identify specific clinical characteristics that are predictive of patient resource use. In order to do this, characteristics of the patients in the STM study and the time it took to care for them were combined and analyzed. In addition, the ratio of salaries for nursing staff and rehabilitative therapy staff were computed in order to calculate nursing and therapy weights for each RUG–III category. These analyses were then used to identify the patient characteristics that best explain weighted patient specific time. From this, the 44 groups and an index for each was calculated. The basic calculation performed for each group was to take the minutes spent providing patient care and multiply them by the weight that represents the staff person's salary. Thus, the registered nurse's minutes were multiplied by 1.41, whereas those of the aide were multiplied by 0.59. The therapy weights include physical therapist (1.32), occupational therapist (1.23), and speech pathologist (1.16) time plus licensed physical therapy assistant (0.87), licensed occupational therapy assistant (0.81), and therapy aide (0.61) time, on a weekly basis. The nursing and therapy weights are multiplied by the number of patients in each group to yield an array of 44 nursing case-mix index scores and 5 therapy case-mix index scores. These indices are shown later in this section (see Tables 2.E and 2.F).

5. Application of the RUG–III System

Following are some illustrative case studies to illustrate how the RUG–III classification system would compare patients with similar descriptions but disparate classifications.

Example 1. Ms. A was recently hospitalized with a stroke. She has several comorbidities that include cardiac dysrhythmia, hypertension, and diabetes mellitus, and experienced a urinary tract infection within the last 30 days. In addition, she has lost voluntary movement in her left arm and leg, and has an unsteady gait, pain almost daily, and some localized edema, but is continent when toileted at regular intervals. She can see, hear, understand, and make herself understood. She tires easily and carries out ADLs slowly. Her mood is frequently tearful, and she expresses sadness about the loss of past life roles. She is concerned about her health and views herself, and is viewed by staff, as having potential for rehabilitation.

Her memory is good, although she does have some difficulty making decisions in new situations. She is involved in the daily life of the nursing home, interacts well with others, and is able to set her own goals. She spends some time in her own room in self-initiated activities.

Ms. A requires the assistance of one person to accomplish her personal hygiene, dressing, toileting (RUG–III ADL index score=4), bed mobility and transferring (ADL scores=4 each), and locomotion and eating (ADL score=2). She uses pressure-relieving chair and bed pads and receives special attention for her skin. She undergoes physical therapy and occupational therapy for 1 hour each, 5 days per week. Ms. A

receives daily restorative/rehabilitative follow-up nursing care and skill training for eating, active and passive range of motion, transferring, dressing, grooming, and locomotion, and participates in a bowel and bladder retraining program. Discharge from the facility is planned within the next 3 months.

As a stroke patient receiving two therapies five times a week, Ms. A is classified in the Very High Rehabilitation category. She has an ADL index score of 14 (4+4+4+2) and will therefore be classified into the RVB group. In case-mix calculations, her case receives a nursing weight of 1.04 and a therapy weight of 1.41.

Example 2, a non-rehabilitation patient. Ms. B has multiple sclerosis. At the present time she is recovering from a bout of pneumonia. She also had a urinary tract infection within the last 30 days. She has lost some voluntary movement in her extremities and cannot balance herself well in a standing position. She is not bedfast, however, and is in a wheelchair during the day. She has a history of pressure sores, but none are present at this time. There is stiffness in her hips, hands, feet, and shoulders. She complains of constipation and is sometimes incontinent of the bladder. She is able to see, hear, fully understand what is said, and is understood.

Her memory is good, and she is independent in her decision making. Her mood, however, is tearful, and she expresses distress. She grieves for her past life as a professional musician, and she is often withdrawn and has been verbally abusive to her roommate during the past week.

Ms. B uses extensive assistance with transferring (RUG–III ADL index score=4), locomotion, and toileting (ADL score=4), and limited assistance with bed mobility (ADL score=3), personal hygiene, and dressing. As she has had a history of pressure sores, she uses bed and chair pressure prevention pads and receives special skin care, positioning, and turning regularly over the day. Her intake and output are monitored, and the nursing staff provides passive and active range of motion and skill training for transferring with a trapeze while encouraging active range of motion where possible. She also began a bowel and bladder retraining program last week. Any discharge plan for Ms. B is uncertain at this time.

With multiple sclerosis and a high level of ADL dependency, Ms. B is classified into the Special Care category. Her ADL score is at least 12 (4+3+4+1). Service counts and mental state are not used in the Special Care category, so her depressed mood does not factor into her assignment into a RUG group, although it influences her plan of care. She will be classified to the SSA group in the Special Care category. In RUG–III case-mix calculations, Ms. B is assigned a nursing weight of 1.01 and a therapy weight of 0 since she did not receive occupational, physical, or speech therapy in the last 7 days. Note that these weights are lower than those assigned to Ms. A in example 1, despite the similarities in their clinical descriptions.

6. Use of the Resident Assessment Instrument—Minimum Data Set (MDS 2.0)

The requirements for patient assessment found at § 483.20 apply to all patients in a Medicare or Medicaid certified long term care facility, regardless of the patient's age, diagnoses, length of stay, or payer source. Certified facilities are required to use the RAI specified by the State to assess patients. Each State's RAI consists of HCFA's MDS at a minimum. The RUG–III classification system and, subsequently, the Medicare SNF prospective payment, are based on the Minimum Data Set (MDS). The MDS contains a core set of screening, clinical, and functional status elements, including common definitions and coding categories, that form the basis of a comprehensive assessment.

In order to receive Medicare payment under PPS, in addition to completion of the uniform MDS as set forth at § 483.20, the facility will be required to complete two additional sections of the MDS: Sections T and U. Section U is currently an optional section of the MDS used to collect information on medication. However, completion of this section is required for States participating in HCFA's Nursing Home Case-Mix and Quality (NHCMQ) demonstration and several other States as well. Although collection of medication information on Section U will be required for Medicare patients under this PPS, we will not require completion and transmission of this information until October 1, 1999. In the interim, we will examine the potential for refining Section U in a way that would streamline data collection, reduce opportunities for error, and thereby maximize the accuracy and usefulness of the data.

Section T provides information on special treatments and therapies not reported elsewhere in the patient assessment. In section T, the facility must record the rehabilitative therapy services (physical therapy, occupational therapy, and speech therapy) that have been ordered and are scheduled to occur during the early days of the patient's SNF stay. As rehabilitation services often are not initiated until after the first MDS assessment's observation period ends, we believe that allowing the patient time for transition is appropriate. Section T provides an overall picture of the amount of rehabilitation that a patient will likely receive through the 15th day from admission. This information on the MDS will make possible an accurate classification of the patient for whom rehabilitation is planned into the appropriate RUG–III group. SNFs must complete this section for services furnished on or after July 1, 1998.

Section T also provides information needed to evaluate a patient's response to therapy. For example, by assessing a patient's ability to walk at his most self-sufficient level, small increments of improvement can be measured. This level of detail is not contained in other areas of the MDS in contrast with the information recorded elsewhere in the MDS, regarding the patient's walking ability most of the time. Assessment of the patient's ''most self sufficient'' can be used to evaluate the effectiveness of physical therapy and nursing rehabilitation, the continued need for therapy and nursing rehabilitation, and maintenance of walking ability immediately after therapy is discontinued.

7. Required Schedule for Completing the MDS

Under section 1888(e)(6) of the Act, SNFs must ''provide the Secretary, in a manner and within the timeframes prescribed by the Secretary, the resident assessment data necessary to develop and implement the rates under this subsection.'' We are requiring that SNFs perform patient assessments by the 5th day (although there is a grace period that allows performance by the 8th day) of the SNF stay, again by the 14th day, by the 30th day, and every 30 days thereafter as long as the patient is in a Medicare Part A stay. A full MDS must be submitted by facilities at each of these timeframes during a patient's Medicare Part A stay. Each Medicare patient is classified in a RUG–III group for each assessment period for which he is in a Part A SNF stay. The group to which the patient classifies is based on the information about his clinical resource needs as recorded on the MDS assessment.

Facilities will send each patient's MDS assessments to the State and claims for Medicare payment to the fiscal intermediary on a 30-day cycle.

Payment will be made according to the RUG–III group(s) recorded on the claim sent to the fiscal intermediary. For the first 30 days in an SNF, a Medicare patient will be assessed three times (at 5 days, 14 days, and 30 days) and perhaps more often, if the patient's needs change requiring additional MDS assessments and care plan modifications. Any of the assessments performed may result in a RUG–III classification change.

Each patient is to be assessed using full or comprehensive assessments according to the stated schedule. The State's RAI constitutes a ''comprehensive'' assessment, which is required at various timeframes according to Federal regulations found at § 483.20. In the following schedule, ''full'' assessment refers to completion of the entire MDS, and ''comprehensive'' refers to completion of the Resident Assessment Protocols (RAPs) in addition to the entire MDS. The SNF provider should adhere to the following assessment schedule for newly admitted and readmitted beneficiaries whose stays are expected to be covered by Medicare during the first 30 days of admission/readmission to the SNF.

Day 0 Represents the period prior to admission

Day 1 Patient admission day and notification of ''Non-coverage''

Day 5 Last day for Assessment Reference Date for the Medicare 5 Day Assessment

Day 14 Last day for Assessment Reference Date for the Medicare 14 day Assessment (In accordance with Federal requirements at § 483.20, RAPS must be completed with the 5 day or the 14 day assessment)

Day 29 Last day for Assessment Reference Date for the Medicare 30 day assessment (RAPs not required for Medicare unless a Significant Change in Status has occurred)

Day 59 Last day for Assessment Reference Date for the Medicare 60 day assessment (RAPs not required for Medicare unless a Significant Change in Status has occurred)

Day 89 Last day for Assessment Reference Date for Medicare 90 day assessment (RAPs not required for Medicare unless a Significant Change in Status has occurred)

Day 100 Last possible day of Medicare coverage. Staff should return to the State-required MDS assessment schedule.

This schedule applies to Medicare beneficiaries during Part A Medicare nursing home stays.

Note that historically, instructions for completing the RAI, as in the *Long Term Care Resident Assessment Instrument User's Manual,* state that ''when calculating when the Resident Assessment Instrument (RAI) is due, the day of admission is counted as day zero.'' Counting the day of admission as day zero has allowed the maximum flexibility in terms of time to complete the RAI. For case-mix reimbursement purposes, however, States that participated in HCFA's Nursing Home Case-Mix and Quality Demonstration (NHCMQ) project have required that the day of admission be counted as day one. The use of the day of admission as day one is continued under the PPS rules for reimbursement scheduling. In support of this scheduling, in the future, HCFA will provide instructions for RAI completion counting the day of admission as day one.

In order to be in compliance with the requirements of Medicare and Medicaid certification, facilities must complete an Initial Admission assessment, including RAPs, within 14 days of a patient's admission to the facility. Within approximately the same time, the requirements for PPS specify that facilities must complete two assessments for each patient in a Medicare-covered Part A stay. These include a Medicare 5-day and a Medicare 14-day assessment. According to the rules for PPS, the RAPs must be completed with either the 5-day or the 14-day assessment, and the facility may choose with which of these assessments to complete the RAPs.

In order to minimize burden on facility staff, in some instances, the same assessment that is completed and electronically submitted to the State to meet the clinical requirements at § 483.20 may also be used to meet the PPS requirements. For example, the facility may use either the Medicare 5-day or the Medicare 14-day assessment (whichever one included the RAPs) to meet both the requirements for PPS, as well as the clinical requirements for completing and transmitting an Initial Admission assessment. In this case, the ''Reason for Assessment'' item on the MDS would be coded both as an Initial Admission assessment and as a Medicare 5-day or 14-day assessment. There is no grace period for the Initial Admission assessment to correspond with the grace period that the PPS rules allow for the Medicare 14-day assessment. Therefore, if a facility is using the Medicare 14-day assessment to also meet the requirement for the Initial Admission assessment, the assessment must be completed by day 14, and the grace period does not apply.

In order to be in compliance with the requirements for Medicare and Medicaid certification, facilities must perform the HCFA Standard Quarterly Review assessment for each resident in the facility at least every 92 days. The requirements for PPS specify that a Medicare 90-day assessment be completed for each patient whose stay is still covered under Medicare. To minimize burden on facility staff, the Medicare 90-day assessment that is completed to meet PPS requirements may also be used to meet the clinical requirements at § 483.20 for completion of a Quarterly Review assessment. In this case, the ''Reason for Assessment'' item on the assessment would be coded both as a ''Quarterly Review'' assessment, and as a Medicare 90-day assessment. Although the PPS rules allow a 5-day grace period in completing the Medicare 90-day assessment, the Quarterly Review assessment must be completed within 92 days of completion of the last assessment. Therefore, if a facility is using the Medicare 90-day assessment to also meet the requirement for the Quarterly Review assessment, the assessment must be completed within 92 days of completion of the prior assessment, and only 2 days of the 5-day grace period could apply.

Facilities must also adhere to Federal regulations that require a comprehensive reassessment if the patient experiences a significant change in status. A significant change is a major change in a patient's status that is not self-limiting, affects more than one area of his health status, and requires interdisciplinary review. Accordingly, a patient must be reassessed whenever significant improvement or decline is consistently noted by facility staff. The current guidelines for determining a significant change in the patient's status are listed in the *Long Term Care Resident Assessment Instrument User's Manual.* These include, for example, a change in the patient's decision-making abilities from 0 or 1 to 2 or 3 on item B4 of the MDS 2.0. As a complement to these standard guidelines, we are requiring under PPS, that a comprehensive assessment be performed when a patient's rehabilitation service is discontinued unless the patient is physically discharged from the facility. For those rare instances in which a Significant Change in Status assessment is not clinically warranted, but rehabilitative services are discontinued, we are requiring a comprehensive assessment to be coded as ''Other Medicare Required Assessment.''

The assessment reference date for this assessment may be no earlier than 8 days after the conclusion of all rehabilitative therapies and no later than 10 days after the conclusion of such services. If the patient expires or is discharged from the facility, no

assessment is required. This assessment will result in a new case-mix classification for the patient and a new rate of payment. The new classification and payment rate will be effective as of the assessment reference date of this comprehensive assessment. If the resulting new classification is below those groups deemed covered by Medicare in the RUG–III hierarchy and the patient would not be covered by the existing administrative criteria for making SNF level of care determinations, a ''continued stay'' denial notice should be issued.

A Significant Change in Status assessment or Other Medicare Required Assessment that falls during the assessment window of a Medicare mandated assessment may take the place of one of the regularly scheduled assessments. If the assessment reference date of an Other Medicare Required Assessment or a Significant Change in Status assessment coincides with the range of days allowable for use as the assessment reference date for a regularly scheduled Medicare assessment, a single assessment may be coded as both a Significant Change in Status or Other Medicare Required Assessment and as a regularly scheduled Medicare assessment. For example, a Significant Change in Status assessment completed on day 28 of the patient's nursing home stay would replace the 30-day scheduled assessment. However, a significant change that occurs on day 40 would not replace any scheduled assessment. Table 2.D below presents the schedule for MDS completion related to days covered and payment.

TABLE 2.D.—MEDICARE ASSESSMENT SCHEDULE

Medicare MDS assessment type	Reason for assessment (AA8b code)	Assessment reference date	Number of days authorized for coverage and payment	Applicable medicare payment days
5 day	1	Days 1–8*	14	1 through 14.
14 day	7	Days 11–14**	16	15 through 30.
30 day	2	Days 21–29	30	31 through 60.
60 day	3	Days 50–59	30	61 through 90.
90 day	4	Days 80–89	10	91 through 100.

*If a patient expires or transfers to another facility before day 8, the facility will still need to prepare an MDS as completely as possible for the RUG–III classification and Medicare payment purposes. Otherwise the days will be paid at the default rate.

**–RAPs follow Federal rules; RAPs must be performed with either the 5-day or 14-day assessment.

SNFs must submit the RAPs with either the 5-day or 14-day assessment. As noted above, RAPs must be completed as part of any Significant Change in Status assessments and Other Medicare Required Assessments that are appropriate. SNFs should consult the current version of the *Long Term Care Resident Assessment Instrument User's Manual* for more specific information regarding the RAPs.

The first MDS assessment for Medicare eligible beneficiaries should be completed by day 5 of the patient's SNF stay. The admission day counts as day 1. The Assessment Reference Date for the 5-day assessment may be any day between days 1 and 5 (although there is a 3-day grace period to day 8).

As stated in the note following Table 2.D, if a patient expires or transfers to another facility before day 8, the facility will still need to prepare an MDS as completely as possible for RUG–III classification and Medicare payment purposes. Otherwise, the days will be paid at the default group rate.

Subsequent to the 5-day assessment, the SNF must complete assessments for each coverage period in accordance with the Medicare assessment schedule. The staff must use the time periods as specified in the current *Long Term Care Resident Assessment Instrument User's Manual* and must include the assessment reference date/last day of the observation period to judge the patient's condition except for the change items found at the end of particular MDS sections. The change items in Sections B, C, E, G, and H are assessed by referring back to the reference day of the last MDS completed.

The nurse coordinating the care of a Medicare Part A covered patient has considerable leeway in determining the reference date for all assessments after the initial MDS. This should be helpful in making the assessment schedule required for Medicare coincide with Significant Change in Status, and Other Medicare Required Assessments that may be necessary, or in avoiding scheduling or service delivery problems during holiday periods. The following is an example: Ms. Smith was admitted on March 21, 1997. The assessment reference date for Ms. Smith's 14-day assessment was April 2, 1997. The nurse coordinator has selected April 16, 1997 as the assessment reference date for her 30-day assessment. In this case, the instructions for the change items should be interpreted as the period between the assessment reference date of April 2, 1997 (the 14-day assessment) and the assessment reference date of April 16, 1997 (the 30-day assessment).

8. The Relationship Between Payment and the MDS

As explained above, each Medicare patient is classified in a RUG–III group for each assessment period for which he is in a Part A SNF stay. The group to which the patient classifies is based on the information about his clinical resource needs as recorded on the MDS assessment.

Facilities will send each patient's MDS assessments to the State and claims for Medicare payment to the fiscal intermediary on a 30-day cycle. Payment will be made according to the RUG–III group(s) recorded on the claim sent to the fiscal intermediary. For the first 30 days in an SNF, a Medicare patient will be assessed three times (at 5 days, 14 days, and 30 days) and perhaps more often, if the patient's needs change requiring additional MDS assessments and care plan modifications. Any of the assessments performed may result in a RUG–III classification change.

For example, a facility may have a patient whose first (5-day) MDS results in assignment to a Special Care group, but whose second assessment (14-day) indicates an assignment to a High Rehabilitation group. The facility must record these groups on its claim and will receive payment at the Special Care group rate for 14 days and then at the High Rehabilitation group rate for the

15th through 30th days. If a third MDS is performed during that 30 days indicating a change in the patient's condition that results in assignment to yet a third RUG–III group, the facility must record three groups on its claim to the fiscal intermediary and will receive payment accordingly for the days in the third RUG–III group. Table 2.D shows the relationship of the billing cycle to the MDS submissions.

9. Assessments and the Transition to the Prospective Payment System

For Medicare patients already in the nursing home during the facility's transition into the PPS, we are providing several alternative assessment schedule options from which to choose.

a. Medicare beneficiaries receiving Part A benefits admitted within the past 30 days. For a Medicare patient in a Part A covered stay, admitted in the 30 days before the SNF became subject to PPS, who has had an MDS completed during those 30 days, facility staff may choose to use the most recent full MDS assessment completed (within the past 30 days) for RUG–III classification. This classification would be effective on the first day the SNF joins PPS and determines the payment the SNF receives for the patient for the first 14 days the facility is in the new system. The next assessment must be completed by the 14th calendar day of the month the facility entered the PPS.

Another option is for the facility staff to choose to treat the beneficiary as a ''new'' admission on the first day of the facility's billing period. In this instance, a Medicare 5-day assessment must be performed as if the day the facility enters the PPS is day 1 of the patient's Part A nursing home stay, and then the assessment schedule followed as it would be for a new admission, as detailed above. There is no change in the patient's Medicare eligibility or coverage. Further, no additional days are added to Medicare's 100-day limit.

b. Medicare beneficiaries receiving Part A benefits admitted over 30 days prior. If a Medicare beneficiary was receiving Medicare Part A benefits for the past 30 days and has not had a full MDS assessment completed within the past 30 days, the beneficiary is considered a new admission to the PPS and follows the assessment schedule presented above (paragraph (a)). The new admission status is only for Medicare MDS assessment scheduling. There is no change in the patient's Medicare eligibility or coverage. Further, no additional days are added to Medicare's 100-day limit.

c. Medicare Part A beneficiaries with less than 14 days of Medicare eligibility remaining. If the patient has less than 14 days of Medicare eligibility remaining when the SNF becomes subject to PPS, the facility has the option of completing an Other Medicare Required assessment or using the most recent assessment to classify the resident.

These guidelines are intended to maximize the beneficiary's opportunity to receive Medicare Part A benefits during the facility's transition from one payment system to another, provided that the Medicare Part A eligibility rules and coverage guidelines are met. Facility staff are able to utilize the RUG–III clinical categories to determine coverage for this group of beneficiaries.

10. Late Assessments

We recognize that the effect on revenue for missing an assessment can be great. To allow facilities flexibility and to minimize their revenue loss, we will permit an assessment to be completed as quickly as possible. Once a late assessment is conducted, the facility should return to the regular Medicare assessment schedule.

Frequent late assessments may result in an on-site review of assessment scheduling practices for the facility. Also, facilities need to be aware that assessments not completed within Federal timeframes established at § 483.20 may be cited as evidence of regulatory noncompliance.

Late 5-day assessments. As discussed above, the assessment reference date for a 5-day assessment may be set as early as day 1 or as late as day 5 of the patient's stay. However, in the event of a late 5-day assessment, a facility will be allowed to use up to and including day 8 as the assessment reference date with no financial penalty. This means that the facility may set an assessment reference date that is up to 3 days beyond the regular schedule and still receive the RUG–III rate calculated from the late assessment for the entire 14-day period of service covered by the 5-day assessment.

A 5-day assessment with an assessment reference date of day 9 or later will be paid at the RUG–III default rate for all 8 or more days of service provided before the assessment reference date of the late or missed assessment. The RUG–III rate calculated from the late assessment will be paid starting on the assessment reference date entered on the late assessment through day 14.

Late 14-day assessments. In order for an SNF to be in compliance with the requirements for Medicare or Medicaid certification, a comprehensive assessment must be performed for each patient in the facility by day 14. Therefore, unless the 5-day assessment included the RAPs, the 14-day assessment must include RAPs and must be completed by day 14. If the RAPs were completed with the 5-day assessment, then this assessment counts as the admission assessment and should be coded as both a Medicare 5-day assessment and as the admission assessment. When the 5-day assessment is the admission assessment (that is, it includes the RAPs), then no RAPs are required with the 14-day assessment, and the 14-day assessment may have an assessment reference date through day 19, and a 5-day grace period like that allowed for the 30- and 60-day assessments.

Late 30-day, 60-day, or 90-day assessments. A 5-day grace period is permitted for late 30- or 60-day assessments with no financial penalty. This means that the facility may set an assessment reference date that is up to 5 days beyond the regular schedule and still receive the RUG–III rate calculated from the late assessment for the entire period of service covered by the assessment.

To be in compliance with the requirements for Medicare and Medicaid certification, facilities must perform assessments quarterly. For this reason, the 90-day assessment grace period is only 2 days, in agreement with that allowed by the certification requirement. The latest that the first quarterly assessment may be completed is on day 92. The 90-day assessment should be coded both as a Medicare 90-day assessment and a quarterly review assessment.

Assessments that have an assessment reference date that is 6 or more days beyond the regular schedule will result in a payment at the RUG–III default rate for those 5 or more days of service without a current assessment. The RUG–III rate calculated from the late assessment will be paid starting on the day of the assessment reference date entered on the late assessment.

In the case of an error on an MDS that has been locked (in accordance with the requirements set forth at § 483.20(f)), the facility must follow the normal MDS correction procedures. These procedures may require that the facility perform a Significant Change in Status assessment or a ''significant correction'' assessment. If appropriate, the facility must perform a new assessment with a new assessment reference period and then submit this new assessment. Payment will be based on the new assessment reference date if appropriate.

11. The Default Rate

As described above, assessments are completed by SNFs according to an assessment schedule specifically designed for Medicare payment, and each assessment applies to specific days within a resident's SNF stay for purposes of making that payment. Compliance with this assessment schedule is critical to ensure that the appropriate level of payment is made by Medicare and the quality of Medicare SNF services is maintained under the PPS. Accordingly, SNFs that fail to perform assessments timely are to be paid a RUG–III default rate for the days of a patient's care for which they are not in compliance with this schedule (assuming that they submit sufficient documentation in lieu of a completed assessment to enable the fiscal intermediary to establish coverage under the existing administrative criteria used for this purpose, as discussed in section II.D of this rule). The RUG-III default rate takes the place of the otherwise applicable Federal rate (it does not supersede the facility-specific portion of the blended rate used for the transition period—see section III of this rule).

The RUG–III default rate may be lower than the Federal rate that would have been paid for a patient had an SNF submitted an assessment in accordance with the prescribed assessment schedule. For the initial period of the PPS, the RUG–III default rate is $117.15 per day for urban SNFs and $116.85 per day for rural SNFs. This rate equals the lowest Federal rate category (PA1) listed in Tables 2.G and 2.H. and is subject to the wage index adjustment.

12. Case-Mix Adjusted Federal Payment Rates

Application of the case-mix indices to the per diem Federal rates presented in Tables 2.A and 2.B result in 44 separate case-mix adjusted payment rates corresponding to the 44 separate RUG–III classification groups described above (see Tables 2.E and 2.F). The case-mix adjusted payment rates are listed separately for urban and rural SNFs (44 each) in Tables 2.E and 2.F below along with the corresponding case-mix index values. The rates are listed in total and by component. The application of the wage index, described later in this section, is the final adjustment applied to the Federal rates.

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Table 2.E
CASE MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES
URBAN

RUG III Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Therapy Non-Case Mix Component	Non-Case Mix Component	**Total Rate**
RUC	1.30	2.25	$142.32	$186.01		$55.88	**$384.21**
RUB	0.95	2.25	$104.01	$186.01		$55.88	**$345.90**
RUA	0.78	2.25	$ 85.39	$186.01		$55.88	**$327.28**
RVC	1.13	1.41	$123.71	$116.56		$55.88	**$296.15**
RVB	1.04	1.41	$113.86	$116.56		$55.88	**$286.30**
RVA	0.81	1.41	$ 88.68	$116.56		$55.88	**$261.12**
RHC	1.26	0.94	$137.94	$ 77.71		$55.88	**$271.53**
RHB	1.06	0.94	$116.05	$ 77.71		$55.88	**$249.64**
RHA	0.87	0.94	$ 95.25	$ 77.71		$55.88	**$228.84**
RMC	1.35	0.77	$147.80	$ 63.66		$55.88	**$267.34**
RMB	1.09	0.77	$119.33	$ 63.66		$55.88	**$238.87**
RMA.	0.96	0.77	$105.10	$ 63.66		$55.88	**$224.64**
RLB	1.11	0.43	$121.52	$ 35.55		$55.88	**$212.95**
RLA	0.80	0.43	$ 87.58	$ 35.55		$55.88	**$179.01**
SE3	1.70		$186.12		$10.91	$55.88	**$252.91**
SE2	1.39		$152.18		$10.91	$55.88	**$218.97**
SE1	1.17		$128.09		$10.91	$55.88	**$194.88**
SSC	1.13		$123.71		$10.91	$55.88	**$190.50**
SSB	1.05		$114.95		$10.91	$55.88	**$181.74**
SSA	1.01		$110.57		$10.91	$55.88	**$177.36**
CC2	1.12		$122.62		$10.91	$55.88	**$189.41**
CC1	0.99		$108.39		$10.91	$55.88	**$175.18**
CB2	0.91		$ 99.63		$10.91	$55.88	**$166.42**
CB1	0.84		$ 91.96		$10.91	$55.88	**$158.75**

RUG III Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Therapy Non-Case Mix Component	Non-Case Mix Component	**Total Rate**
CA2	0.83		$ 90.87		$10.91	$55.88	**$157.66**
CA1	0.75		$ 82.11		$10.91	$55.88	**$148.90**
IB2	0.69		$ 75.54		$10.91	$55.88	**$142.33**
IB1	0.67		$ 73.35		$10.91	$55.88	**$140.14**
IA2	0.57		$ 62.40		$10.91	$55.88	**$129.19**
IA1	0.53		$ 58.02		$10.91	$55.88	**$124.81**
BB2	0.68		$ 74.45		$10.91	$55.88	**$141.24**
BB1	0.65		$ 71.16		$10.91	$55.88	**$137.95**
BA2	0.56		$ 61.31		$10.91	$55.88	**$128.10**
BA1	0.48		$ 52.55		$10.91	$55.88	**$119.34**
PE2	0.79		$ 86.49		$10.91	$55.88	**$153.28**
PE1	0.77		$ 84.30		$10.91	$55.88	**$151.09**
PD2	0.72		$ 78.83		$10.91	$55.88	**$145.62**
PD1	0.70		$ 76.64		$10.91	$55.88	**$143.43**
PC2	0.65		$ 71.16		$10.91	$55.88	**$137.95**
PC1	0.64		$ 70.07		$10.91	$55.88	**$136.86**
PB2	0.51		$ 55.83		$10.91	$55.88	**$122.62**
PB1	0.50		$ 54.74		$10.91	$55.88	**$121.53**
PA2	0.49		$ 53.65		$10.91	$55.88	**$120.44**
PA1	0.46		$ 50.36		$10.91	$55.88	**$117.15**

Table 2.F
CASE MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES
RURAL

RUG III Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Therapy Non-Case Mix Component	Non-Case Mix Component	**Total Rate**
RUC	1.30	2.25	$136.34	$214.90		$56.95	**$408.19**
RUB	0.95	2.25	$ 99.64	$214.90		$56.95	**$371.49**
RUA	0.78	2.25	$ 81.81	$214.90		$56.95	**$353.66**
RVC	1.13	1.41	$118.51	$134.67		$56.95	**$310.13**
RVB	1.04	1.41	$109.08	$134.67		$56.95	**$300.70**
RVA	0.81	1.41	$ 84.95	$134.67		$56.95	**$276.57**
RHC	1.26	0.94	$132.15	$ 89.78		$56.95	**$278.88**
RHB	1.06	0.94	$111.17	$ 89.78		$56.95	**$257.90**
RHA	0.87	0.94	$ 91.25	$ 89.78		$56.95	**$237.98**
RMC	1.35	0.77	$141.59	$ 73.54		$56.95	**$272.08**
RMB	1.09	0.77	$114.32	$ 73.54		$56.95	**$244.81**
RMA	0.96	0.77	$100.68	$ 73.54		$56.95	**$231.17**
RLB	1.11	0.43	$116.42	$ 41.07		$56.95	**$214.44**
RLA	0.80	0.43	$ 83.90	$ 41.07		$56.95	**$181.92**
SE3	1.70		$178.30		$11.66	$56.95	**$246.91**
SE2	1.39		$145.78		$11.66	$56.95	**$214.39**
SE1	1.17		$122.71		$11.66	$56.95	**$191.32**
SSC	1.13		$118.51		$11.66	$56.95	**$187.12**
SSB	1.05		$110.12		$11.66	$56.95	**$178.73**
SSA	1.01		$105.93		$11.66	$56.95	**$174.54**
CC2	1.12		$117.47		$11.66	$56.95	**$186.08**
CC1	0.99		$103.83		$11.66	$56.95	**$172.44**
CB2	0.91		$ 95.44		$11.66	$56.95	**$164.05**
CB1	0.84		$ 88.10		$11.66	$56.95	**$156.71**

RUG III Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Therapy Non-Case Mix Component	Non-Case Mix Component	**Total Rate**
CA2	0.83		$ 87.05		$11.66	$56.95	**$155.66**
CA1	0.75		$ 78.66		$11.66	$56.95	**$147.27**
IB2	0.69		$ 72.37		$11.66	$56.95	**$140.98**
IB1	0.67		$ 70.27		$11.66	$56.95	**$138.88**
IA2	0.57		$ 59.78		$11.66	$56.95	**$128.39**
IA1	0.53		$ 55.59		$11.66	$56.95	**$124.20**
BB2	0.68		$ 71.32		$11.66	$56.95	**$139.93**
BB1	0.65		$ 68.17		$11.66	$56.95	**$136.78**
BA2	0.56		$ 58.73		$11.66	$56.95	**$127.34**
BA1	0.48		$ 50.34		$11.66	$56.95	**$118.95**
PE2	0.79		$ 82.86		$11.66	$56.95	**$151.47**
PE1	0.77		$ 80.76		$11.66	$56.95	**$149.37**
PD2	0.72		$ 75.51		$11.66	$56.95	**$144.12**
PD1	0.70		$ 73.42		$11.66	$56.95	**$143.03**
PC2	0.65		$ 68.17		$11.66	$56.95	**$136.78**
PC1	0.64		$ 67.12		$11.66	$56.95	**$135.73**
PB2	0.51		$ 53.49		$11.66	$56.95	**$122.10**
PB1	0.50		$ 52.44		$11.66	$56.95	**$121.05**
PA2	0.49		$ 51.39		$11.66	$56.95	**$120.00**
PA1	0.46		$ 48.24		$11.66	$56.95	**$116.85**

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C. Wage Index Adjustment to Federal Rates

Section 1888(e)(4)(G)(ii) of the Act requires that we provide for adjustments to the Federal rates to account for differences in area wage levels using ''an appropriate wage index as determined by the Secretary.'' As discussed elsewhere in this rule, for the rates effective with this rule, we are using wage index values that are based on hospital wage data from cost reporting periods beginning in fiscal year 1994—the most recent hospital wage data in effect before the effective date of this rule. Accordingly, the wage values used in this rule are based on the same wage data as used to compute the wage index values for the hospital prospective payment system for discharges occurring in fiscal year 1998. To compute the SNF wage index values, HCFA groups wage data from all hospitals by urban (MSA) and rural area. Total wages and hours are summed for all hospitals in each area. An average hourly wage is computed for each area by dividing the total wages by the total hours. Wage index values are computed for each area by comparing the area specific average hourly wage to the national average hourly wage (computed in a similar manner). (A detailed description of the methodology used to compute the hospital prospective payment wage index is set forth in the final rule published in the **Federal Register** on August 29, 1997 (62 FR 45966).)

The SNF wage index values are based on the Metropolitan Statistical Area (MSA) designations in effect prior to publication of this rule. For purposes of computing SNF wage index values, we are not taking into account changes in geographic classification for certain rural hospitals required under section 1886(d)(8)(B) of the Act or geographic reclassifications based on decisions of the Medicare Geographic Classification Review Board or the Secretary under section 1886(d)(10) of the Act. For SNF routine cost limits established under section 1888(a) of the Act and in effect for cost reporting periods beginning prior to July 1, 1998, HCFA has always applied a hospital wage index that does not reflect geographic reclassifications. Changing the basis of the wage index now would likely have a distributional impact on payments. In consideration of this and the fact that HCFA may be changing to a SNF wage index in the near future (which could also have distributional effects), we find it appropriate to employ a hospital wage index that does not reflect these reclassifications. Accordingly, we continue to believe that the MSA (or non-MSA) designation provides the best method for determining the wage index values used for SNF payments and the physical location of hospitals is the appropriate basis upon which to construct the wage index.

Table 2.I at the end of this section presents the wage indices applicable to urban and rural areas for use in making geographic adjustments to the Federal rates. Similar to the methodology described earlier relating to the standardization of the cost data for geographic differences in wage levels, the wage index adjustment is applied to the labor-related portion of the Federal rate, which is 75.888 percent of the total rate. The schedule of Federal rates below shows the Federal rates by labor-related and non-labor related components. Instructions and an example related to the application of the wage index to the case-mix adjusted rates are provided following the table.

In addition, section 1888(e)(4)(G) of the Act requires that the wage index adjustment to the Federal rates be made in a manner that does not result in aggregate payments that are greater or less than those that would otherwise be made if the rates were not adjusted by the wage index. In the initial year of the PPS, this requirement is addressed through the standardization methodology, described earlier, which ensures that the application of the wage index has no effect on the level of aggregate payments (that is, any effects are purely distributional). In future years, HCFA must make wage index budget neutrality adjustment in updating the payment rates.

TABLE 2.G.—CASE MIX ADJUSTED FEDERAL RATES FOR URBAN SNFS BY LABOR AND NON-LABOR COMPONENT

RUGs III category	Labor-related	Non-labor related	Total Federal rate
RUC	$291.57	$92.64	$384.21
RUB	262.50	83.40	345.90
RUA	248.37	78.91	327.28
RVC	224.74	71.41	296.15
RVB	217.27	69.03	286.30
RVA	198.16	62.96	261.12
RHC	206.06	65.47	271.53
RHB	189.45	60.19	249.64
RHA	173.66	55.18	228.84
RMC	202.88	64.46	267.34
RMB	181.27	57.60	238.87
RMA	170.47	54.17	224.64
RLB	161.60	51.35	212.95
RLA	135.85	43.16	179.01
SE3	191.93	60.98	252.91
SE2	166.17	52.80	218.97
SE1	147.89	46.99	194.88
SSC	144.57	45.93	190.50
SSB	137.92	43.82	181.74
SSA	134.59	42.77	177.36
CC2	143.74	45.67	189.41
CC1	132.94	42.24	175.18
CB2	126.29	40.13	166.42
CB1	120.47	38.28	158.75
CA2	119.65	38.01	157.66
CA1	113.00	35.90	148.90
IB2	108.01	34.32	142.33

TABLE 2.G.—CASE MIX ADJUSTED FEDERAL RATES FOR URBAN SNFS BY LABOR AND NON-LABOR COMPONENT—Continued

RUGs III category	Labor-related	Non-labor related	Total Federal rate
IB1	106.35	33.79	140.14
IA2	98.04	31.15	129.19
IA1	94.72	30.09	124.81
BB2	107.18	34.06	141.24
BB1	104.69	33.26	137.95
BA2	97.21	30.89	128.10
BA1	90.56	28.78	119.34
PE2	116.32	36.96	153.28
PE1	114.66	36.43	151.09
PD2	110.51	35.11	145.62
PD1	108.85	34.58	143.43
PC2	104.69	33.26	137.95
PC1	103.86	33.00	136.86
PB2	93.05	29.57	122.62
PB1	92.23	29.30	121.53
PA2	91.40	29.04	120.44
PA1	88.90	28.25	117.15

TABLE 2.H.—CASE MIX ADJUSTED FEDERAL RATES FOR RURAL SNFS BY LABOR AND NON-LABOR COMPONENT

RUGs III category	Labor-related	Non-labor related	Total Federal rate
RUC	$309.77	$98.42	$408.19
RUB	281.92	89.57	371.49
RUA	268.39	85.27	353.66
RVC	235.35	74.78	310.13
RVB	228.20	72.50	300.70
RVA	209.88	66.69	276.57
RHC	211.64	67.24	278.88
RHB	195.72	62.18	257.90
RHA	180.60	57.38	237.98
RMC	206.48	65.60	272.08
RMB	186.78	59.03	244.81
RMA	175.43	55.74	231.17
RLB	162.73	51.71	214.44
RLA	138.06	43.86	181.92
SE3	187.38	59.53	246.91
SE2	162.70	51.69	214.39
SE1	145.19	46.13	191.32
SSC	142.00	45.12	187.12
SSB	135.63	43.10	178.73
SSA	132.45	42.09	174.54
CC2	141.21	44.87	186.08
CC1	130.86	41.58	172.44
CB2	124.49	39.56	164.05
CB1	118.92	37.79	156.71
CA2	118.13	37.53	155.66
CA1	111.76	35.51	147.27
IB2	106.99	33.99	140.98
IB1	105.39	33.49	138.88
IA2	97.43	30.96	128.39
IA1	94.25	29.95	124.20
BB2	106.19	33.74	139.93
BB1	103.80	32.98	136.78
BA2	96.64	30.70	127.34
BA1	90.27	28.68	118.95
PE2	114.95	36.52	151.47
PE1	113.35	36.02	149.37
PD2	109.37	34.75	144.12
PD1	107.78	34.25	142.03
PC2	103.80	32.98	136.78
PC1	103.00	32.73	135.73
PB2	92.66	29.44	122.10
PB1	91.86	29.19	121.05
PA2	91.07	28.93	120.00
PA1	88.68	28.17	116.85

For any RUG–III group, to compute a wage adjusted Federal payment rate applicable to the initial period of the PPS, the labor related portion of the payment rate is multiplied by the SNF's appropriate wage index factor listed in Table 2.I. The product of that calculation is added to the corresponding non-labor related component. The resulting amount is the Federal rate applicable to a patient in that RUG–III group for that SNF. See the example below.

ABC SNF is located in State College, Pennsylvania. The per diem Federal rate applicable to an Ultra High Rehabilitation 'A' patient (RUA) is calculated using the rates listed in Table 2.G and the wage index factor found in Table 2.I. Accordingly, the computation of the adjusted per diem rate is made as follows: (248.37×.9635)+78.91=$318.21 per diem.

This Federal rate will be applicable to all patients in the RUA category for Happy Valley SNF for the initial period of the PPS (July 1, 1998 through September 30, 1999).

D. Updates to the Federal Rates

For the initial period of the PPS beginning on July 1, 1998 and ending on September 30, 1999, the payment rates are those contained in this interim final rule. In accordance with section 1888(e)(4)(H) of the Act, for each succeeding fiscal year, we will publish the rates in the **Federal Register** before August 1 of the year preceding the affected Federal fiscal year.

For fiscal years 2000 through 2002, section 1888(e)(4)(E)(ii) of the Act requires that the rates be increased by a factor equal to the SNF market basket index change minus 1 percentage point. In addition, for subsequent fiscal years, this section requires the rates to be increased by the applicable SNF market basket index change.

Section 1888(e)(4)(F) of the Act provides that the Secretary ''may'' adjust the unadjusted Federal per diem rates if the Secretary ''determines that the adjustments under subparagraph (G)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments'' during the fiscal year because of changes in the aggregate case-mix of the Medicare patient population that are not related to actual patient condition (that is, ''case-mix creep''). HCFA is currently developing a methodology to implement this adjustment.

In addition, since enactment of the BBA 1997, various suggestions have been made relating to adjustments to the rates promulgated in this interim final regulation. Some have suggested that the rates should be increased to reflect such factors as additional nursing care, the future growth of subacute care practices, specific services, and other items that may not be accurately reflected in the rates, etc. Other suggestions have related to downward adjustments to the rates to reflect the presence of inappropriate care or payments in the 1995 cost data used to establish the rates promulgated in this rule. For example, concerns have been raised regarding whether these data are inflated, reflecting medically unnecessary care and/or improper payments related to therapies and other ancillary services and that the inclusion of such costs results in inappropriately high payments to SNFs under the PPS. Studies by the Office of the Inspector General (OIG) and HCFA program integrity activities have found that incorrect payments have been made to SNFs in the past. One way to remove such costs from the data is the application of adjustments to the 1995 data base and recomputing the payment rates. However, the magnitude of these incorrect payments is not definitively known at this time. Therefore, the OIG, in conjunction with HCFA, is proposing to examine the extent to which the base period costs reflect costs that were inappropriately allowed. If this examination reveals excessive inappropriate costs, we would address this issue in a future proposed rule, or perhaps seek legislation to adjust future payment rates downward.

TABLE 2.I.—WAGE INDEX FOR URBAN AREAS

Urban Area (Constituent counties or county equivalents)	Wage index
0040 Abilene, TX	0.8287
Taylor, TX	
0060 Aguadilla, PR	0.4188
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9772
Portage, OH	
Summit, OH	
0120 Albany, GA	0.7914
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY	0.8480
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9309
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.8162
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	1.0086
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9137
Blair, PA	
0320 Amarillo, TX	0.9425
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2842
Anchorage, AK	
0440 Ann Arbor, MI	1.1785
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8266
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.8996
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4218
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9072
Buncombe, NC	
Madison, NC	
0500 Athens, GA	0.9087
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA	0.9823
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
De Kalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic City-Cape May, NJ	1.1155
Atlantic City, NJ	
Cape May, NJ	
0600 Augusta-Aiken, GA–SC	0.9333
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX	0.9133

TABLE 2.I.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent counties or county equivalents)	Wage index
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA	1.0014
Kern, CA	
0720 Baltimore, MD	0.9689
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Annes, MD	
0733 Bangor, ME	0.9478
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.4291
Barnstable, MA	
0760 Baton Rouge, LA	0.8382
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8593
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1221
Whatcom, WA	
0870 Benton Harbor, MI	0.8634
Berrien, MI	
0875 Bergen-Passaic, NJ	1.2156
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9783
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8415
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY	0.8914
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.9005
Blount, AL	
Jefferson, AL	
St Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7695
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.9128
Monroe, IN	
1040 Bloomington-Normal, IL	0.8733
McLean, IL	
1080 Boise City, ID	0.8856
Ada, ID	
Canyon, ID	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1506
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	

TABLE 2.I.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent counties or county equivalents)	Wage index
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	1.0015
Boulder, CO	
1145 Brazoria, TX	0.9341
Brazoria, TX	
1150 Bremerton, WA	1.0999
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.8740
Cameron, TX	
1260 Bryan-College Station, TX	0.8571
Brazos, TX	
1280 Buffalo-Niagara Falls, NY	0.9272
Erie, NY	
Niagara, NY	
1303 Burlington, VT	1.0142
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4459
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.8961
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9013
Natrona, WY	
1360 Cedar Rapids, IA	0.8529
Linn, IA	
1400 Champaign-Urbana, IL	0.8824
Champaign, IL	
1440 Charleston-North Charleston, SC	0.8807
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.9142
Kanawha, WV	
Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC–SC	0.9710
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	0.9051
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN–GA	0.8658
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY	0.7555
Laramie, WY	
1600 Chicago, IL	1.0860

TABLE 2.I.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent counties or county equivalents)	Wage index
Cook, IL	
De Kalb, IL	
Du Page, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	1.0429
Butte, CA	
1640 Cincinnati, OH–KY–IN	0.9474
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN–KY	0.7852
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH	0.9804
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9316
El Paso, CO	
1740 Columbia, MO	0.9001
Boone, MO	
1760 Columbia, SC	0.9192
Lexington, SC	
Richland, SC	
1800 Columbus, GA–AL	0.8288
Russell, AL	
Chattanoochee, GA	
Harris, GA	
Muscogee, GA	
1840 Columbus, OH	0.9793
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8945
Nueces, TX	
San Patricio, TX	
1900 Cumberland, MD–WV	0.8822
Allegany, MD	
Mineral, WV	
1920 Dallas, TX	0.9703
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	

TABLE 2.I.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent counties or county equivalents)	Wage index
1950 Danville, VA	0.8146
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA–IL	0.8405
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9584
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.8375
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8286
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL	0.7915
Macon, IL	
2080 Denver, CO	1.0386
Adams, CO	
Arapahoe, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.8837
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI	1.0825
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.8070
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9303
Kent, DE	
2200 Dubuque, IA	0.8088
Dubuque, IA	
2240 Duluth-Superior, MN–WI	0.9779
St Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0632
Dutchess, NY	
2290 Eau Claire, WI	0.8764
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	1.0123
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9081
Elkhart, IN	
2335 Elmira, NY	0.8247
Chemung, NY	
2340 Enid, OK	0.7962
Garfield, OK	
2360 Erie, PA	0.8862
Erie, PA	
2400 Eugene-Springfield, OR	1.1435
Lane, OR	
2440 Evansville-Henderson, IN–KY	0.8641
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND–MN	0.8837
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8734
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.7461
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ–UT	0.9115
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.1171
Genesee, MI	
2650 Florence, AL	0.7551
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8711
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0248
Larimer, CO	
2680 Ft Lauderdale, FL	1.0448
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.8788
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	1.0257
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR–OK	0.7769
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.8765
Okaloosa, FL	
2760 Fort Wayne, IN	0.8901
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Forth Worth-Arlington, TX	0.9979
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0607
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8815
Etowah, AL	
2900 Gainesville, FL	0.9616
Alachua, FL	
2920 Galveston-Texas City, TX	1.0564
Galveston, TX	
2960 Gary, IN	0.9633
Lake, IN	
Porter, IN	
2975 Glens Falls, NY	0.8386
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8443
Wayne, NC	
2985 Grand Forks, ND–MN	0.8745
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9090
Mesa, CO	
3000 Grand Rapids-Muskegon-Holland, MI	1.0147
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.8803
Cascade, MT	
3060 Greeley, CO	1.0097
Weld, CO	
3080 Green Bay, WI	0.9097
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC	0.9351
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9064
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9059
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9681
Washington, MD	
3200 Hamilton-Middletown, OH	0.8767
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	1.0187
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT	1.2562
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 Hattiesburg, MS	0.7192
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.8686
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1816
Honolulu, HI	
3350 Houma, LA	0.7854
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX	0.9855
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	

TABLE 2.I.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent counties or county equivalents)	Wage index
3400 Huntington-Ashland, WV–KY–OH	0.9160
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8485
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN	0.9848
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9413
Johnson, IA	
3520 Jackson, MI	0.9052
Jackson, MI	
3560 Jackson, MS	0.7760
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.8522
Chester, TN	
Madison, TN	
3600 Jacksonville, FL	0.8969
Clay, FL	
Duval, FL	
Nassau, FL	
St Johns, FL	
3605 Jacksonville, NC	0.6973
Onslow, NC	
3610 Jamestown, NY	0.7552
Chautaqua, NY	
3620 Janesville-Beloit, WI	0.8824
Rock, WI	
3640 Jersey City, NJ	1.1412
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN–VA	0.9114
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8378
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7443
Craighead, AR	
3710 Joplin, MO	0.7510
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0668
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	0.8653
Kankakee, IL	

TABLE 2.I.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent counties or county equivalents)	Wage index
3760 Kansas City, KS–MO	0.9564
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9196
Kenosha, WI	
3810 Killeen-Temple, TX	1.0252
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8831
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.8416
Howard, IN	
Tipton, IN	
3870 La Crosse, WI–MN	0.8749
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8206
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.9174
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7776
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.8806
Polk, FL	
4000 Lancaster, PA	0.9481
Lancaster, PA	
4040 Lansing-East Lansing, MI	1.0088
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.7325
Webb, TX	
4100 Las Cruces, NM	0.8646
Dona Ana, NM	
4120 Las Vegas, NV–AZ	1.0592
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.8608
Douglas, KS	
4200 Lawton, OK	0.9045
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9536
Androscoggin, ME	
4280 Lexington, KY	0.8390
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	

TABLE 2.I.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent counties or county equivalents)	Wage index
Woodford, KY	
4320 Lima, OH	0.9185
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	0.9231
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8490
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8613
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA	1.2232
Los Angeles, CA	
4520 Louisville, KY–IN	0.9507
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8400
Lubbock, TX	
4640 Lynchburg, VA	0.8228
Amherst, VA	
Bedford City, VA	
Bedford, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.9227
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0055
Dane, WI	
4800 Mansfield, OH	0.8639
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4475
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8371
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0354
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.8819
Brevard, FL	
4920 Memphis, TN–AR–MS	0.8589
Crittenden, AR	
De Soto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	1.0947
Merced, CA	

TABLE 2.I.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent counties or county equivalents)	Wage index
5000 Miami, FL	0.9859
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ	1.1059
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 Milwaukee-Waukesha, WI	0.9819
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St Paul, MN–WI	1.0733
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Sherburne, MN	
Washington, MN	
Wright, MN	
Pierce, WI	
St Croix, WI	
5160 Mobile, AL	0.8455
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0794
Stanislaus, CA	
5190 Monmouth-Ocean, NJ	1.0934
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8414
Ouachita, LA	
5240 Montgomery, AL	0.7671
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.9173
Delaware, IN	
5330 Myrtle Beach, SC	0.8072
Horry, SC	
5345 Naples, FL	1.0109
Collier, FL	
5360 Nashville, TN	0.9182
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY	1.3807
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2618
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT	1.2013
New London, CT	
5560 New Orleans, LA	0.9566
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St Bernard, LA	
St Charles, LA	
St James, LA	
St John The Baptist, LA	
St Tammany, LA	
5600 New York, NY	1.4449
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ	1.1980
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY–PA	1.1283
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA–NC	0.8316
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City VA	
Williamsburg City, VA	
York, VA	
5775 Oakland, CA	1.5068
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9032
Marion, FL	
5800 Odessa-Midland, TX	0.8660
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK	0.8481
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.0901
Thurston, WA	
5920 Omaha, NE–IA	0.9421
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA	1.1605
Orange, CA	
5960 Orlando, FL	0.9397
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.7480
Daviess, KY	
6015 Panama City, FL	0.8337
Bay, FL	
6020 Parkersburg-Marietta, WV–OH	0.8046
Washington, OH	
Wood, WV	
6080 Pensacola, FL	0.8193
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8571
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA–NJ	1.1398
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ	0.9606
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7826
Jefferson, AR	
6280 Pittsburgh, PA	0.9725
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA	1.0960
Berkshire, MA	
6340 Pocatello, ID	0.9586
Bannock, ID	
6360 Ponce, PR	0.4589
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9627
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR–WA	1.1344
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Pawtucket, RI	1.1049
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	

TABLE 2.I.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent counties or county equivalents)	Wage index
6520 Provo-Orem, UT	1.0073
Utah, UT	
6560 Pueblo, CO	0.8450
Pueblo, CO	
6580 Punta Gorda, FL	0.8725
Charlotte, FL	
6600 Racine, WI	0.8934
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC	0.9818
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8345
Pennington, SD	
6680 Reading, PA	0.9516
Berks, PA	
6690 Redding, CA	1.1790
Shasta, CA	
6720 Reno, NV	1.0768
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	0.9918
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9152
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 Riverside-San Bernardino, CA	1.1307
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8402
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.0502
Olmsted, MN	
6840 Rochester, NY	0.9524
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9081
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9029
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA	1.2202
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9564
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St Cloud, MN	0.9544
Benton, MN	
Stearns, MN	
7000 St Joseph, MO	0.8366
Andrews, MO	
Buchanan, MO	
7040 St Louis, MO–IL	0.9130
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St Charles, MO	
St Louis, MO	
St Louis City, MO	
Warren, MO	
Sullivan City, MO	
7080 Salem, OR	0.9935
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4513
Monterey, CA	
7160 Salt Lake City-Ogden, UT	0.9857
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.7780
Tom Green, TX	
7240 San Antonio, TX	0.8499
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA	1.2193
San Diego, CA	
7360 San Francisco, CA	1.4180
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA	1.4332
Santa Clara, CA	
7440 San Juan-Bayamon, PR	0.4625
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Ceiba, PR	
Comerio, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Morovis, PR	
Naguabo, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.1374
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0688
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.4187
Santa Cruz, CA	
7490 Santa Fe, NM	1.0332
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.2815
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9757
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.8638
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton—Wilkes-Barre—Hazleton, PA	0.8539
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA	1.1339
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA	0.8783
Mercer, PA	
7620 Sheboygan, WI	0.7862
Sheboygan, WI	
7640 Sherman-Denison, TX	0.8499
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.9381
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA–NE	0.8031
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.8712
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9868
St Joseph, IN	
7840 Spokane, WA	1.0486
Spokane, WA	
7880 Springfield, IL	0.8713
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.7989
Christian, MO	

TABLE 2.I.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Area (Constituent counties or county equivalents)	Wage index
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.0740
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.9635
Centre, PA	
8080 Steubenville-Weirton, OH–WV	0.8645
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.1496
San Joaquin, CA	
8140 Sumter, SC	0.7842
Sumter, SC	
8160 Syracuse, NY	0.9464
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1016
Pierce, WA	
8240 Tallahassee, FL	0.8332
Gadsden, FL	
Leon, FL	
8280 Tampa-St Petersburg-Clearwater, FL	0.9103
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN	0.8614
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana, AR-Texarkana, TX	0.8664
Miller, AR	
Bowie, TX	
8400 Toledo, OH	1.0390
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9438
Shawnee, KS	
8480 Trenton, NJ	1.0380
Mercer, NJ	
8520 Tucson, AZ	0.9180
Pima, AZ	
8560 Tulsa, OK	0.8074
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8187
Tuscaloosa, AL	
8640 Tyler, TX	0.9567
Smith, TX	
8680 Utica-Rome, NY	0.8398
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3754
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.0946
Ventura, CA	
8750 Victoria, TX	0.8474
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0110
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA	0.9924
Tulare, CA	
8800 Waco, TX	0.7696
McLennan, TX	
8840 Washington, DC–MD–VA–WV	1.0911
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpepper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 Waterloo-Cedar Falls, IA	0.8640
Black Hawk, IA	
8940 Wausau, WI	1.0545
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL	1.0372
Palm Beach, FL	
9000 Wheeling, OH–WV	0.7707
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9403
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.7646
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8548
Lycoming, PA	
9160 Wilmington-Newark, DE–MD	1.1538
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9322
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0102
Yakima, WA	
9270 Yolo, CA	1.1431
Yolo, CA	
9280 York, PA	0.9415
York, PA	
9320 Youngstown-Warren, OH	0.9937
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0324
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.9732
Yuma, AZ	

TABLE 2.I.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7260
Alaska	1.2302
Arizona	0.7989
Arkansas	0.6995
California	0.9977
Colorado	0.8129
Connecticut	1.2617
Delaware	0.8925
Florida	0.8838
Georgia	0.7761
Hawaii	1.0229
Idaho	0.8221
Illinois	0.7644
Indiana	0.8161
Iowa	0.7391
Kansas	0.7203
Kentucky	0.7772
Louisiana	0.7383
Maine	0.8468
Maryland	0.8617
Massachusetts	1.0718
Michigan	0.8923
Minnesota	0.8179
Mississippi	0.6911
Missouri	0.7205
Montana	0.8302
Nebraska	0.7401
Nevada	0.8914
New Hampshire	0.9717
New Jersey [1]	.....
New Mexico	0.8070
New York	0.8401
North Carolina	0.7937
North Dakota	0.7360
Ohio	0.8434
Oklahoma	0.7072
Oregon	0.9975
Pennsylvania	0.8421
Puerto Rico	0.3939
Rhode Island [1]	.....
South Carolina	0.7921
South Dakota	0.6983
Tennessee	0.7353
Texas	0.7404
Utah	0.8926
Vermont	0.9314
Virginia	0.7782
Washington	1.0221
West Virginia	0.7938
Wisconsin	0.8471
Wyoming	0.8247

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

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

Section 1814(a)(2)(B) of the Act provides that, in order for Part A to make payment under the extended care benefit, a physician, nurse practitioner, or clinical nurse specialist must initially certify (and periodically recertify) that the beneficiary needs a specific level of care, specifically, skilled nursing or rehabilitation services on a daily basis which, as a practical matter, can only be provided in an SNF on an inpatient basis. Longstanding administrative criteria for determining whether a beneficiary meets this statutory SNF level of care definition appear in regulations at §§ 409.31 through 409.35 and manual instructions in the Medicare Intermediary Manual, Part 3 (MIM–3), §§ 3132ff and the Skilled Nursing Facility Manual §§ 214ff. These criteria entail a retrospective review that focuses primarily on a beneficiary's need for and receipt of specific, individual skilled services as indicators of the need for a covered SNF level of care. (The certification/recertification procedure itself is implemented in regulations at § 424.20.)

In this context, the RUG–III system serves three distinct but related purposes:

- Streamlining and simplifying the process for determining that a beneficiary meets the statutory criteria for an SNF level of care (which is a prerequisite for making program payment under the extended care benefit), by automatically classifying those beneficiaries assigned to any of the highest 26 of the 44 RUG–III groups as meeting the definition. (For those beneficiaries assigned to the lowest 18 groups, level of care determinations are performed on an individual basis, using the existing administrative criteria established for this purpose.)
- Determining the level of the Part A per diem payment under the SNF PPS, which varies with the resource intensity of the particular RUG–III group to which an individual beneficiary is assigned. In addition to developing a per diem payment rate for each of the RUG–III groups, we are also creating a default payment rate (as discussed previously in section II.B.11.) to address situations such as those in which the facility's failure to submit a completed assessment in a timely manner prevents the beneficiary from being assigned to a particular RUG–III group. In order to receive payment at the default rate in the absence of completing an assessment timely, the SNF would have to submit sufficient information to its Medicare fiscal intermediary (FI) to enable the FI to establish coverage under the existing administrative criteria.
- Providing an additional basis for making an administrative presumption (under regulations at § 409.60(c)(2)) that an SNF resident who has exhausted Part A benefits continues to meet the skilled level of care definition in the SNF, since a resident assigned to any of the upper 26 RUG–III groups is automatically classified as meeting this definition. Such a resident continues to be considered an ''inpatient'' of the SNF for purposes of prolonging his or her current benefit period under section 1861(a)(2) of the Act and § 409.60(b)(2) of the regulations.

As discussed below, we believe that certain specific modifications are appropriate in the existing administrative criteria that are used for making SNF level of care determinations, in order to achieve greater consistency between them and the RUG–III classification system. Under the demonstration, those beneficiaries assigned to any of the highest 26 of the 44 RUG–III groups have been defined as meeting the SNF level of care specified in the statute. Thus, the RUG–III classification system used under the demonstration and the existing administrative level of care criteria essentially represent two different approaches toward achieving the same objective—identifying those beneficiaries who meet the SNF level of care definition in section 1814(a)(2)(B) of the Act. Under the demonstration, RUG–III has been used as a means of qualifying beneficiaries for coverage, not disqualifying them. That is, those beneficiaries assigned to any of the upper 26 groups are automatically classified as meeting the SNF level of care definition while those beneficiaries assigned to any of the lower 18 groups are not automatically classified as either meeting or not meeting the definition, but instead receive an individual level of care determination using the existing administrative criteria. This procedure will continue under the new SNF PPS. Thus, a beneficiary who is assigned to one of the upper 26 RUG–III groups is automatically designated as meeting the SNF level of care definition, and the required initial certification under § 424.20(a) regarding such a beneficiary's general need for an SNF level of care would, in effect, simply serve to confirm the correctness of this designation. Accordingly, we are amending the regulations at § 424.20(a) to provide that, at the option of the individual completing it, the initial certification for a beneficiary who is assigned to one of the upper 26 RUG–III groups can either consist of the existing content described in that provision or, alternatively, can state simply that the beneficiary's assignment to that particular RUG–III group is correct.

Under this type of framework, it is not essential for the RUG–III system to conform exactly to the existing administrative criteria, since any beneficiary who does not initially meet the criteria for coverage under the former will then receive an individual level of care determination under the latter. Nevertheless, it is desirable from a programmatic standpoint to reconcile, whenever possible, any specific inconsistencies that may exist between these two approaches in their treatment of particular conditions and circumstances. Further, for the reasons discussed below, we believe that resolving these inconsistencies in favor of the approach taken under RUG–III would also help bring the existing administrative criteria more into line with the current state of clinical practice. We note that these changes in the existing administrative criteria will become effective with the introduction of the Part A SNF PPS and its RUG–III classification system (that is, for cost reporting periods beginning on or after July 1, 1998), and will be implemented on a prospective basis only. Accordingly, we will advise Medicare contractors that any beneficiary who, upon the effective date of these changes, is currently in a covered SNF stay will not have his or her coverage terminated on the basis of these revisions for the duration of that covered stay.

The existing administrative criteria for making SNF level of care determinations focus primarily on the use of specific, individual skilled services as indicators of a beneficiary's need for a covered level of care. The particular services identified in these criteria date back to the Senate Finance Committee Report language (S. Rep. No. 92–1230, pp. 282–285) that accompanied the Social Security Amendments of 1972 (Public Law 92–603). However, in the 25 years since that legislation was enacted, the state of clinical practice for the nursing home population has advanced dramatically, to the point where some of the specific types of services cited in the Committee Report either have fallen largely into disuse or have now become routinely available in less intensive settings. Accordingly, with the passage of time, some of the individual services identified as skilled in the existing administrative criteria no longer, in themselves, represent valid indicators of

the need for a covered SNF level of care. Consequently, while such services might still be considered ''skilled'' in a technical sense (in that they may arguably require rendition by skilled personnel in order to be furnished safely and effectively), we believe that they are no longer appropriate for inclusion in the SNF level of care criteria.

For example, we believe that from a clinical as well as programmatic standpoint, it is no longer necessary or appropriate to include ''hypodermoclysis'' (injection of fluids into the subcutaneous tissues to supply the body with liquids quickly) in the list of examples of skilled nursing services at § 409.33(b). Medically, this service is equivalent to giving fluids in an intravenous infusion. As more SNFs have become proficient in the administration of intravenous medications and fluids, the number of cases in which this service would be appropriate becomes extremely small. Although there may be a very small number of beneficiaries who cannot be hydrated with intravenous fluids, it is likely that they would be sufficiently medically complex as to be classified into one of the top 26 RUG–III categories, regardless of the use of hypodermoclysis.

We also believe that the ordering of subcutaneous injections can no longer be considered sufficient in itself to justify the designation of a covered SNF level of care. We note that the most frequently administered type of subcutaneous medication is insulin, which has long been defined as a nonskilled service with respect to any beneficiary who is capable of self-administration. Further, with the evolving state of clinical practice over time, the administration of a subcutaneous injection has now become commonly accepted as a nonskilled service even in less intensive settings such as physician offices and home health agencies, making its continued categorization as a skilled service in the SNF context increasingly anomalous. In the RUG–III classifications, an insulin-dependent diabetic beneficiary who is clinically unstable enough to have had two physician order changes within the preceding 7 days would be assigned to one of the top 26 groups and, thus, would automatically be classified as meeting the standard for a covered level of care. By contrast, a beneficiary who has stabilized and continues to receive subcutaneous injections on a chronic basis will, in all likelihood, have already exhausted the 100 days of available SNF coverage per benefit period at that point. In this situation, categorizing the injections as a nonskilled service would actually work to the beneficiary's advantage, as it would enable such a beneficiary to end that benefit period in the SNF under regulations at § 409.60(b)(2).

The vast majority of urinary catheters are placed in the urethra, but a few are suprapubic. The current administrative criteria also identify the insertion into the urethra and sterile irrigation of urinary catheters as a skilled nursing service. However, RUG–III does not consider any of these catheters in assigning patients to a RUG–III category. Further, we believe that it may well be inherently undesirable to specify the use of urinary catheters as a criterion that effectively governs SNF coverage determinations, because of the risk that this creates of providing an unwarranted incentive for the inappropriate use of urinary catheters. It is widely recognized that there is a significant amount of unnecessary use of catheters for the convenience of care givers, with the potential to place beneficiaries at increased risk of infection. Nevertheless, we also recognize that a catheter can be medically necessary, especially in those particular situations where obstruction is present. Accordingly, we are not deleting this particular procedure from the administrative criteria at this time. We invite comments on whether the care of suprapubic catheters should be considered skilled.

The RUG–III groups recognize enteral feeding as a criterion for patient classification only if it is providing the patient with more 26 percent of his or her calories and at least 501 milliliters of hydration daily. Historically, the administrative criteria have only required the mere presence of a ''Levin tube'' (now referred to as a nasogastric tube) or a gastrostomy tube for enteral feeding. We note that, in recent years, gastrostomy tube feedings have become the more commonly used procedure, as the chronic use of nasogastric tubes has been replaced because of the increased risk of pneumonia from aspirating fluid into the lungs. The demonstration took a more specifically defined approach because a few beneficiaries in all the demonstration states were found to have had feeding tubes retained even though they were no longer used (or even usable), with the only apparent purpose being to maintain the beneficiary's ''skilled'' status. Because we believe that it is clearly inappropriate for such a practice to serve as an indicator of the need for a covered level of care, we are revising the administrative criteria to adopt the RUG–III system's more specific approach. That approach incorporates specific criteria (that is, comprising at least 26 per cent of daily calorie requirements and providing at least 501 milliliters of fluid per day) that effectively limit the recognition of enteral feeding as a skilled service (regardless of whether administered by nasogastric, gastrostomy, or gastro-jejunostomy tube) to those instances in which it currently is clinically relevant to the beneficiary. We note that this particular change would not result in removing enteral feeding altogether from the list of skilled nursing services in § 409.33(b), but merely would provide more specific, objective criteria for ensuring that coverage determinations take this particular procedure into account only in those instances where its use is, in fact, reasonable and necessary in accordance with section 1862(a)(1) of the Act.

Under the existing administrative criteria, ''management and evaluation of a care plan,'' ''observation and assessment,'' and ''patient education'' needed to teach a patient self-maintenance during the initial stages of treatment would be sufficient in themselves to justify the need for skilled nursing services. The RUG–III system uses nursing rehabilitation frequency of physician visits and number of days on which physician orders change as criteria to assign patients. ''Nursing rehabilitation'' is defined in the *Long Term Care Resident Assessment Manual.* The services considered to be nursing rehabilitation in the PPS system include, but are not limited to, teaching self-care for diabetic management, self-administration of medications, and ostomy care.

It is our experience in the demonstration that these criteria effectively serve as proxies to the existing categories of ''management and evaluation of a care plan,'' ''observation and assessment,'' and ''patient education'' (see the preceding discussion on the RUG–III Clinically Complex category). Observation and assessment (§ 409.33(a)(2)) involves a medically fragile beneficiary who (although not presently receiving any specific skilled services) could potentially undergo a sudden and rapid decline at any time and, consequently, may require skilled expertise on the part of facility staff in order to recognize and respond quickly to the earliest signs of an impending change in condition.

Because the category of observation and assessment is, by definition, limited to a beneficiary whose condition is potentially unstable, the RUG–III criteria for frequency of physician visits and number of order changes clearly represent appropriate proxies in this situation. They similarly serve as appropriate proxies for the category of

skilled management and evaluation (§ 403.33(a)(1)) of an aggregate of nonskilled services (which is generally invoked only during the first few days of a beneficiary's SNF stay, until more specific skilled care needs can be identified through the completion of the resident assessment) and of patient education (§ 409.33(a)(3), which involves teaching self-maintenance during the initial stages of treatment), since these categories are generally confined to the initial portion of the SNF stay, typically before the beneficiary's condition has stabilized. Accordingly, because we anticipate that essentially all patients falling into these categories will be assigned to one of the highest 26 RUG–III groups, we believe that it is no longer necessary to retain these particular categories in the administrative criteria.

As noted above, the dramatic advances in the state of medical and nursing practice that have occurred over the past 25 years have necessitated a reevaluation of some of the specific elements in the existing SNF level of care criteria. These advances in clinical practice have also been accompanied by a significant improvement in the ability to collect and utilize clinical data for program purposes, as exemplified by the MDS and RUG–III. Therefore, we believe it may be appropriate to consider the feasibility of ultimately moving beyond the limited, incremental adjustments in the existing SNF level of care criteria discussed above, in favor of a more fundamental change in the overall process of performing SNF level of care determinations themselves. Specifically, it may be possible to eliminate the use of the existing administrative criteria altogether, by utilizing RUG–III as the exclusive means for making these determinations rather than as a mere adjunct to the administrative criteria.

We believe that the RUG–III system's basic approach, which provides for an ongoing evaluation of an entire cluster of patient indicators, may well represent a more predictable and reliable way of making accurate SNF level of care determinations than the existing administrative criteria's primary focus on reviewing claims information retrospectively for the presence or absence of individual skilled services. Besides being a far simpler procedure from an administrative standpoint, we believe that basing SNF level of care determinations exclusively on the RUG–III system would represent a significant improvement over certain aspects of the existing criteria:

• *Greater reliability in predicting in advance whether a particular beneficiary will qualify for coverage.* Under the current process of determining Medicare coverage with the existing administrative criteria based on a retrospective claims review, it can be difficult to predict with certainty whether a particular beneficiary's SNF care will be covered. One early attempt to address the resulting problem of retroactive coverage denials was the enactment of the ''presumed coverage'' provision in section 228(a) of Public Law 92–603, which was designed to grant periods of SNF coverage prospectively on the basis of a beneficiary's diagnosis. However, in section 941 of the Omnibus Reconciliation Act of 1980 (Public Law 96–499), the Congress ultimately repealed this provision as unworkable. Thus, while the subsequently-enacted hospital PPS was able to use diagnosis successfully as a predictor of resource intensity for acute care, the long-term care setting required the development of indicators that were more sensitive to the particular characteristics of patients in this setting. We believe that in the RUG–III classification system, we have now developed such an instrument, with the potential to bring greater reliability and predictability to the SNF coverage determination process.

• *Increased consistency and uniformity among different contractors in making level of care determinations.* The process of retrospective claims review conducted under the existing administrative criteria inherently relies upon the medical judgment of the individual reviewer. Thus, it would be possible for two claims with essentially identical sets of facts to be adjudicated differently by different contractors. By contrast, RUG–III utilizes a unified set of specific clinical criteria that is more coherent and objective, thus diminishing the potential for variation based on differences in individual judgment.

It is worth noting that even the existing criteria implicitly acknowledge the limitations of an approach that looks solely at the presence or absence of individual skilled services. As mentioned previously, the existing criteria have historically recognized situations that may require skilled overall management and evaluation of the care plan of a beneficiary who receives only an aggregate of unskilled services, or that may require skilled observation and assessment of changes in the condition of an extremely unstable and medically fragile beneficiary, even though the beneficiary does not presently receive any specific skilled services. Further, RUG–III's approach of evaluating a broad cluster of services and other patient indicators is consistent with the recent Medicare trend of grouping individual services into increasingly larger bundles for program purposes, as exemplified by the SNF PPS and Consolidated Billing provisions.

Another reason that it may now be feasible to rely exclusively on the RUG–III system in making level of care determinations is that the upper 26 RUG–III categories and the existing administrative criteria (as now modified) should serve to identify increasingly similar sets of patients as meeting the SNF level of care definition. We also note a steady decline over the course of the demonstration in the proportion of covered days for those beneficiaries assigned to any of the lower 18 RUG–III groups (which initially represented approximately 15 percent of total covered days), to the point where such beneficiaries ultimately accounted for only about 5 to 8 percent of total covered days. Thus, one possible approach might be simply to establish that beneficiaries assigned to the highest 26 groups meet the SNF level of care definition, while those assigned to the lowest 18 groups do not, and we specifically solicit comments on the feasibility of this approach. However, we also solicit comments on the possible extent and specific nature of situations in which beneficiaries who are assigned to one of the lower 18 RUG–III groups might nonetheless meet the statutory standard for an SNF level of care, including information on their clinical profiles as well as the specific basis on which they would qualify for Medicare SNF coverage.

We are also creating a new, rebuttable presumption of an SNF resident's continued ''inpatient'' status for benefit period purposes, based on his or her assignment to one of the upper 26 RUG–III groups. We are adding this new administrative presumption to paragraph (c)(2) of § 409.60 rather than to paragraph (c)(1) since, unlike the presumptions included in paragraph (c)(1), it is not limited to instances in which a claim for Medicare SNF benefits is actually filed. Thus, a benefit period determination under this presumption could be rebutted by presenting evidence establishing that the beneficiary should have been assigned to one of the lower 18 RUG-III groups which, in turn, would permit a determination that the beneficiary was not actually receiving a covered level of care.

III. Three-Year Transition Period

Under sections 1888(e) (1) and (2) of the Act, during a facility's first three

cost reporting periods that begin on or after July 1, 1998 (transition period), the facility's PPS rate will be equal to the sum of a percentage of an adjusted facility-specific per diem rate and a percentage of the adjusted Federal per diem rate. After the transition period, the PPS rate will equal the adjusted Federal per diem rate. The transition period payment method will not apply to SNFs that first received Medicare payments (interim or otherwise) on or after October 1, 1995 under present or previous ownership; these facilities will be paid based on 100 percent of the Federal rate.

The facility-specific per diem rate is the sum of the facility's total allowable Part A Medicare costs and an estimate of the amounts that would be payable under Part B for covered SNF services for cost reporting periods beginning in fiscal year 1995 (base year). The base year cost report used to compute the facility-specific per diem rate in the transition period must be the latest available cost report. It may be settled (either tentative or final) or as-submitted for Medicare payment purposes. Under section 1888(e)(3) of the Act, any adjustments to the base year cost report made as a result of settlement or other action by the fiscal intermediary, including cost limit exceptions/exemptions, results of an appeal, etc., will result in a retroactive adjustment to the facility-specific per diem rate. The instructions below should be used to calculate the facility-specific per diem rate.

A. Determination of Facility-Specific Per Diem Rates

1. Part A Cost Determination

The facility-specific per diem rate reflects the total allowable Part A Medicare cost (routine, ancillary, and capital-related) incurred during a facility's cost reporting period beginning in Federal fiscal year 1995 (base year). The facility-specific per diem rate will be adjusted to account for the amounts of (1) exceptions granted to the inpatient routine services cost limits under § 413.30(f), and (2) new provider exemptions from the cost limits under § 413.30(e), only to the extent that routine service costs do not exceed 150 percent of applicable unadjusted cost limits.

Part A Medicare costs associated with approved educational activities, as defined in § 413.85, are not included in the facility-specific per diem rate. A facility's actual reasonable costs of approved educational activities will be separately identified and apportioned to the Medicare program for payment purposes on the Medicare cost report effective for cost reporting periods beginning on or after July 1, 1998.

Under section 1888(e)(3)(B)(ii) of the Act, for facilities participating in the Nursing Home Case-Mix and Quality Demonstration (RUG–III), the Part A Medicare costs used to compute the facility-specific per diem rate will be the aggregate RUG–III payment received for services furnished in the cost reporting period beginning calendar year 1997 plus the routine capital costs and ancillary costs (other than occupational therapy, physical therapy, and speech pathology costs) as reported on the facility's Medicare cost report that begins in calendar year 1997.

For those low volume SNFs that received a prospectively determined payment rate for SNF routine services, under section 1888(d) of the Act and part 413, subpart I, the facility-specific per diem rate will be the applicable prospectively determined payment rate plus Medicare ancillary cost per diem.

Calculations to determine Medicare Part A costs are to be made as follows:

a. Freestanding Skilled Nursing Facilities. (1) Skilled Nursing Facilities Without an Exception for Medical and Paramedical Education (§ 413.30(f)(4)) or a New Provider Exemption in the Base Year.

i. Routine Costs

Step 1. Determine total program routine service costs for comparison to the cost limitation (HCFA–2540–92, worksheet D–1, line 23 or HCFA–2540–96, worksheet D–1, line 25).

Step 2. Determine Medicare Routine medical education costs—worksheet B, part I, line 16, column 14 divided by total patient days (Worksheet S–3, line 1, column 7) then multiplied by total Medicare days (Worksheet S–3, line 1, column 4).

Step 3. Subtract amount in Step 2. from amount in Step 1. above.

Step 4. Compare amount in Step 3. above to the inpatient routine service cost limitation, including exception amounts other than Medical and Paramedical Education: see (2) below (HCFA–2540–92, worksheet D–1, line 24 or HCFA–2540–96, worksheet D–1, line 27) and take the lesser of the two amounts.

Step 5. Add the amount in Step 4. to the program capital related cost (HCFA–2540–92, worksheet D–1, line 20 or HCFA–2540–96, worksheet D–1, line 22).

ii. Part A Ancillary Costs

Step 1. Determine total program inpatient ancillary services (HCFA–2540–92 or HCFA–2540–96, Worksheet E, part I, line 1).

Step 2. Determine Medicare Ancillary medical education costs—worksheet B, part I, calculate separately each line 21–33, dividing column 14 by column 18. Multiply the resulting percentage by the corresponding line (lines 21–33) on worksheet D, column 4. Total the resulting amounts calculated for lines 21–33.

Step 3. Subtract amount in Step 2. from the amount in Step 1. above.

iii. Part A cost Equals the Amount in i.Step 5. Plus the Amount in ii.Step 3. Above

(2) Skilled Nursing Facilities With an Exception for Medical and Paramedical Education in the Base Year.

i. Routine Costs

Step 1. Determine total program routine service costs for comparison to the cost limitation (HCFA–2540–92, worksheet D–1, line 23 or HCFA–2540–96, worksheet D–1, line 25).

Step 2. Determine Medicare Routine medical education costs—worksheet B, part I, line 16, column 14 divided by total patient days (Worksheet S–3, line 1, column 7) then multiplied by total Medicare days (Worksheet S–3, line 1, column 4).

Step 3. Subtract the amount in Step 2. from the amount in Step 1. above

Step 4. From the inpatient routine service cost limitation, including all exception amounts granted, (HCFA–2540–92, worksheet D–1, line 24 or HCFA–2540–96, worksheet D–1, line 27) subtract the exception amount granted for medical and paramedical education costs.

Step 5. Compare amount in Step 3. above with the amount in Step 4. above and take the lesser of the two amounts.

Step 6. Add amount in Step 5. to the program capital related cost (HCFA–2540–92, worksheet D–1, line 20 or HCFA–2540–96, worksheet D–1, line 22).

ii. Part A Ancillary Costs

Step 1. Determine total program inpatient ancillary services (HCFA–2540–92 or HCFA–2540–96, Worksheet E, part I, line 1).

Step 2. Determine Medicare Ancillary medical education costs—worksheet B, part I, calculate separately each line 21–33, dividing column 14 by column 18. Multiply the resulting percentage by the corresponding line (lines 21–33) on worksheet D, column 4. Total the amounts calculated for lines 21–33.

Step 3. Subtract amount in Step 2. from the amount in Step 1. above.

iii. Part A cost Equals the Amount in i.Step 6. Plus the Amount in ii.Step 3. Above

(3) Skilled Nursing Facilities With New Provider Exemptions From the Cost Limits in the Base Year.

i. Routine Costs

Step 1. Determine total program routine service costs for comparison to the cost limitation (HCFA–2540–92, worksheet D–1, line 23 or HCFA–2540–96, worksheet D–1, line 25).

Step 2. Determine Medicare Routine medical education costs—worksheet B, part I, line 16, column 14 divided by total patient days (Worksheet S–3, line 1, column 7) then multiplied by total Medicare days (Worksheet S–3, line 1, column 4).

Step 3. Subtract amount in Step 2. from the amount in Step 1. above.

Step 4. Multiply the unadjusted inpatient routine service cost limitation (the cost limit amount had the SNF not received an exemption, which is normally reported on HCFA–2540–92, worksheet D–1, line 24 or HCFA–2540–96, worksheet D–1, line 27) by 1.5.

Step 5. Compare amount in Step 3. above with the amount in Step 4. above and take the lesser of the two amounts.

Step 6. Add to the amount in Step 5. the program capital related cost (HCFA–2540–92, worksheet D–1, line 20 or HCFA–2540–96, worksheet D–1, line 22).

ii. Part A Ancillary Costs

Step 1. Determine total program inpatient ancillary services (HCFA–2540–92 or HCFA–2540–96, Worksheet E, part I, line 1).

Step 2. Determine Medicare Ancillary medical education costs—worksheet B, part I, calculate separately each line 21–33, dividing column 14 by column 18. Multiply the resulting percentage by the corresponding line (lines 21–33) on worksheet D, column 4. Total the amounts calculated for lines 21–33.

Step 3. Subtract amount in Step 2. from the amount in Step 1. above.

iii. Part A Cost Equals the Amount in i. Step 6. Plus the Amount in ii.Step 3. Above

b. Hospital-based skilled nursing facilities. (1) Skilled Nursing Facilities Without an Exception for Medical and Paramedical Education or a New Provider Exemption.

i. Routine Costs

Step 1. Determine total program routine service costs for comparison to the cost limitation (HCFA–2552–92 or HCFA–2552–96, worksheet D–1, part III, line 76).

Step 2. Determine Medicare Routine medical education costs—worksheet B part I, line 34, sum of columns 21 and 24 (only amounts that are for approved education programs), divided by total patient days (worksheet S–3, part I, line 11 (HCFA–2552–92) or part I, line 15 (HCFA–2552–96) column 6) then multiplied by total Medicare days (worksheet S–3, part I, line 11 (HCFA–2552–92) or part I, line 15 (HCFA–2552–96), column 4).

Step 3. Subtract amount in Step 2. from the amount in Step 1. above.

Step 4. Compare amount in Step 3. above to the inpatient routine service cost limitation, including exception amounts other than Medical and Paramedical education; see (2) below, (HCFA–2552–92 or HCFA–2552–96, worksheet D–1, part III, line 78) and take the lesser of the two amounts.

Step 5. Add to amount in Step 4. The program capital related cost (HCFA–2552–92 or HCFA–2552–96, worksheet D–1, part III, line 73).

ii. Part A Ancillary Costs

Step 1. Determine total program inpatient ancillary services (HCFA–2552–92 or HCFA–2552–96, worksheet D–1, part III, line 80).

Step 2. Determine Medicare Ancillary medical education costs—worksheet B, part I, (calculate separately each line 37–59), dividing the sum of columns 21 and 24 (approved programs only) by column 27. Multiply the resulting percentage by the corresponding line (lines 37–59) on worksheet D–4 (SNF), column 3. Total the amounts calculated for lines 37–59.

Step 3. Subtract amount in Step 2. from the amount in Step 1. above.

iii. Part A Cost Equals the Amount in i.Step 5. Plus the Amount in ii.Step 3. Above

(2) Skilled Nursing Facilities With an Exception for Medical and Paramedical Education in the Base Year.

i. Routine Costs

Step 1. Determine total program routine service costs for comparison to the cost limitation (HCFA–2552–92 or HCFA–2552–96, worksheet D–1, part III, line 76).

Step 2. Determine Medicare Routine medical education costs—worksheet B part I, line 34, sum of columns 21 and 24 (only amounts that are for approved education programs), divided by total patient days (worksheet S–3, part I, line 11 (HCFA–2552–92) or part I, line 15 (HCFA–2552–96) column 6) then multiplied by total Medicare days (worksheet S–3, part I, line 11 (HCFA–2552–92) or part I, line 15 (HCFA–2552–96), column 4).

Step 3. Subtract amount in Step 2. from the amount in Step 1. above.

Step 4. From the inpatient routine service cost limitation, including all exception amounts granted, (HCFA–2552–92 or HCFA–2552–96, worksheet D–1, part III, line 78) subtract the exception amount granted for medical and paramedical education costs.

Step 5. Compare amount in Step 3. above with the amount in Step 4. above and take the lesser of the two amounts.

Step 6. Add to the amount in Step 5. the program capital related cost (HCFA–2552–92 or HCFA–2552–96, worksheet D–1, part III, line 73).

ii. Part A Ancillary Costs

Step 1. Determine total program inpatient ancillary services (HCFA–2552–92 or HCFA–2552–96, worksheet D–1, part III, line 80).

Step 2. Determine Medicare Ancillary medical education costs—worksheet B, part I (calculate separately each line 37–59), dividing the sum of columns 21 and 24 (approved programs only) by column 27. Multiply the resulting percentage by the corresponding line (lines 37–59) on worksheet D–4 (SNF), column 3. Total the amounts calculated for lines 37–59.

Step 3. Subtract amount in Step 2. from the amount in Step 1. above.

iii. Part A Cost Equals the Amount in i.Step 6. plus the amount in ii.Step 3. Above

(3) Skilled Nursing Facilities with exemptions from the cost limits in the base year.

i. Routine Costs

Step 1. Determine total program routine service costs for comparison to the cost limitation (HCFA–2552–92 or HCFA–2552–96, worksheet D–1, part III, line 76).

Step 2. Determine Medicare Routine medical education costs—worksheet B, part I, line 34, sum of columns 21 and 24 (only amounts that are for approved education programs), divided by total patient days (worksheet S–3, part I, line 11 (HCFA–2552–92) or part I, line 15 (HCFA–2552–96), column 6) then multiplied by total Medicare days (worksheet S–3, part I, line 11 (HCFA–2552–92) or part I, line 15 (HCFA–2552–96), column 4).

Step 3. Subtract amount in Step 2. from the amount in Step 1. above.

Step 4. Multiply the unadjusted inpatient routine service cost limitation (the cost limit amount had the SNF not received an exemption, which is normally reported on HCFA–2552–92 or HCFA–2552–96, worksheet D–1, part III, line 78) by 1.5.

Step 5. Compare amount in Step 3. above with the amount in Step 4. above and take the lesser of the two amounts.

Step 6. Add to the amount in Step 4. the program capital related cost (HCFA–2552–92 or HCFA–2552–96, worksheet D–1, part III, line 73).

ii. Part A Ancillary Costs

Step 1. Determine total program inpatient ancillary services (HCFA–2552–92 or HCFA–2552–96, worksheet D–1, part III, line 80).

Step 2. Determine Medicare Ancillary medical education costs—worksheet B, part I (calculate separately each line 37–59), dividing the sum of columns 21 and 24 (approved programs only) by column 27. Multiply the resulting percentage by the corresponding line (lines 37–59) on worksheet D–4 (SNF), column 3. Total the amounts calculated for lines 37–59.

Step 3. Subtract the amount in Step 2. from the amount in Step 1. above.

iii. Part A Cost Equals the Amount in i.Step 6. Plus the Amount in ii.Step 3. Above

c. Medicare low volume Skilled Nursing Facilities electing prospectively determined payment rate (fewer than 1500 Medicare days).

(1) Providers Filing HCFA–2540–S–87.

Step 1. Determine inpatient ancillary services Part A (HCFA–2540–S–87, worksheet E, part A, line 1).

Step 2. Determine inpatient routine PPS amount (HCFA–2540–S–87, worksheet E, part A, line 6).

Step 3. Part A cost equals the amount in Step 1. plus the amount in Step 2. above.

(2) Providers Filing HCFA–2540 or HCFA–2552.

Step 1. Determine the prospective payment amount is used as the routine cost.

Step 2. Follow the steps under a.(1)(ii) if you are a freestanding SNF or b.(1)(ii) if you are a hospital-based SNF to calculate the ancillary costs.

Step 3. Part A cost equals the amount in Step 1. plus the amount in Step 2. above.

d. Providers participating in the multistate nursing home case-mix and quality demonstration—calculation of the prospective payment system rate. For providers that received payment under the RUGs–III demonstration during a cost reporting period that began in calendar year 1997, we will determine their facility-specific per diem rate using the methodology described below. It is possible that some providers participated in the demonstration but did not have a cost reporting period that began in calendar year 1997. For those providers, we will determine their facility-specific per diem rate by using the calculations in (a), (b), or (c) above. As with the facility-specific per diem applicable to other providers, the allowable costs will be subject to change based on the settlement of the cost report used to determine the total payment under the demonstration. In addition, we derive a special market basket inflation factor to adjust the 1997 costs to the midpoint of the rate setting period (July 1, 1998 to September 30, 1999).

Step 1. Determine the aggregate payment during the cost reporting period that began in calendar year 1997—RUGs–III payment plus routine capital costs plus ancillary costs (other than Occupational Therapy, Physical Therapy, and Speech Pathology).

Step 2. Divide the amount in Step 1. by the applicable total inpatient days for the cost reporting period.

Step 3. Adjust the amount in Step 2. by 1.031532 (inflation factor)—Do not use Table 4.F.

The amount in Step 3 is the facility-specific rate that is applicable for the facility's first cost reporting period beginning after July 1, 1998. A separate calculation for Part B services is not required.

e. Base period cost reports that are adjusted for exception amounts or other post settlement adjustments. Intermediaries will calculate a provider's Medicare Part A costs, as described above, using the latest available version of the cost report in the settlement process. Adjustments made in subsequent cost report versions, through the settlement or reopening process, will result in a revision to the facility-specific rate. Examples of these adjustments include exception amounts or other post-settlement adjustments.

B. Determination of the Part B Estimate

HCFA will supply each intermediary with the estimated Part B charges for each provider that it serves. As explained above, the BBA 1997 requires that the facility-specific per diem rates reflect items and services (other than those specifically excluded) for which, prior to July 1, 1998, payment had been made under Part B but furnished to SNF residents during a Part A covered stay. Accordingly, it was necessary to determine the Part B allowable charges (including coinsurance) associated with the SNFs contained in the cost report data base. This was accomplished by matching 100 percent of the Medicare Part B SNF claims associated with Part A covered SNF stays related to the SNF cost reporting periods beginning in the 1995 base year. The matched Part B allowable charges were computed at a facility level by the appropriate cost report cost center (for example, laboratory services, supplies) with the cost report data.

C. Calculation of the Facility-Specific Per Diem Rate

The facility-specific per diem rate is equal to the sum of Medicare Part A costs as determined in section III.A above and the Medicare Part B estimate described in section III.B above.

Example: The rules as shown under b.(2) above will be used in this example.

ABC SNF is a hospital-based SNF which received an exception of $10,000 of which $5,000 was for Medical and Paramedical Education costs in accordance with the rules at § 413.30(f)(4) in its base year. ABC SNF filed its cost report using HCFA–2552–96. ABC's facility-specific per diem rate for its first cost reporting period beginning in the transition period is calculated as follows:

Step 1. ABC SNF reported program routine service costs for comparison to the cost limits on worksheet D–1, part III, line 76 of $200,000.

Step 2. Total (all patients) routine medical education costs (approved programs) from worksheet B, part I, line 34, the sum of columns 21 and 24 totaled $25,000. Total patient days from worksheet S–3, part I, line 15, column 6 were 5,000 and total Medicare days (worksheet S–3, part I, line 15, column 4) were 1,000. Dividing the total costs of $25,000 by the total days of 5,000 gives you a cost per day of $5.00. Multiply the cost per day by the Medicare days of 1,000, which results in the total Medicare routine medical education cost of $5,000.

Step 3. Subtract the amount in Step 2. ($5,000) from the amount in Step 1. ($200,000) or $195,000 ($195.00 per Medicare day).

Step 4. ABC SNF's inpatient routine service cost limitation amount without any exception amounts is $180,000, the amount with all exception amounts including the $5,000 exception amount for medical and paramedical education costs from worksheet D–1, part III, line 78 is $190,000 ($180,000 plus $10,000). Subtract the exception amount for medical and paramedical education of $5,000 to equal $185,000.

Step 5. Determine the lesser amount in Step 3. and Step 4. above—$185,000.

Step 6. Add the program capital-related cost of $20,000 from worksheet D–1, part III, line 73 to the amount in Step 5 above to equal $205,000.

Step 7. ABC SNF has total program inpatient ancillary services costs on

worksheet D–1, part III, line 80 of $350,000.

Step 8. Determine Medicare ancillary medical education costs (approved programs) from worksheet B, part I, lines 37–59. Calculating each line (separately calculate each line) by taking the sum of columns 21 and 24 and dividing by column 27 (approved programs only). Multiply this percentage by the corresponding line (lines 37–59) on worksheet D–4 (SNF), column 3. Totaling the amounts calculated for lines 37–59 ABC SNF had Medicare ancillary medical education costs of $35,000.

Step 9. Subtract amount in Step 8 ($35,000) from line 7 ($350,000) or $315,000.

Step 10. Determine the estimated Part B amount supplied by HCFA for ABC. Assume, for this example, that this amount is $50,000.

Step 11. Add amounts in Step 6 ($205,000), Step 9 ($315,000), and Step 10 ($50,000) to determine the facility-specific per diem rate of $570.00 ($570,000 divided by 1,000 Medicare days).

D. Computation of the Skilled Nursing Facility Prospective Payment System Rate During the Transition

For the first three cost reporting periods beginning on or after July 1, 1998 (transition period), an SNF's payment under the PPS is the sum of a percentage of the facility-specific per diem rate and a percentage of the Federal per diem rate. Under section 1888(e)(2)(C) of the Act, for the first cost reporting period in the transition period, the SNF payment will be the sum of 75 percent of the facility-specific per diem rate and 25 percent of the Federal per diem rate. For the second cost reporting period, the SNF payment will be the sum of 50 percent of the facility-specific per diem rate and 50 percent of the Federal per diem rate. For the third cost reporting period, the SNF payment will be the sum of 25 percent of the facility-specific per diem rate and 75 percent of the Federal per diem rate. For all subsequent cost reporting periods beginning after the transition period, the SNF payment will be equal to 100 percent of the Federal per diem rate. See the example below.

Example of computation of adjusted PPS rates and SNF payment:

Using the ABC SNF described in this section, the following shows the adjustments made to the facility-specific per diem rate and the Federal per diem rate to compute the provider's actual per diem PPS payment in the transition period. ABC's 12-month cost reporting period begins July 1, 1998.

Step 1.

Compute:

Facility-specific per diem rate		$570.00
Market Basket Adjustment (Table 4.F)	×	1.05149
Adjusted facility-specific rate	....	$599.35

Step 2.

Compute Federal per diem rate:

SNF ABC from above is located in State College, PA with a wage index of 0.9635.

RUG group	Labor portion*	Wage index	Adjusted labor	Nonlabor portion*	Adjusted rate	Medicare days	Payment
RVC	$224.74	0.9635	$216.54	$71.41	$287.95	50	$14,398
RHC	206.06	.9635	198.54	65.47	264.01	100	26,401
Total						150	40,799

*From Table 2.G.

Step 3.

Apply transition period percentages:

Facility-specific per diem rate $599.35×150 days=	$89,903
Times transition percentage (75 percent)	×.75
Actual facility-specific PPS payment	$67,427
Federal PPS payment	$40,799
Times transition percentage (25 percent)	×.25
Actual Federal PPS payment	$10,200

Step 4.

Compute total PPS payment

ABC's total PPS payment ($67,427+$10,200)	$77,627

IV. The Skilled Nursing Facility Market Basket Index

Section 1888(e)(5)(A) of the Act requires the Secretary to establish an SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in the SNF PPS. Accordingly, as described below, we have developed an SNF market basket index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses.

A. Rebasing and Revising of the Skilled Nursing Facility Market Basket

1. Background

Effective for cost reporting periods beginning on or after October 1, 1979, we developed and adopted a routine SNF input price index, that is, the SNF market basket using data from 1977 as the base year.

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

The 1977-based routine SNF market basket was for routine costs (ancillary services and capital-related costs were excluded). The percentage change in the 1977-based routine market basket reflects the average change in the price of a fixed set of goods and services purchased by SNFs to furnish routine services. We first used the market basket to adjust SNF cost limits to reflect the average increase in the prices of the goods and services used to furnish routine reasonable costs for SNF care. This approach linked the increase in the cost limits to the efficient utilization of resources. For background information, see the August 31, 1979 **Federal Register** (44 FR 51542).

For purposes of SNF PPS, the total cost SNF market basket is a fixed-weight (Laspeyres type) price index constructed in three steps. First, a base period is selected and total base period expenditure for cost shares is estimated for mutually exclusive and exhaustive spending categories. Total costs for routine services, ancillary costs, and capital-related costs are used. These proportions are called ''cost'' or ''expenditure'' weights. The second step essential for developing an input price index is to match each expenditure category to a price/wage variable, called a price proxy. These price proxy variables are drawn from publicly

available statistical series published on a consistent schedule, preferably at least quarterly. In the final step, the price level for each spending category is multiplied by the expenditure weight for that category. The sum of these products (that is, weights multiplied by proxy index levels) for all cost categories yields the composite index level in the market basket for a given quarter or year. Repeating the third step for other quarters and years produces a time series of market basket index levels. Dividing one index level by an earlier index level produces rates of growth in the input price index.

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

To implement section 1888(e)(5)(A) of the Act, it is necessary to revise and rebase the routine cost market basket so the cost weights and price proxies reflect the mix of goods and services that SNFs purchase for all costs (routine, ancillary, and capital-related) encompassed by SNF PPS. The current SNF routine cost weights (excluding ancillary costs and capital-related costs) are from calendar year 1977. To the extent feasible, the data used to revise and rebase the SNF market basket are from fiscal year 1992. If data from an earlier period supplement fiscal year 1992 data, they have been aged forward for price changes.

2. Rebasing and Revising the Skilled Nursing Facility Market Basket

The terms ''rebasing'' and ''revising,'' while often used interchangeably, actually denote different activities. Rebasing means moving the base year for the structure of costs of an input price index (for example, for this rule, we have moved the base year cost structure from calendar year 1977 to fiscal year 1992). Revising means changing data sources, cost categories, and/or price proxies used in the input price index.

To implement section 1888(e)(5)(A) of the Act, we are rebasing and revising the routine SNF market basket (excluding ancillary and capital-related costs) to reflect 1992 total cost data (routine, ancillary, and capital-related), the latest available relatively complete data on the structure of SNF costs; and to modify certain variables used as the price proxies for some of the cost categories.

In developing the revised market basket, we reviewed SNF expenditure data for the market basket cost categories. We reviewed Medicare Cost Reports for PPS–9 for each freestanding SNF that had Medicare expenses greater than 1 percent of total expenses. PPS–9 cost reports are those with cost reporting periods beginning after September 30, 1991 and before October 1, 1992. Data on SNF expenditures for six major expense categories (wages and salaries, employee benefits, contract labor, pharmaceuticals, capital-related, and a residual ''all other'') were edited and tabulated. After totals for these main cost categories were calculated, we then determined the proportion of total costs that each category represented. The proportions represent the revised and rebased major market basket weights for total costs including routine, ancillary, and capital-related costs.

Relative weights within the six categories were derived using U.S. Department of Commerce data for the nursing home industry. Relative cost shares from the Bureau of the Census' 1992 Asset and Expenditure Survey and the Bureau of Economic Analysis' (BEA) 1992 Input-Output Tables were used to disaggregate and allocate costs within the six categories from the 1992 SNF Medicare Cost Reports. The BEA Input-Output database, which is updated at 5-year intervals, was most recently described in the Survey of Current Business, ''Benchmark Input-Output Accounts for the U.S. Economy, 1992'' (November 1997).

We developed the capital-related portion of the rebased and revised SNF PPS market basket using the same overall methodology used to develop the hospital PPS capital input price index. The methodology for hospitals is described in full detail in the May 31, 1996 (61 FR 27466) and the August 30, 1996 (61 FR 46196) **Federal Register** publications. The strength of this HCFA methodology is that it reflects the vintage nature of capital, which is the acquisition and use of capital over time. Price levels are determined for capital acquired in current and prior years and vintage-weighted based on historical capital acquisition patterns. These vintage-weighted price changes reflect the price changes associated with the capital acquisition process.

Because there are fewer data on capital-related costs for the SNF industry than for the hospital industry, we developed a methodology that makes the maximum use of the existing SNF data. We have developed a framework that integrates existing SNF capital data with related data sources and assumptions. We determined that reasonable changes in the capital-related assumptions have little impact on the overall SNF market basket (routine costs, capital-related costs, and ancillary costs). We also compared the price changes from the capital-related component of the SNF market basket to the price changes in the hospital PPS capital input price index and other price indexes. The comparison showed that the changes in the different indexes were reasonable in relation to changes with the SNF capital-related component. A detailed explanation of how both the cost category weights and the vintage weights were determined, which price proxies were chosen, the effect of using different assumptions, and a comparison of capital-related components of the rebased SNF PPS market basket to other price indexes is given in the Appendix.

Our work resulted in 21 separate categories for the rebased and revised total market basket. The 1977-based routine cost SNF market basket had 12 separate cost categories. Detailed descriptions of each cost category and respective price proxy in the 1992-based market basket are provided in the Appendix to this rule. The six major categories for the revised and rebased cost categories and weights derived from SNF Medicare Cost Reports are summarized in Table 4.A below.

TABLE 4.A—1992 SKILLED NURSING FACILITY MARKET BASKET MAJOR COST CATEGORIES AND WEIGHTS FROM MEDICARE COST REPORTS

Cost categories	1992-based skilled nursing facility market basket weights (percent)
Wages and Salaries	47.805
Employee Benefits	10.023
Contract Labor	12.852
Pharmaceuticals	2.531
Capital-related Costs	9.777
All Other Costs	17.012
Total Costs	100.000

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

- Employment Cost Indexes—Employment Cost Indexes (ECIs)

measure the rate of change in employee wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. They are not affected by shifts in occupation or industry mix. ECIs were not available when we developed the calendar year 1977-based routine SNF market basket. ECIs are superior to Average Hourly Earnings (AHEs) as price proxies for input price indexes for two reasons: (1) they measure pure price change, and (2) they are available by occupational groups, not just by industry.

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

• Producer Price Indexes—PPIs are used to measure price changes for goods sold in other than retail markets. For example, a PPI for movable equipment was used, rather than a CPI for equipment.

The contract labor weight of 12.852 was reallocated to (1) wages and salaries, (2) employee benefits, and (3) the all other expenses cost category so that the same price proxies that were used for direct labor and nonlabor costs could be applied to contract costs. The rebased and revised cost categories, weights, and price proxies for the 1992-based SNF market basket are listed in Table 4.B below.

TABLE 4.B—1992-BASED COST CATEGORIES, WEIGHTS, AND PRICE PROXIES

Cost category	1992-based market basket weight	Price proxy
Operating Expenses	90.223	
Compensation	67.059	
Wages and Salaries	54.262	ECI for Wages and Salaries for Private Nursing Homes
Employee benefits	12.797	ECI for Benefits for Private Nursing Homes
Nonmedical professional fees	1.916	ECI for Compensation for Private Professional, Technical and Specialty workers
Utilities	2.500	
Electricity	1.626	PPI for Commercial Electric Power
Fuels, nonhighway	0.332	PPI for Commercial Natural Gas
Water and sewerage	0.542	CPI-U for Water and Sewerage
Other Expenses	18.747	
Other Products	10.964	
Pharmaceuticals	2.531	PPI for Prescription Drugs
Food	3.353	
Food, wholesale purchase	2.577	PPI for Processed Foods
Food, retail purchase	0.776	CPI-U for Food Away From Home
Chemicals	0.720	PPI for Industrial Chemicals
Rubber and plastics	1.529	PPI for Rubber and Plastic Products
Paper products	1.005	PPI for Converted Paper and Paperboard
Miscellaneous products	1.826	PPI for Finished Goods
Other Services	7.783	
Telephone Services	0.385	CPI-U for Telephone Services
Labor-intensive Services	3.686	ECI for Compensation for Private Service Occupations
Non labor-intensive services	3.713	CPI-U for All Items
Capital-related Expenses	9.777	
Total Depreciation	5.915	
Building & Fixed Equipment	4.118	Boeckh Institutional Construction Index
Movable Equipment	1.797	PPI for Machinery & Equipment
Total Interest	3.189	
Government & Nonprofit SNFs	1.658	Average Yield Municipal Bonds (Bond Buyer Index-20 bonds)
For-Profit SNFs	1.531	Average Yield Moody's AAA Bonds
Other Capital-related Expenses	0.674	CPI-U for Residential Rent
Total	* 100.000	

* may not add due to rounding

In the 1992-based total costs market basket, the labor-related share is 75.888 percent, while the non-labor-related share is 24.112 percent. The labor-related share for the 1977-based routine cost market basket (81.2 percent) included wages and salaries, employee benefits, health services, business services, and miscellaneous costs, while the labor-related share of the 1992 total cost market basket (75.888 percent) includes wages and salaries, employee benefits, professional fees, labor-intensive services, and a 33 percent share of capital-related expenses as shown on Table 4.C below. The share of labor-related costs in 1992 reflects the change from only routine costs to total costs (routine, ancillary, and capital-related) and the changing mix of SNF services between 1977 and 1992.

The labor-related share for capital-related expenses was determined to be 33 percent of capital-related expenses, or 3.227 percent of the total PPS SNF market basket. This share was estimated from a statistical analysis of individual SNF Medicare Cost Reports for 1993 since nearly all reports from this year were settled. The statistical analysis was necessary because the proportion of capital-related expenses related to local area wage costs cannot be directly determined from the SNF capital-related market basket as it can for operating and ancillary costs.

We performed regression analysis with capital-related costs per day in SNFs as the dependent variable and relevant explanatory variables for size, complexity, efficiency, age of capital, and local wage variation. To account for

these factors, we used number of beds, case-mix indexes, occupancy rate, ownership, age of assets, length of stay, FTEs per bed, and the wage index values based on hospital wage index (wages and employee benefits) as independent variables. The regression statistics showed each variable was statistically significant and an adjusted r-square that was acceptable given the large number of observations. The independent variable most relevant for our purpose is the wage index values based on hospital wage data, since this index is being used to adjust payments under SNF PPS for geographic variation in local labor costs. The regressions use log transformations for the dependent and independent variables, hence the coefficients can be interpreted as elasticities. The coefficient for the wage index value was 0.33 with a t-value of 4.3. The interpretation of this coefficient as an elasticity is that a 10 percent increase in the wage index value leads to a 3.3 percent increase in capital-related costs per day. This coefficient is equivalent to the portion of capital-related expenses in the SNF market basket that are considered to be labor-related. Multiplying the 0.33 by the capital-related share of 9.777 yields a labor-related share for capital of 3.227 percent of the total SNF market basket.

Conceptually it seems appropriate that capital-related expenses would vary less with local wages than would operating expenses for SNFs. Operating expenses for SNFs are determined in large part from the labor inputs for relatively low-skilled employees that are tightly linked to local wage levels in local labor markets. Wages, salaries, and benefits constitute a majority of the operating costs of providing SNF services; the labor-related share of operating expenses is 80.6 percent. For capital-related expenses, however, annual costs in the current year are for capital purchased over time. Capital-related expenses are determined in some proportion by local area costs (such as construction worker wages and building materials costs) that are reflected in the price of the capital asset. However, many other inputs that determine capital costs are not related to local area wage costs, such as equipment prices and interest rates. We found a similar lower share for capital-related expenses in hospitals.

We also conducted regression analyses with operating and total costs per day for SNFs as the dependent variable. The findings of our analysis of SNF operating and total costs per day are consistent with the PPS SNF market basket weights and structure. For operating costs per day, the regression analysis yielded a coefficient nearly the same as the operating labor-related share from the SNF market basket. The regression of total costs per day yielded a coefficient of 0.74 percent, nearly the same as the total labor-related share (operating and capital-related) from the SNF market basket. We also conducted a similar regression analysis on hospital costs per case and determined the results to be consistent with the PPS hospital market basket.

Approaching the labor-related share several different ways validated the appropriateness of using regression analysis. Therefore, we are using this analysis in determining the labor-related share for PPS SNF capital-related expenses.

TABLE 4.C—1992-BASED LABOR-RELATED SHARE

Cost category	1992-based market basket weight
Wages and Salaries	54.262
Employee Benefits	12.797
Nonmedical Professional Fees	1.916
Labor-intensive Services	3.686
Capital-related	3.227
Total	75.888

All price proxies for the rebased SNF market basket are listed in Table 4.B and summarized in the Appendix to this rule. A comparison of the yearly historical percent changes from 1994 through 1996 for the current 1977-based routine costs market basket and the 1992-based total cost market basket is shown below in Table 4.D.

TABLE 4.D—COMPARISON OF THE 1977-BASED SKILLED NURSING FACILITY ROUTINE COSTS MARKET BASKET AND THE 1992-BASED SKILLED NURSING FACILITY TOTAL COSTS MARKET BASKET, PERCENT CHANGES, 1994–1996*

Fiscal years beginning October 1	Skilled Nursing Facility Routine Market Basket, CY 1977 base	Skilled nursing facility total cost market basket, FY 1992 base
Historical:		
October 1993, FY 1994	3.6	3.2
October 1994, FY 1995	2.8	3.0
October 1995, FY 1996	2.6	2.7

TABLE 4.D—COMPARISON OF THE 1977-BASED SKILLED NURSING FACILITY ROUTINE COSTS MARKET BASKET AND THE 1992-BASED SKILLED NURSING FACILITY TOTAL COSTS MARKET BASKET, PERCENT CHANGES, 1994–1996*—Continued

Fiscal years beginning October 1	Skilled Nursing Facility Routine Market Basket, CY 1977 base	Skilled nursing facility total cost market basket, FY 1992 base
Historical Average: 1994–1996	3.0	3.0

*Note: The 1992 total cost market basket is measuring a different cost concept than the 1977 routine cost market basket. Differences between the two indexes are expected.

Source: Standard & Poor's DRI HCC, 4th QTR, 1997; @USSIM/TREND25YR1197 @CISSIM/CONTROL974.

Released by HCFA, OACT, National Health Statistics Group.

Note that the historical average rate of growth for 1994 through 1996 for the SNF 1992-based total cost market basket is equal to that of the 1977-based routine market basket. We believe that the 1992-based SNF total cost market basket provides a more current measure of the annual increases in total cost care than the 1977-based SNF market basket because: (1) the cost structure includes routine, ancillary, and capital-related costs, not just routine cost, (2) the cost structure reflects the structure of costs for the most recent year for which there are relatively complete data, and (3) superior new wage-price variables have been incorporated into the 1992-based index. The forecasted rates of growth used to compute the projected SNF market basket percentages, described in the next section, are shown below in Table 4.E.

TABLE 4.E—SKILLED NURSING FACILITY TOTAL COST MARKET BASKET, FORECASTED CHANGE, 1997–2000

Fiscal years beginning October 1	Skilled Nursing facility total cost market basket
October 1996, FY 1997	2.4
October 1997, FY 1998	2.8
October 1998, FY 1999	3.0
October 1999, FY 2000	3.1
Forecasted Average: 1997–2000	2.8

Source: Standard & Poor's DRI HCC, 4th QTR, 1997; @USSIM/TREND25YR1197 @CISSIM/CONTROL974.

Released by HCFA, OACT, National Health Statistics Group.

We are considering a mechanism to adjust future SNF PPS rates for forecast errors. The forecasted SNF total cost market basket changes shown in Table 4.E are based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming rate setting period. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increases in prices faced by SNFs and the forecast used in calculating the update factors. We are reviewing the analytical framework for updating the standard Federal rate under the hospital PPS to account for forecast errors. If this framework is chosen to update the SNF PPS rate, an adjustment would be made only if the forecasted market basket percentage change for any year differs from the actual percentage change by 0.25 percentage points or more. There would be a 2-year lag between the forecast and the measurement of the forecast error. Thus, for example, we would adjust for an error in forecasting the 1997 market basket percentage used to compute the PPS rates effective with this interim final rule through an adjustment to the fiscal year 1999 update to the SNF PPS rates.

B. 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, described in the previous section, from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved. The facility-specific portion and Federal portion of the SNF PPS rates effective with this rule are based on cost reporting periods beginning in Federal fiscal year 1995 (base year). The percentage increases in the SNF market basket index will be used to compute the update factors to reflect cost increases occurring between the cost reporting periods represented in the base year and the midpoint of the fiscal year (or other period). We used the Standard & Poor's DRI CC, 4th quarter 1997 historical and forecasted percentage increases of the revised and rebased SNF market basket index for routine, ancillary, and capital-related expenses, described in the previous section, to compute the update factors. The update factors, as described below, will be used to adjust the base year costs for computing the facility-specific portion and Federal portion of the SNF PPS rates.

1. Facility-Specific Rate Update Factor

Under section 1888(e)(3)(D)(i) of the Act, for the facility-specific portion of the SNF PPS rate, we will update a facility's base year costs up to the facility's first cost reporting period beginning on or after July 1, 1998 and before October 1, 1999 (initial period) by the SNF market basket percentage, reduced by one percentage point. We took the following steps to develop the 12-month cost reporting period facility-specific rate update factors shown in Table 4.F.

Step 1. Determine the cumulative growth from the average market basket level for each 12-month cost report period to the average market basket level for its corresponding 12-month period beginning on or after July 1, 1998.

Step 2. From the cumulative growth in Step 1, determine the average annual rate of growth for the period from each beginning 12-month period's average market basket index level to its corresponding 12-month period beginning on or after July 1, 1998.

Step 3. Subtract 1.0 percentage point from each average annual rate of growth calculated in Step 2.

Step 4. Determine what the revised cumulative growth for each 12-month's period average index level would have been, using the revised average annual rates of growth from Step 3. The resulting update factors are shown in Table 4.F.

TABLE 4.F—UPDATE FACTORS[1] FOR FACILITY-SPECIFIC PORTION OF THE SNF PPS RATES—ADJUST TO 12-MONTH COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 1998 AND BEFORE OCTOBER 1, 1999 [(INITIAL PERIOD) FROM COST REPORTING PERIODS BEGINNING IN FY 1995 (BASE YEAR)]

If 12-month cost reporting period in initial period begins	Adjust from 12-month cost reporting period in base year that begins	Using update factor of
July 1, 1998	July 1, 1995	1.05149
August 1, 1998	August 1, 1995	1.05197
September 1, 1998	September 1, 1995	1.05253
October 1, 1998	October 1, 1994	1.07116
November 1, 1998	November 1, 1994	1.07125
December 1, 1998	December 1, 1994	1.07126
January 1, 1999	January 1, 1995	1.07143
February 1, 1999	February 1, 1995	1.07176
March 1, 1999	March 1, 1995	1.07226
April 1, 1999	April 1,1995	1.07270
May 1, 1999	May 1, 1995	1.07308
June 1, 1999	June 1, 1995	1.07340
July 1, 1999	July 1, 1995	1.07381
August 1, 1999	August 1, 1995	1.07428
September 1, 1999	September 1, 1995	1.07484

[1] *Source:* Standard & Poor's DRI, 4th Qtr 1997; @USSIM/TREND25YR1197@CISSIM/CONTROL974

A 12-month cost reporting period that begins on July 1, August 1, or September 1 will have two cost reporting periods within the initial period. Table 4.F provides update factors for these three beginning dates for 1998 and 1999. The 1998 cost reporting period is considered the first cost reporting period for the purposes of applying the facility-specific percentage in the transition period. The 1999 cost reporting period, for the same provider, is considered the second cost reporting period for the purposes of applying the facility-specific percentage in the transition period. The transition period percentages are presented elsewhere in this rule.

SNFs may have cost reporting periods that are fewer than 12 months in duration (short period). This may occur, for example, when a provider enters the Medicare program after its selected fiscal year has already begun, or when a provider experiences a change of ownership before the end of the cost reporting period. Since short periods affect a small number of providers, relative to the total number of SNFs, and the facility-specific portion of the SNF PPS rate is subject to a transition period, we do not believe consideration of computing a ''short period specific'' update factor is warranted. Accordingly, we will apply the following rules to short periods.

a. Short period in base year. First, select the later short period in the base year for the affected provider. Second, if necessary, adjust the beginning or end of the short period as follows. Short periods may not necessarily begin on the first of the month or end on the last day of the month. In order to simplify the process of determining the short period update factor, if the short period begins before the 16th of the month, it will be adjusted to a beginning date of the 1st of that month. If the short period begins on or after the 16th of the month, it will be adjusted to the beginning of the next month. Also, if the short period ends before the 16th of the month, it will be adjusted to the end of the preceding month, or, if the short period ends on or after the 16th of the month, it will be adjusted to the end of that month. Third, determine the midpoint of the short period. Fourth, use the following midpoint guidelines to determine which 12-month update factor to use from Table 4.F.

If the midpoint of short period falls between	Use factor for this 12-month period
March 16, 1995–April 15, 1995	October 1994–September 1995
April 16, 1995–May 15, 1995	November 1994–October 1995
May 16, 1995–June 15, 1995	December 1994–November 1995
June 16, 1995–July 15, 1995	January 1995–December 1995
July 16, 1995–August 15, 1995	February 1995–January 1996
August 16, 1995–September 15, 1995	March 1995–February 1996
September 16, 1995–October 15, 1995	April 1995–March 1996
October 16, 1995–November 15, 1995	May 1995–April 1996
November 16, 1995–December 15, 1995	June 1995–May 1996
December 16, 1995–January 15, 1996	July 1995–June 1996
January 16, 1996–February 15, 1996	August 1995–July 1996
February 16, 1996–March 15, 1996	September 1995–August 1996

b. Short period in initial period. Providers with short periods that begin on or after July 1, 1998 and before October 1, 1999 (initial period) should use the instructions above to adjust the beginning date of the short period and then use the 12-month factor that corresponds to the beginning date of the ''adjusted to period'' in Table 4.F. The first short period in the initial period is considered the first cost reporting period for the purposes of applying the facility-specific percentage in the transition period. Each subsequent short period, for the same provider, of any duration is considered the second or third cost reporting period for the purposes of applying the facility-specific percentage in the transition period. The transition period percentages are presented elsewhere in this rule.

c. Short period between base year and initial period. A provider may experience a change of ownership or may receive proper approval to change its cost reporting period between the base year cost reporting period and the initial period. If this occurs, the base year cost reporting period may begin on a date that is different than that of the initial period. In these instances, use the beginning date of the initial period to determine the 12-month factor that corresponds to the beginning date of the ''adjusted to period'' in Table 4.F.

2. Federal Rate Update Factor

To develop the Federal rates, we updated each facility's base year costs up to the midpoint of the initial period by the SNF market basket percentages, reduced by one percentage point. We developed the Federal rate adjustment factors using the following methodology:

Step 1. Determine the cumulative growth from the average market basket level for each 12-month cost reporting period to the average market basket level for the 15-month common period.

Step 2. From the cumulative growth in Step 1., determine the average annual rate of growth for the period from each beginning 12-month period's average market basket index level to the average market basket index level of the ending 15-month common period.

Step 3. Subtract 1.0 percentage point from each average annual rate of growth calculated in Step 2.

Step 4. Determine what the revised cumulative growth for each period's average index level would have been, using the revised average annual rates of growth from Step 3.

Step 5. Apply the revised cumulative percentage growth to the average market basket index level for the beginning cost reporting period, which yields revised 15-month average index levels for the common ending period.

Step 6. Using the revised 15-month average index levels determined in Step 5, calculate the ratio of each revised average index level to the original average common period index level.

Step 7. To determine the revised factors to apply to SNF cost reporting periods beginning between October 1, 1994 and September 30, 1995, multiply each factor for adjusting cost reports to the common period by the ratios determined in Step 6. This yields revised factors that reflect an average annual rate equal to the SNF market basket percentage minus 1 percentage point.

These revised update factors were used to compute the Federal portion of the SNF PPS rate shown in Tables 2.A and 2.B.

V. Consolidated Billing

A. Background of the Skilled Nursing Facility Consolidated Billing Provision

Section 4432(b) of the BBA 1997 amended the Social Security Act to establish a requirement for SNF Consolidated Billing, effective for items and services furnished on or after July 1, 1998. SNF Consolidated Billing is a comprehensive billing requirement (similar to the one that has been in effect for inpatient hospital services for well over a decade), under which the SNF itself is responsible for billing Medicare for virtually all of the services that its residents receive. SNF Consolidated Billing is necessary for a number of reasons.

Historically, an SNF could choose to furnish services to its residents either directly with its own resources, or under an ''arrangement'' with an outside source; in either instance, the SNF itself was responsible for submitting the bill for the service to its Medicare fiscal intermediary (FI). However, the SNF has also had the additional option of ''unbundling'' a service altogether; that is, permitting an outside supplier to furnish the service directly to an SNF resident and to submit a bill independently to the carrier under Part B, in lieu of any actual involvement by the SNF itself. The ability on the part of suppliers to submit separate bills directly to the carrier for these unbundled services has been extremely problematic in several ways.

First, it has created a potential for duplicate billing. For example, an SNF might include a particular service in its bill to the FI under Part A at the same time that an outside supplier is improperly submitting a Part B claim to the carrier for the identical service. Unless the Medicare contractors detect this inappropriate duplication in billing, the program ultimately pays twice for the same service.

Further, even in instances where only the supplier bills for the service, the practice of unbundling has resulted in additional out-of-pocket liability for the beneficiary. Under Part A, an SNF resident's only financial liability during a covered stay is for the SNF coinsurance that begins after the 20th day of the stay. The SNF coinsurance amount is set at a flat rate per day (which, by law, represents ⅛ of the current inpatient hospital deductible amount), and this amount does not vary with the number of services that the resident actually receives from one day to the next. This means that even if the SNF furnishes some additional services on a given day, the resident's daily coinsurance amount under Part A does not increase. However, if the SNF decides instead to unbundle those services to an outside supplier which then bills the carrier under Part B, this causes the resident to incur an additional out-of-pocket liability for any unmet deductible under Part B, as well as for Part B's 20 percent coinsurance.

Finally, along with the potential for duplicate billing and for subjecting the beneficiary to needless expense, unbundling has raised quality of care and program integrity concerns for SNF residents—including those who are not in a covered Part A stay—by dispersing the responsibility for providing resident care among a myriad of outside suppliers. This fragmentation in the provision and billing of services has diminished the SNF's own capacity to oversee, coordinate, and account for the total package of care that its residents receive, and has rendered the SNF less able to guard against inappropriate billing practices and utilization.

For years, HCFA pursued legislative proposals to prohibit the practice of unbundling in SNFs, but without success. As with inpatient hospital services, the event that finally brought about a comprehensive billing requirement for SNF services was the creation of a PPS for SNFs. In order to have a prospective payment that includes all of the medically necessary services that an SNF resident receives, it is essential to tie all of those services into a single facility package, by prohibiting unbundling. Otherwise, the Medicare program would once again be faced with potentially paying twice for the same service—once to the SNF under the Part A prospective payment, and again to an outside supplier under Part B.

B. Skilled Nursing Facility Consolidated Billing Legislation

Under the SNF Consolidated Billing requirement established by section 4432(b) of the BBA 1997, the SNF itself has the Medicare billing responsibility for virtually all of the Medicare-covered services that its residents receive. The following is a discussion of the specific provisions of the legislation.

1. Specific Provisions of the Legislation

- Section 4432(b)(1) of the BBA 1997 adds a new paragraph (18) to section 1862(a) of the Act, which prohibits Medicare coverage of services furnished to an SNF resident (other than those services that are specifically excluded from the SNF Consolidated Billing requirement) unless they are furnished or arranged for by the SNF itself.
- Section 4432(b)(2) of the BBA 1997 adds a new paragraph (E) to section 1842(b)(6) of the Act, which specifies that, for any such services that are covered under Part B, Medicare makes payment to the SNF rather than to the beneficiary.
- Section 4432(b)(3) of the BBA 1997 adds to section 1888(e) of the Act a new paragraph (9), which requires that the payment amount for Part B services furnished to an SNF resident shall be the amount prescribed in the otherwise applicable fee schedule, and a new paragraph (10), which requires the SNF's Part B bills to identify all items and services through a uniform coding system to be specified by the Secretary. Under this authority, we are specifying the HCFA Common Procedure Coding System (HCPCS) as the coding system to be used. The HCPCS coding requirement is intended to enable the Medicare contractor to identify individual items and services more readily on the claim; this, in turn, will help enable the contractor to limit the amounts it pays the SNF to any applicable Part B fee schedule amounts in accordance with section 1888(e)(9) of the Act.
- Section 4432(b)(4) of the BBA 1997 adds a new paragraph (t) to section 1842 of the Act, which requires physicians to include the SNF's Medicare provider number on bills for physician services furnished to SNF residents that are separately billable to the Part B carrier (see discussion in section V.B.2. below).
- Section 4432(b)(5) of the BBA 1997 includes a series of conforming amendments. The SNF Consolidated Billing provision requires an SNF to furnish virtually all services to its residents, either directly or under ''arrangements'' with an outside source in which the SNF itself bills Medicare. Accordingly, section 4432(b)(5)(D) amends section 1861(h) of the Act to expand the scope of SNF services that Part A can cover under the extended care benefit to include services furnished under arrangements between the SNF and an outside source, as discussed in section VI. below. Section 4432(b)(5)(F) adds a new clause (ii) to section 1866(a)(1)(H) of the Act to make compliance with the SNF Consolidated Billing provision a specific requirement under the terms of an SNF's Medicare provider agreement.

2. Types of Services That Are Subject to the Provision

Like the SNF PPS itself, SNF Consolidated Billing applies comprehensively to the ''covered skilled nursing facility services'' described in section 1888(e)(2)(A)(i) of the Act when furnished to SNF residents, except for those services that appear on a short list of exclusions described in section 1888(e)(2)(A)(ii) of the Act. However, in practical terms, the SNF Consolidated Billing and PPS provisions encompass slightly different sets of services, since the SNF PPS includes a few individual services that are not subject to the Consolidated Billing provision. This is because the SNF PPS encompasses the entire range of Part A extended care services that are coverable under section 1861(h) of the Act when furnished or arranged for by the SNF itself, including an extremely small number of such services (for example, dialysis services) that section 1888(e)(2)(A)(ii) of the Act specifically identifies as alternatively being billable separately under Part B.

Similarly, the Consolidated Billing provision encompasses a small number of services that are not coverable under Part A or includable in the PPS payment, even though furnished or arranged for by the SNF itself during a covered Part A stay. This is because the services included in the SNF PPS payment are, by definition, limited to the range of diagnostic and therapeutic services that are coverable under the Part A extended care benefit, while the Consolidated Billing provision encompasses not only those types of services, but also certain preventive and screening services that are not considered diagnostic or therapeutic in nature and, thus, are coverable only under Part B. (See the portion of section 1861(h) of the Act following paragraph (7), which limits the scope of coverage under the Part A extended care benefit to those ''diagnostic and therapeutic'' services that are coverable under the inpatient hospital benefit, and section 1862(a)(1) of the Act, which describes preventive services to avoid the occurrence of a medical condition altogether (paragraph (B)) and screening services to detect the presence of a medical condition while it is still in an asymptomatic state (paragraph (F)) as being separate and distinct categories from services to diagnose or treat a condition that has already manifested itself (paragraph (A)). Thus, for example, if an SNF resident receives a vaccination for pneumococcal pneumonia or hepatitis B in the course of a covered Part A stay, this would not represent a diagnostic or therapeutic service that could be covered under the Part A extended care benefit, but a preventive service that is coverable only as one of the ''medical and other health services'' included under Part B (see section 1861(s)(10) of the Act). Accordingly, while the SNF's Part A PPS payment would not include this service, the Consolidated Billing provision would still require the SNF itself to submit the bill for the service to Part B.

The statutory list of excluded services in section 1888(e)(2)(A)(ii) of the Act consists of a number of specific service categories. These include several types of practitioner services that are exempt from the Consolidated Billing requirement and, thus, are still to be billed separately to the Part B carrier. These exempt practitioner services include the following:

- Physicians' services furnished to individual SNF residents (section 4432(b)(4) of the BBA 1997 requires such bills to include the SNF's Medicare provider number).
- Physician assistants working under a physician's supervision.
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician.
- Certified nurse-midwives.
- Qualified psychologists.
- Certified registered nurse anesthetists.

In addition to these exempt categories of practitioner services, section 1888(e)(2)(A)(ii) of the Act also excludes the following types of services:

- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies as described in section 1861(s)(2)(F) of the Act;
- Erythropoietin (EPO) for certain dialysis patients as described in section 1861(s)(2)(O) of the Act, subject to methods and standards established by the Secretary in regulations for its safe and effective use (see §§ 405.2163(g) and (h)); and
- For services furnished during 1998 only: The transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS Code R0076) furnished during 1998. This reflects section 4559 of the BBA 1997, which temporarily restores separate Part B payment for the transportation of portable electrocardiogram equipment used in furnishing tests during 1998.

Further, we note that hospice care (as defined in section 1861(dd) of the Act) is not subject to Consolidated Billing when an SNF resident elects to receive care under the Medicare hospice benefit, since the hospice (rather than the SNF) assumes the overall responsibility for those care needs relating to the beneficiary's terminal condition, while the SNF itself retains responsibility only for those aspects of the beneficiary's care needs that are not related to the terminal condition (see further discussion in section V.B.4. below). In addition, as discussed in section V.B.4. below, we are clarifying that in terms of ambulance services, the Consolidated Billing provision applies only to ambulance transportation furnished *during* the SNF stay, and not to an ambulance trip that occurs at either the beginning or end of the stay.

With regard to the services of physicians and other practitioners, even though the SNF Consolidated Billing requirement generally does not apply to the specific types of practitioners listed above, it does apply to certain particular subcategories of their services, which must be billed by and paid to the SNF. Section 1888(e)(2)(A)(ii) of the Act specifies that physical, occupational, and speech-language therapy services furnished to SNF residents are subject to Consolidated Billing and, therefore, must be billed by the SNF itself, regardless of whether these services are furnished by (or under the supervision of) a physician or other health care professional. In effect, this statutory provision converts the coverage of what would otherwise be practitioner services into provider (that is, SNF) services. Thus, those practitioner services that fall within the categories of physical, occupational, or speech language therapy services must be billed by the SNF to its FI, and the practitioner cannot submit a separate bill to the Part B carrier. (We note that the Physicians' Current Procedural Terminology (CPT) coding used on physician and other practitioner bills enables the Part B carrier to identify those services that are physical, occupational, and speech-language therapy services.)

Further, with respect to physicians' services, we are providing—consistent with the longstanding policy under the bundling requirement for inpatient hospital services—that the SNF Consolidated Billing provision excludes only those particular physicians' services that meet the criteria described in § 415.102(a) for payment on a fee schedule basis. Essentially, these are services (ordinarily requiring performance by a physician) that the physician personally furnishes to an individual beneficiary, which contribute directly to that beneficiary's diagnosis or treatment and, in the case of radiology or laboratory services, meet the additional requirements specified in §§ 415.120 and 415.130, respectively. By contrast, this exclusion of the types of physicians' services described in § 415.102(a) does not extend to more generalized physician functions that typically occur in the provider setting (such as quality control activities), which are performed not for an individual beneficiary but for the overall benefit of the provider's entire patient population, and are considered a provider cost under §§ 415.55 and 415.60.

In addition, the Consolidated Billing requirement does not exempt those types of nonphysician services that would otherwise be billed to the Part B carrier in conjunction with related physician services and paid under a single, global fee. For example, payment for diagnostic radiology services is sometimes made through a global fee that includes both a technical component (for the diagnostic test itself) and a professional component (for the physician's interpretation of the test). However, under Consolidated Billing,

when such services are furnished to an SNF resident, only the professional (physician) component is billed separately as a physician's service, while the technical (nonphysician) component must be billed by the SNF itself.

Also, while the SNF Consolidated Billing provision does not apply to the professional services that a physician or other exempt practitioner performs personally, it does apply to those services that are furnished to an SNF resident by someone other than the practitioner, as an incident to the practitioner's professional service. This position is consistent with the approach that has long been taken under the hospital bundling requirement, as well as with section 1888(e)(2)(A)(ii) of the Act, which specifically identifies ''physicians'' services'' themselves as the service category that is excluded from SNF Consolidated Billing. Physicians' services, in turn, are covered by Part B under section 1861(s)(1) of the Act and are defined in section 1861(q) as being performed by a physician, while ''incident to'' services are covered under a separate statutory authority (section 1861(s)(2)(A) of the Act) and are, by definition, not performed by a physician. Similarly, for the other types of practitioner services that are exempt from the SNF Consolidated Billing requirement, we are specifying that this exemption applies only to the professional services that the practitioner performs personally, and that services furnished by others as an incident to the practitioner's professional service are themselves subject to the Consolidated Billing requirement.

We believe that to do otherwise with regard to these ''incident to'' services would effectively create a loophole through which a potentially broad and diverse array of services could be unbundled, merely by virtue of being furnished under the general auspices of such practitioners. This, in turn, would ultimately defeat the very purpose of the SNF Consolidated Billing provision—that is, to make the SNF itself responsible for billing Medicare for essentially all of its residents' services, other than those identified in a small number of narrow and specifically delimited exclusions. Further, as noted above, both the Consolidated Billing and SNF PPS provisions employ the same statutory list of excluded services. Thus, the approach we are adopting with regard to the limited range of services that qualify for exclusion is essential not only to safeguard the integrity of the Consolidated Billing requirement, but also that of the SNF PPS itself.

Finally, we note that laboratory services are subject to the SNF Consolidated Billing requirement. Thus, when an outside laboratory performs tests for SNF residents, the Medicare billing must be done by the SNF itself rather than by the outside laboratory. However, it will be necessary for the Congress to make a conforming change in section 1833(h)(5)(A) of the Act, in order to resolve a technical inconsistency in the text of that provision. The current wording of that section of the Act generally allows Part B to make payment for clinical diagnostic laboratory tests only to the person or entity that actually performs (or supervises the performance of) the test. This provision already contains a specific exception at section 1833(h)(5)(A)(iii) of the Act that permits a hospital to receive Part B payment for laboratory services that the hospital obtains under arrangements made with an outside laboratory. As mentioned previously, hospitals have long had a comprehensive Medicare billing requirement, which served as a model for the one now being established for SNFs. Accordingly, we believe that the BBA 1997's lack of a conforming change that explicitly extends the payment provision's existing hospital exception to SNFs is merely an inadvertent oversight, and we plan to pursue a technical amendment to make an appropriate conforming change in the text of section 1833(h)(5)(A) of the Act.

3. Facilities That Are Subject to the Provision

In terms of facilities (as explained in the following discussion of SNF ''resident'' status), the Consolidated Billing requirement applies to Medicare-participating SNFs, including distinct part SNFs. Consolidated Billing does not apply to a nursing home that has no Medicare certification whatsoever, such as a nursing home that does not participate at all in either the Medicare or Medicaid programs, or a nursing home that exclusively participates only in the Medicaid program as a nursing facility (NF). However, Consolidated Billing does apply to services furnished to residents in any nursing home of which a distinct part is a Medicare-participating SNF. This means that if any portion of a nursing home has Medicare SNF certification, Consolidated Billing applies to the entire nursing home. (This avoids creating a perverse incentive for SNFs to set aside a nonparticipating section in which they could otherwise circumvent the Consolidated Billing requirement for those residents who are not in a covered Part A stay.)

Thus, when a nursing home limits its Medicare participation as an SNF to only a distinct part of the overall institution—

- In terms of program payment, Part A coverage under the extended care benefit is limited to the portion of the nursing home that actually participates in Medicare as an SNF; and
- In terms of Medicare billing responsibility, the Consolidated Billing requirement applies to the entire nursing home.

We note that if the surrounding institution that houses a Medicare distinct part SNF includes an entity other than a nursing home (that is, a hospital, or a domiciliary or ''board and care'' home), then the Consolidated Billing requirement would not apply to that entity, but would apply only to the nursing home itself (including the nursing home's participating distinct part SNF along with any nonparticipating remainder).

4. Skilled Nursing Facility ''Resident'' Status for Purposes of This Provision

For purposes of determining program payment in the specific context of the Part A extended care benefit, section 1861(h) of the Act limits coverage to those beneficiaries who reside in an SNF, which section 1819(a) of the Act defines as an institution (or a distinct part of an institution) that is actually certified as meeting the SNF requirements for participation. However, in excluding Medicare coverage for unbundled services furnished to SNF residents, section 4432(b)(1) of the BBA 1997 further specifies that this provision applies to services furnished to any beneficiary who ''* * * is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations) * * * .'' This statutory language establishes that, for purposes of the SNF Consolidated Billing provision, the Congress intended:

- That the definition of an SNF resident should include not only those beneficiaries who reside in the certified area of a nursing home, but also (as discussed in the preceding section) those who reside in the nonparticipating portion of any nursing home that also includes a Medicare-certified distinct part SNF; and
- To grant the Secretary the specific authority to define the concept of ''services furnished to SNF residents'' further in regulations.

Accordingly, for purposes of the SNF Consolidated Billing provision, we are

defining an SNF ''resident'' in the regulations as including beneficiaries who reside in Medicare-certified SNFs, as well as those beneficiaries who reside anywhere within a nursing home if that nursing home includes a distinct part that is a Medicare-certified SNF.

We note that the SNF Consolidated Billing legislation defines the scope of this provision in terms of a comprehensive package of services furnished to an SNF resident. For example, in terms of ambulance services, the initial ambulance trip that first brings a beneficiary to the SNF would not be subject to the Consolidated Billing provision (since the beneficiary, at that point, has not yet been admitted to the SNF as a resident). Similarly, an ambulance trip that occurs at the end of an SNF stay, in connection with one of the events that (as discussed below) ends a beneficiary's status as an SNF resident for Consolidated Billing purposes, would not be subject to the Consolidated Billing provision. By contrast, ambulance transportation furnished *during* an SNF stay is subject to the SNF Consolidated Billing provision.

As noted above, the Consolidated Billing requirement is intended to encompass a comprehensive package of services furnished to an SNF resident. Accordingly, we believe that it is necessary to prevent a facility from being able to circumvent this requirement and unbundle particular services that would otherwise be an integral part of the package, merely by temporarily discontinuing a beneficiary's status as a ''resident'' of the SNF just long enough to receive the services (for example, by briefly sending the beneficiary offsite to receive them as a hospital or clinic outpatient), and immediately thereafter reinstating the beneficiary's status as an SNF ''resident.'' Therefore, we are providing that a beneficiary's departure from the facility does not automatically end his or her status as an SNF ''resident'' for Consolidated Billing purposes. Rather, the beneficiary's status as an SNF resident in this context would end when one of the following events occurs—

- The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital (CAH, formerly referred to as a rural primary care hospital (RPCH)) or as a resident to another SNF;
- The beneficiary receives services, under a plan of care, from a Medicare-participating home health agency;
- The beneficiary receives outpatient services from a Medicare-participating hospital or CAH (but only with respect to those services that are not furnished pursuant to the resident assessment or the comprehensive care plan required under § 483.20); or
- The beneficiary is formally discharged or otherwise departs from the SNF (for example, on a leave of absence), unless readmitted to that or another SNF within 24 consecutive hours. This means that the facility's responsibilities under the Consolidated Billing provision (including its responsibility to furnish or make arrangements for needed care and services) remain in effect until the beneficiary's status as an SNF ''resident'' ends due to the occurrence of one of the events described above.

We are providing that, for purposes of determining the applicability of the SNF Consolidated Billing requirement, a beneficiary's status as an SNF resident ends at the point when the beneficiary is admitted as an inpatient to a participating hospital or CAH, or as a resident to another SNF, even if the beneficiary subsequently returns to the original SNF within 24 hours of departure. This is because these settings all represent situations in which another provider has assumed the ongoing responsibility for the beneficiary's comprehensive care needs. For the same reason, we are including the receipt of services from a participating home health agency under a plan of care as another event that would end a beneficiary's status as an SNF ''resident'' for Consolidated Billing purposes. We note that these situations are distinct, however, from one in which a terminally ill SNF resident elects to receive care under the Medicare hospice benefit, since a hospice assumes responsibility only for those care needs that relate to the beneficiary's terminal condition, while the SNF itself remains responsible for any care needs that are unrelated to the terminal condition. This is equally true whether an SNF resident receives the hospice care while still in the SNF or during a temporary absence from the facility. Accordingly, an SNF resident's election to receive care under the Medicare hospice benefit would not result in a blanket exclusion of all services furnished to that resident from the Consolidated Billing requirement; rather, as discussed previously in section V.B.2., only the specific aspects of such a resident's care that are actually provided under the hospice benefit are excluded from the Consolidated Billing provision, while care that is unrelated to the resident's terminal condition remains subject to the provision.

Similarly, when an SNF resident receives outpatient services at a hospital, the hospital does not necessarily assume any ongoing responsibility for the resident's comprehensive care needs beyond the outpatient visit itself, which often may represent nothing more than a single, isolated encounter. We do not believe that such an event, when followed shortly thereafter by the resident's return to the SNF, should serve to relieve the SNF categorically of any Medicare billing responsibility for services furnished during the outpatient visit, especially with respect to those types of services that SNFs would ordinarily include within the comprehensive package of care furnished to a resident (such as physical, occupational, and speech-language therapy, or types of medical supplies and diagnostic tests that are routinely furnished or arranged for by SNFs).

At the same time, however, we recognize that there are certain types of intensive diagnostic or invasive procedures that are specific to the hospital setting and that are well beyond the normal scope of SNF services. Further, we note that Medicare's longstanding comprehensive billing or ''bundling'' requirement for inpatient hospital services under section 1862(a)(14) of the Act was subsequently expanded to apply to outpatient hospital services as well, and that section 4523 of the BBA 1997 provides for the establishment of a PPS for these outpatient hospital services. Thus, when an SNF resident is sent to a hospital to receive outpatient services, it is necessary to delineate the respective areas of responsibility for the SNF under the Consolidated Billing provision, and for the hospital under the outpatient bundling provision, with regard to these services.

Accordingly, we are providing that in situations where a beneficiary receives outpatient services from a Medicare-participating hospital or CAH while temporarily absent from the SNF, the beneficiary continues to be considered an SNF resident specifically with regard to those services that are furnished pursuant to the comprehensive care plan required under the regulations at § 483.20(d), which is developed to address the resident's care needs identified in the comprehensive assessment under § 483.20(b). Such services are, therefore, subject to the SNF Consolidated Billing provision, while those other services that, under commonly accepted standards of medical practice, lie exclusively within the purview of hospitals rather than SNFs, are not subject to SNF Consolidated Billing, but are instead bundled to the hospital (for example,

cardiac catheterization, CT scans, magnetic resonance imaging, ambulatory surgery involving the use of an operating room). We believe that it is appropriate to specify the resident's comprehensive care plan as the basis for defining the extent of the SNF's responsibility in this situation, since it is this same resident assessment and care planning process that provides the basis for establishing SNF coverage and determining the actual level of Part A payment under the SNF PPS. In effect, this defines the SNF's responsibility in terms of the scope of services included under the extended care benefit, as explained below. This same scope of services would effectively define the extent of the SNF's responsibility with regard to a beneficiary who has resided exclusively in the institution's nonparticipating portion which, under the law, is subject to the SNF Consolidated Billing provision but not to the SNF requirements for participation regarding resident assessment and care planning.

As indicated in § 483.20(d)(1), the resident assessment must thoroughly identify the resident's medical, nursing, and mental and psychosocial needs, and the plan of care must describe in a comprehensive manner the services that the SNF itself assumes the responsibility to furnish, or make arrangements for, in order to address these needs. However,the comprehensive care plan does not typically address emergency services (which, by their nature, cannot be anticipated and planned in advance) or those types of intensive diagnostic or invasive procedures that, as discussed previously, appropriately lie within the purview of hospitals rather than SNFs. By contrast, the care plan must address the beneficiary's need for the broad categories of services that section 1861(h) of the Act identifies as being included within the scope of the extended care benefit, such as nursing care and associated room and board (sections 1861(h)(1) and (2) of the Act); physical, occupational, and speech-language therapy (section 1861(h)(3) of the Act); medical social services (section 1861(h)(4) of the Act); drugs, biologicals, supplies, appliances, and equipment that represent an ordinary part of the facility's inpatient care and treatment (section 1861(h)(5) of the Act); and services that an SNF furnishes through its transfer agreement hospital (section 1861(h)(6) of the Act).

As amended by the BBA 1997, section 1861(h)(7) of the Act also includes coverage of other types of services that SNFs generally provide, either directly or under arrangements with outside sources. As discussed in section VI. below with regard to the conforming revisions in regulations at § 409.27, longstanding administrative policy has also included within this category most of the medical and other health services described in section 1861(s) of the Act, with certain exceptions. For example, physician services (section 1861(s)(1) of the Act) cannot be regarded as services that are ''generally provided'' by SNFs, since they are not within the scope of the inpatient hospital benefit (see section 1861(b)(4) of the Act) and, accordingly, are also not within the scope of the extended care benefit (see section 1861(h) of the Act following paragraph (7)). In addition, as discussed previously in section V.B.2., preventive services such as vaccines for pneumococcal pneumonia or hepatitis B (section 1861(s)(10) of the Act) and screening services such as screening mammographies or pap smears (sections 1861(s)(13) and (14) of the Act, respectively) are not within the scope of the extended care benefit, since they are not considered reasonable and necessary for the diagnosis or treatment of a condition that has already manifested itself. Finally, the extended care benefit does not include the types of acute or emergent services discussed above as being exclusively within the purview of hospitals rather than SNFs, since these are types of services that SNFs themselves do not generally provide, either directly or under arrangements.

We specifically invite comments on the treatment of outpatient hospital services furnished to SNF residents under the SNF Consolidated Billing provision, including other possible ways to exempt those particular outpatient hospital procedures that are clearly beyond the scope of SNF services while preserving the integrity of the SNF service package itself. We also note that further refinements in this policy may eventually become necessary, in order to ensure consistency with the new outpatient hospital PPS as its specific characteristics are developed.

In addition, effective January 1, 1999, section 4541 of the BBA 1997 imposes an annual per beneficiary limit of $1,500 on all outpatient physical therapy services (including speech-language therapy services), and imposes a similar limit on all outpatient occupational therapy services, but specifically excludes services furnished by a hospital's outpatient department from each of these annual limits. We note that this exclusion of hospital outpatient department services does not apply to services furnished to a beneficiary who is an SNF resident for Consolidated Billing purposes. For an SNF resident who is not in a covered stay and has reached the annual $1,500 limit, this avoids creating a perverse incentive to have a hospital outpatient department furnish therapy services that the resident could appropriately receive from the SNF itself. We will specifically address this point in the regulations that we are currently developing to implement section 4541 of the BBA 1997.

Another event that would generally end a beneficiary's ''resident'' status for SNF Consolidated Billing purposes would be the beneficiary's formal discharge from the SNF, or a departure from the SNF without a formal discharge (for example, for a trial visit home on a leave of absence), unless followed within 24 consecutive hours by a readmission to that or another SNF. We are using a 24-hour timeframe for readmission following any discharge or other departure from the SNF because we believe that this duration should generally be sufficient to preclude situations in which the beneficiary is temporarily sent outside the SNF for only a brief period to receive a service offsite (for example, through an outpatient visit to a hospital or clinic), merely to circumvent the SNF Consolidated Billing requirement. Further, as indicated above, we believe that in most situations where a beneficiary with comprehensive care needs is absent from the SNF for 24 consecutive hours, another provider will have already assumed the ongoing responsibility for those comprehensive care needs by that point in time.

In addition, we note that section 1886(a)(4) of the Act includes a preadmission ''payment window'' provision for hospitals, under which certain Part B services furnished by a hospital or by an entity wholly owned or operated by the hospital within 3 days (or, for non-PPS hospitals, within 1 day) before an inpatient admission to that hospital are included in the Medicare Part A payment for the hospital admission itself (see §§ 412.2(c)(5) (for PPS hospitals) and 413.40(c)(2) (for non-PPS hospitals)). Further, section 1833(d) of the Act prohibits payment under Part B for any services for which Part A can make payment. Thus, if a hospital inpatient has spent a portion of the preadmission period as a resident of an SNF that is wholly owned or operated by the admitting hospital, this would preclude coverage (and SNF billing) under Part B for diagnostic services and other admission-related services received as an SNF resident during the

preadmission period, since those services would be included in the hospital's Part A payment for the subsequent inpatient admission.

5. Effects of This Provision

For those services that are subject to the SNF Consolidated Billing requirement, Medicare will no longer permit ''unbundling'' (that is, Medicare billing by any entity other than the SNF itself). Rather, the SNF itself will have to furnish the services—either directly, or under arrangements with an outside supplier in which the SNF itself (rather than the supplier) bills Medicare. Section 1861(w)(1) of the Act defines ''arrangements'' as those in which the SNF's receipt of Medicare payment for a beneficiary's covered service discharges the liability of the beneficiary or any other person to pay for the service. Further, longstanding manual instructions at MIM–3, § 3007 and § 206 of the Medicare SNF Manual provide that in making such arrangements, an SNF should not act merely as a billing conduit, but should also exercise professional responsibility over the arranged-for services. However, the requirement for the SNF to furnish under ''arrangements'' any services that it obtains from an outside supplier does not mandate the SNF itself to meet the applicable supplier standards for that service, but merely to select an outside supplier that meets them. For example, when an SNF bills for ambulance services furnished to its residents under arrangements with an outside supplier, this does not make the SNF itself responsible for meeting the ambulance regulations' standards regarding vehicles and vehicle staffing (see § 410.40(a)), but merely for selecting an outside supplier that itself meets these standards. Similarly, under the requirements for participation at § 483.75(k)(1)(ii), if an SNF elects to provide portable x-ray services under arrangements with an outside supplier, the SNF is responsible only for selecting a portable x-ray supplier that itself meets the applicable Medicare conditions for coverage (see subpart C of part 486); under § 483.75(k)(1)(i), an SNF must itself meet the applicable provider standards for diagnostic radiology services (at § 482.26) only if the SNF elects to provide such services directly with its own resources.

When the SNF furnishes services under an arrangement with an outside supplier, the outside supplier must look to the SNF instead of to Medicare Part B for payment, and the terms of the supplier's payment by the SNF are established exclusively through contractual agreements negotiated between the two parties themselves, rather than being prescribed for them by the Medicare program. For a resident in a covered Part A stay, all services furnished by the SNF (either directly, or under arrangements with an outside supplier) are included in the SNF's Part A bill. For a resident who is not in a covered Part A stay (Part A benefits exhausted, posthospital or level of care requirements not met, etc.), the SNF itself submits all bills to Part B.

We note that while new section 1888(e)(9) of the Act provides that the amount of Part B payment shall be the amount provided under the applicable fee schedule for an SNF's services—including those services provided under arrangements with an outside supplier—the law is silent with regard to how much (if any) of this fee schedule amount the SNF itself can retain when it pays the supplier. If an outside supplier agrees to furnish services to the SNF for less than the applicable fee schedule amount, we are concerned that allowing the SNF to retain the difference for each service billed to Part B is likely to create a financial incentive for the SNF to provide unnecessary services. The approach that we favor as a means of solving this problem would be to request legislation to limit the SNF's Part B payment to the lower of the applicable fee schedule amount or the amount that the supplier actually charges the SNF. Another option—which we did not select—would be to require that the SNF pay to the supplier the entire fee schedule payment amount, less a reasonable charge for administration. We specifically invite comments on the extent to which this problem may arise and on the advisability of pursuing our suggested legislative approach or other approaches.

While the SNF Consolidated Billing requirement prohibits Medicare billing by any entity other than the SNF, we note that this does not preclude an SNF from engaging the services of an outside entity to assist the SNF in performing the specific tasks involved in actually completing and sending in the bill itself. This practice, known as ''contract billing,'' is permissible as long as the billing takes place under the SNF's Medicare provider number, and the SNF itself remains the legally responsible billing party. However, an SNF is precluded from relinquishing or reassigning to any other party the actual legal responsibility for and control over a claim. This reflects the Medicare law's general prohibitions with regard to the reassignment of claims at sections 1815(c) and 1842(b)(6) of the Act and regulations at subpart F of part 424, as well as the specific prohibitions on reassignment of provider claims discussed in the manual instructions at MIM–3, §§ 3488ff.

The changes introduced by the Consolidated Billing provision will bring about a number of significant program improvements. First, this requirement provides an essential foundation for the new Part A SNF PPS, by bundling into a single facility package those services that the PPS payment is intended to capture. Second, it spares beneficiaries who are in covered Part A stays from incurring out-of-pocket liability for Part B deductibles and coinsurance. Third, it eliminates the potential for duplicative billings for the same service to the FI by the SNF and to the carrier by an outside supplier. Fourth, this requirement will help promote greater quality of care, by enhancing the SNF's capacity to meet its existing responsibility to oversee and coordinate the entire package of care that each of its residents receives. Finally, by making the SNF itself more directly accountable for this overall package of care and services, the Consolidated Billing requirement may help restrain certain inappropriate billing practices, while at the same time helping to ensure that each resident actually receives those services for which there is a legitimate medical need.

C. Effective Date for Consolidated Billing

Unlike the SNF PPS itself, the effective date of the Consolidated Billing requirement is not tied to the start of the individual SNF's first cost reporting period that begins on or after July 1, 1998. Rather, the Consolidated Billing provision is effective for services furnished on or after July 1, 1998. We note that in April 1998, HCFA issued Program Memorandum (PM) No. AB–98–18, which contains operational instructions for Medicare contractors on the implementation of consolidated billing. The PM provides that, for individual facilities that lack the capability to perform consolidated billing as of the July 1 effective date, the SNF must begin consolidated billing with respect to items and services furnished on or after the earlier of (1) January 1, 1999 or (2) the date the facility comes under the PPS.

VI. Changes in the Regulations

As discussed below, we are making a number of revisions in the regulations in order to implement both the prospective payment system and the SNF Consolidated Billing provision and

its conforming statutory changes. First, we are revising the regulations in 42 CFR part 410, subpart I, which deal with payment of benefits under Part B, in order to implement section 1842(b)(6)(E) of the Act, as amended by section 4432(b)(2) of the BBA 1997. Specifically, we are adding a new paragraph (b)(14) to § 410.150, which specifies that for those services subject to the SNF Consolidated Billing requirement, Medicare makes Part B payment to the SNF rather than to the beneficiary. We are also making certain conforming changes to provisions in part 410, subpart B, which describe Part B coverage of individual medical and other health services, such as outpatient hospital services (§ 410.27(a)(1)(i)), hospital or CAH diagnostic tests (§ 410.28(a)(1)), diagnostic tests (§ 410.32(e)), and ambulance services (§ 410.40(b)).

In addition, we are revising the regulations in part 411, subpart A, which deal with exclusions from Medicare coverage, in order to implement section 1862(a)(18) of the Act, as amended by section 4432(b)(1) of the BBA 1997. Specifically, we are adding a new paragraph (p)(1) to § 411.15, which excludes from coverage any service furnished to an SNF resident (other than those individual services listed in new paragraph (p)(2) of this section) by an entity other than the SNF itself. In addition, a new paragraph (p)(3) will set out the definition of an SNF ''resident'' for purposes of this provision, as discussed previously in section V.B.4.

We are revising the regulations in part 413, which deal with Medicare payment to providers of services. Section 413.1 establishes that providers are generally paid on the basis of reasonable cost, and then sets out several specific exceptions to this general principle. Currently, the only exception for SNFs is at § 413.1(g), with regard to the existing Part A PPS under section 1888(d) of the Act, which applies exclusively to low volume SNFs. However, under sections 4432(a) and (b)(5)(H) of the BBA 1997, the existing SNF Part A payment methodologies (that is, on a reasonable cost basis, or under a PPS established specifically for low volume SNFs) will be superseded by the new PPS for SNFs generally, effective with cost reporting periods beginning on or after July 1, 1998. Accordingly, we are revising § 413.1(g) as follows, to reflect the BBA 1997 provisions for a general SNF PPS, as well as its related conforming changes. In paragraph (g)(1), we clarify that the previous SNF payment methodology (that is, either on a reasonable cost basis or under the low volume SNF PPS) is effective only for those cost reporting periods beginning before July 1, 1998. In paragraph (g)(2)(i), we provide that effective with cost reporting periods beginning on or after July 1, 1998, payment for services furnished during a covered Part A stay will be made in accordance with the new SNF PPS under section 1888(e) of the Act, as implemented by regulations in the new subpart J of part 413. This new subpart will set forth the regulatory framework of the new PPS. It specifically discusses the scope and basis of the PPS rates as well as the methodology for computing them. It also describes the transition phase of the PPS and related rules.

In paragraph (g)(2)(ii), we implement section 1888(e)(9) of the Act (as amended by section 4432(b)(3) of the BBA 1997), which provides that the payment amount for services that are not furnished during a covered Part A stay shall be the amount provided under the otherwise applicable Part B fee schedule. Unlike the new Part A PPS for SNFs, the effective date for the Part B fee schedule provision is not tied to the beginning of an individual SNF's cost reporting period, but rather, is effective for all services furnished on or after July 1, 1998. Consequently, we note that there is a potential overlap between this provision and the reasonable cost provision described in paragraph (g)(1), during the period of time running from July 1, 1998, until the conclusion of an individual SNF's last cost reporting period beginning prior to that date. Accordingly, we are revising the beginning of paragraph (g)(1), to clarify that Part B payment during that period of time is made according to the new fee schedule provision rather than the previous payment methodology. Finally, we are implementing a conforming change in section 4432(b)(5)(A) of the BBA 1997 by revising paragraph (b)(4) of § 483.20, to indicate that the frequency of resident assessments specified in that section of the regulations is subject to the timeframes prescribed under the SNF PPS in new subpart J of part 413.

We are revising the portion of part 424 dealing with the prescribed certification and recertification (§ 424.20) that the requirements for a covered SNF level of care are met, along with that portion of part 409 that sets out the level of care requirements themselves (at § 409.30), to reflect the use of the RUG–III groups, as discussed previously in section II.D. of this preamble. We are also revising certain portions of part 424 that deal with claims for payment. Specifically, we are revising § 424.32(a)(2) to require the inclusion of an SNF's Medicare provider number on claims for physician services furnished to an SNF resident. We are also adding to § 424.32(a) the requirement for an SNF to include HCPCS coding on its Part B claims.

We are also revising the regulations in part 489, subpart B (which deal with the basic requirements of Medicare provider agreements), in order to implement section 1866(a)(1)(H)(ii) of the Act, as amended by section 4432(b)(5)(F) of the BBA 1997. Specifically, we are adding a new paragraph (s) to § 489.20, which will require a participating SNF, under the terms of its provider agreement, to furnish all services that are subject to the Consolidated Billing provision, either directly or under an arrangement with an outside source in which the SNF itself bills Medicare.

In addition, we are making a number of conforming changes in part 409, subpart C of the regulations, as discussed below. Section 1861(h) of the Act describes coverage of ''extended care'' (that is, Part A SNF) services. In addition to the specific service categories set out in paragraphs (1) through (6) of section 1861(h), paragraph (7) provides for coverage of other services that are generally provided in this setting. Prior to the BBA 1997, coverage of services ''generally provided by'' SNFs under this statutory authority required not only for a particular service to be ''generally provided'' (that is, for the provision of that type of service to be the prevailing practice among SNFs nationwide), but also for the service to be provided directly ''by'' the SNF itself. However, section 4432(b)(5)(D) of the BBA 1997 has now expanded section 1861(h)(7) of the Act to include coverage of services that are generally provided ''under arrangements . . . made by'' SNFs with outside sources. As a result, the extended care benefit now covers the full range of services that SNFs generally provide, either directly or under arrangements with outside sources. For example, the services of respiratory therapists have until now been specifically coverable as extended care services only when provided directly by those therapists who are employees of the SNF's transfer agreement hospital under section 1861(h)(6) of the Act. Since these are services that SNFs historically have ''generally provided'' (albeit in the limited context of the transfer agreement hospital provision), we are now revising the regulations at § 409.27 to permit coverage of respiratory therapy services under amended section 1861(h)(7) of the Act when provided under an arrangement between the SNF and a

respiratory therapist, regardless of whether the therapist is employed by the SNF's transfer agreement hospital.

We are also revising this section of the regulations to incorporate longstanding manual instructions in MIM–3, § 3133.9.A and in § 230.10.A. of the SNF Manual, which specify that the medical and other health services identified in section 1861(s) of the Act are considered to be generally furnished by SNFs and, therefore, coverable under the Part A extended care benefit. We specify that such coverage would be subject to any applicable limitations or exclusions. For example, the Part A extended care benefit cannot include coverage of those services (such as physician services) that are not within the scope of the inpatient hospital benefit. As discussed previously in section V.B.2., the preventive and screening procedures specified in section 1861(s) of the Act are not coverable as extended care services, since they are not considered to be reasonable and necessary for diagnosing or treating a condition that has already manifested itself. Finally, coverage under this provision does not include specific types of services (such as the intensive or emergency types of hospital services discussed previously in section V.B.4.) that SNFs themselves do not generally provide, either directly or under arrangements.

In addition to specifically revising the regulations at § 409.27 to reflect the recent BBA 1997 amendment of section 1861(h)(7) of the Act, we are also taking this opportunity to revise the overall organization of subpart C of part 409 so that it more accurately reflects the format of its statutory authority, section 1861(h) of the Act. As a result, we are making the following revisions in this subpart:

- We are renumbering the provisions in § 409.20(a) to conform more closely to the numbering used in the corresponding statutory authority at section 1861(h) of the Act.
- A new § 409.21, entitled ''Nursing care,'' corresponds to section 1861(h)(1) of the Act, which authorizes coverage under the extended care benefit of nursing care provided by or under the supervision of a registered professional nurse. This new section also includes a more direct statement of the policy with regard to coverage of private duty nurses in SNFs, which until now has been reflected in § 409.20(b)(1) when read in combination with § 409.12(b).
- A new § 409.24, entitled ''Medical social services,'' corresponds to section 1861(h)(4) of the Act, which authorizes coverage under the extended care benefit of medical social services. This new section incorporates the services described in longstanding manual instructions at § 3133.4 of MIM–3 and § 230.4 of the Medicare SNF Manual, and which also appear (in the context of Comprehensive Outpatient Rehabilitation Facility (CORF) services) in existing regulations at § 410.100(h) of this chapter.
- The material previously contained in §§ 409.24 (''Drugs and biologicals'') and 409.25 (''Supplies, appliances, and equipment'') is combined into a new § 409.25, entitled ''Drugs, biologicals, supplies, appliances, and equipment,'' which corresponds to section 1861(h)(5) of the Act.
- The material previously contained in §§ 409.26 (''Services furnished by an intern or a resident-in-training'') and 409.27 (''Other diagnostic or therapeutic services'') is combined into a new § 409.26, entitled ''Transfer agreement hospital services,'' which corresponds to section 1861(h)(6) of the Act. We are also clarifying that the references in this context to an institution that has a swing-bed approval apply specifically to those services that the institution furnishes to its own SNF-level inpatients under its swing bed approval.
- A new § 409.27, entitled ''Other services generally provided by (or under arrangements made by) SNFs,'' corresponds to section 1861(h)(7) of the Act, as amended by section 4432(b)(5)(D) of the BBA 1997. We are also including a conforming change in the section heading and text of § 409.20(b)(2).

Further, in view of the previously discussed statutory change to allow Part A coverage of the full range of services that SNFs generally provide, either directly or under arrangements with outside sources, we are making a conforming change to the long-term care facility requirements for participation at § 483.75(h) of this chapter. Previously, § 483.75(h) provided for the furnishing of any services by outside sources under either an ''arrangement'' (which, by definition, makes the facility itself responsible for billing the program) or an ''agreement'' (which does not necessarily mandate this result). We are now revising this provision so that it more accurately reflects the statutory authority at section 1819(b)(4)(A) of the Act, as well as revised section 1861(h)(7). Section 1819(b)(4)(A) of the Act, which specifies the range of services that a nursing home must furnish in order to participate in the Medicare program as an SNF, allows for ''agreements'' only with respect to dental services (for which virtually no coverage exists under the Medicare program), and provides that all other required services must be furnished either directly by the SNF itself or under ''arrangements'' with an outside source in which the SNF itself bills Medicare.

Finally, as discussed in section II.D., we are making certain specific modifications in the existing SNF level of care criteria contained in part 409, subpart D. Further, we are also adding to subpart F of part 409 a new administrative presumption with regard to the ending of a benefit period in an SNF, at § 409.60(c)(2).

VII. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VIII. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and its reasons in the rule. We find that the circumstances surrounding this rule make it impracticable to pursue a process of notice-and-comment rulemaking before the provisions of this rule take effect.

The BBA 1997 was enacted on August 5, 1997. As discussed earlier in this rule, the effective date for the SNF PPS is for cost reporting periods beginning on or after July 1, 1998. In addition, section 4432(a) of the BBA 1997 requires publication of the prospective payment rates prior to May 1, 1998. The resulting timeframe allowed HCFA 9 months to complete the process of development and review of the regulations to implement the PPS and related changes. The immense scope of SNF PPS development combined with this limited time period made it impracticable to conduct notice-and-comment rulemaking before the statutory effective date of the PPS. In addition to the normal length of time needed to develop and review a

regulation of this magnitude, the time schedule associated with the completion of development of a number of critical components of the PPS made it impossible to complete the calculation of the payment rates in time to promulgate a notice of proposed rulemaking. For example, the national case-mix indices and SNF market basket index, set forth earlier in this rule, had to be developed. As discussed earlier, these indices are an essential element of the case-mix payment and rate setting methodology. In addition, these indices are essential for standardizing and updating the Federal payment rates as required by the BBA 1997. Also, the redesign and validation of the MEDPAR analog, development of the Part B estimate included in the PPS rates, and research related to application of the case-mix adjustment to certain ancillary services (for example, drugs, laboratory services, medical supplies) were important components of the rate setting methodology, which required much time to develop.

We believe it evident that HCFA could not compute payment rates and complete the numerous components of the PPS and Consolidated Billing requirements that are described in this rule until immediately prior to the publication date required by statute and, therefore, it was impracticable to complete notice-and-comment rule making before May 1. Therefore, we find good cause to waive the notice of proposed rulemaking and to issue this final rule on an interim final basis. We are providing a 60-day comment period for public comment.

Effect of the Contract with America Advancement Act, Pub. L. 104–121

This rule has been determined to be a major rule as defined in Title 5, United States Code, section 804(2). Ordinarily, under 5 U.S.C. 801, as added by section 251 of Pub. L. 104–121, major rule shall take effect 60 days after the later of (1) the date a report on the rule is submitted to the Congress or (2) the date the rule is published in the **Federal Register**. However, section 808(2) of Title 5, United States Code, provides that, notwithstanding 5 U.S.C. 801, a major rule shall take effect at such time as the Federal agency promulgating the rule determines if for good cause the agency finds that notice and public procedure are impracticable, unnecessary, or contrary to the public interest. As indicated above, for good cause we find that it was impracticable to complete notice and comment procedures before publication of this rule. Accordingly, pursuant to 5 U.S.C. 808(2), these regulations are effective on July 1, 1998.

IX. Regulatory Impact Statement

We have examined the impacts of this interim final rule as required by Executive Order 12866, the Unfunded Mandates Reform Act of 1995, and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). The payment changes set forth in this interim final rule due to the BBA 1997 will result in projected savings for fiscal years 1999 through 2002 in excess of $100 million per year. Because the projected savings resulting from this interim final rule are expected to exceed $100 million, it is considered a major rule.

The Unfunded Mandates Reform Act of 1995 also requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits for any rule that may result in an annual expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. This interim final rule does not mandate any requirements for State, local, or tribal governments. We believe the private sector costs of this rule fall below these thresholds, as well.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations and governmental agencies. Most SNFs and suppliers are considered small entities, either by nonprofit status or by having revenues of $5 million or less annually. Intermediaries and carriers are not considered to be small entities.

A. Background

This interim final rule sets forth a schedule of prospectively determined per diem rates to be used for payments under the Medicare program as well as a Consolidated Billing requirement. Section 1888(e)(4)(H) of the Act requires that the Secretary establish and publish prospectively determined per diem rates at least 60 days prior to the beginning of the period to which such rates are to be applied.

As required under section 1888(e)(4)(H), this interim final rule sets forth the first schedule of unadjusted Federal per diem rates, to be used for payment beginning July 1, 1998.

While section 1888(e) specifies the base year and certain other components of computing the payment rates, the statute does allow us broad authority in the establishment of several key elements of the system, and HCFA had some opportunity to consider alternatives for these elements. These include the case-mix methodology (including the assessment schedule), market basket index, wage index, and urban/rural distinction used in the development and/or adjustment of the Federal rates. In addition, the incorporation of the case mix methodology into the coverage requirements involved discretion on HCFA's part. Most of these elements, and the alternatives that were considered, were discussed in detail earlier in the preamble of this rule. Several that may warrant some additional discussion include the case mix system and associated assessment schedule.

Regarding the case mix system, as we have noted in the background portion of the preamble, we are aware of a variety of case-mix systems used by various States in the administration of their Medicaid payment systems for nursing homes. However, due to the different range of covered services furnished by Medicaid nursing homes and differences in approaches taken by the unique State systems, none of these case-mix systems met our needs. As a classification and weighting system, the only case-mix system that was suited for the Medicare patient population is the RUG-III methodology we are implementing as part of this PPS.

With regard to the assessment schedule, the schedule adopted in this rule was the result of analysis of information from our Multistate Nursing Home Case-Mix and Quality Demonstration. In developing this schedule, we weighed the need for the payment system to capture changes in patient condition against the burden on SNFs and their staffs. The resulting schedule is designed to balance these competing considerations.

B. Impact of This Interim Final Rule

Below, the impact of this rule is discussed in terms of its fiscal impact on the budget and in terms of its impact on providers and suppliers. The estimated fiscal impact of this rule is discussed first.

1. Budgetary Impact

The effect of this rule is that the rates will result in estimated 5-year annual savings ranging from $30 million to $4.28 billion, as shown in Table IX.1 below. (It should also be noted that Table IX.1 shows the impact for FYs 2000 through 2002 even though an update to this rule will go out effective October 1, 1999 (and every subsequent fiscal year) that will set forth a new schedule of rates to be used for FY 2000. These numbers are shown to provide a full picture of the impact of this new payment system once it is fully phased in to 100 percent of the Federal rate.) These savings include both the savings to Medicare fee-for-service and managed care payments. The managed care savings make up approximately 25 percent of the total savings.

This table takes into account the behaviors that we believe SNFs will engage in order to minimize any perceived adverse effects of section 4432 of the BBA 1997 on their payments. We believe these behavioral offsets might include an increase in the number of covered days and an increase in the average case-mix for each facility. We believe that, on average, these behavioral offsets will result in a 45 percent reduction in the effects these rates might otherwise have on an individual SNF.

TABLE IX.1—SAVINGS TO THE MEDICARE PROGRAM

[In millions of dollars]

(A)		(B)	(C)	(D)	(E)	(F)
FY	Transition	Inflation	Other	Part A	Part B	Total
1998	0	30	−20	10	20	30
1999	90	1500	−70	1520	60	1580
2000	240	2880	−80	3040	60	3100
2001	410	3480	−80	3810	70	3880
2002	610	3690	−90	4210	70	4280

Column (A) shows the savings from the transition to the Federal rate. This reflects the effect of eliminating exceptions and limiting exemptions as required by the Act and discussed earlier in this rule. This was estimated by calculating the effect for a sample of SNFs which had exceptions and exemptions and extrapolating the results to the entire SNF industry. It also reflects the effect of applying a lower weight to the higher per diem costs of hospital-based SNFs in computing the Federal rates as required by the Act as amended by the BBA 1997 and described earlier in this rule. Column (B) shows the savings from using the statutorily determined update factor, which will result in lower payment increases than allowed under the current cost-based system. These payment increases under the cost-based system were computed using historical trends of these increases and projecting a continuation of those trends into the future. As can be seen from the table, most of the savings are the result of this provision. As noted, this component of the rate setting methodology is required by statute and does not allow for our consideration of any alternatives. Column (C) shows the cost of shifting the Consolidated Billing piece into Part A of Medicare. Column (D) shows the total savings to Part A of Medicare. It is column (A) plus column (B) plus column (C). Column (E) shows the total savings to Part B of Medicare resulting from the Consolidated Billing provisions. The sum of column (E) and Column (C) represents the impact of the Consolidated Billing provision on the Part B coinsurance. Column (F) is the total savings from this rule and is column (D) plus column (E).

2. Impact on Providers and Suppliers

Table IX.2 below shows the number of facilities projected to experience a decrease in Medicare SNF payments under the new prospective payment rates and the percentage change for the type of facility.

TABLE IX.2—IMPACT ON SNFS BY TYPE

Type of SNF	(A) Total number of SNFs	(B) Number of SNFs with lower payment	(C) Estimated average percentage reduction in payments
MSA Freestanding	5617	5568	17
MSA Hospital Based	683	676	19
Non-MSA Freestanding	2204	2185	17
Non-MSA Hospital Based	533	529	18
Total	9037	8958	17

Specifically, column (A) of the table shows the total number of SNFs in the data base for FY 1995 cost reporting periods. Column (B) shows the number of SNFs whose payment rate for cost reporting periods beginning July 1, 1998 would be lower than the payment they would have received under the former cost-based methodology for cost reporting periods beginning July 1, 1998. We estimated the payments received under the new system based on a facility level case-mix score developed using the case-mix indices and the MEDPAR analog described earlier in this rule. We estimated the payments received under the former system by using the same average inflation factor from the 1995 data for each facility. Column (C) shows the expected reduction in payments between the two payment methodologies on a percentage basis.

The results listed in Table IX.2 should be viewed with caution and as illustrative of broad groupings of SNFs. The effects of these provisions on

individual SNFs are unknown. As stated previously, in developing these estimates, we assumed each facility would increase costs at the national average rate. This national average increase includes the higher costs of new facilities entering the program. Therefore this increase is slightly higher than the true amount for existing facilities. We do, however, expect total payments to SNFs to decrease compared to payments that would have occurred under the former cost-based methodology. The effects of this decrease in payments to any individual SNF will depend on that SNF's ability to operate under the new payment methodology and on the proportion of its revenues that comes from the Medicare program.

Under the RFA, an economic impact is significant if the annual total costs or revenues of a substantial number of entities will increase or decrease by at least 3 percent. Medicare payments generally do not account for a high proportion of SNF revenue (about 10 percent on average) and this rule reduces those payments by approximately 17 percent on average. Therefore, total revenues for SNFs will be reduced by about 1.7 percent. As stated above we are unable to determine the effects on individual SNFs and therefore are unable to determine if the new SNF per diem rates will result in a substantial number of SNFs experiencing significant decreases in their total revenues.

We do not expect suppliers of items and services to SNFs to be significantly affected economically by the Consolidated Billing provisions. Total Medicare reimbursement to suppliers is about $4 billion each year. As shown in Table IX.1, column (E), the reimbursement for these items and services is about $60 million each year. Therefore, Consolidated Billing related to the services provided to patients in Part A SNF stays should have a minimal impact on suppliers, generally. The majority of ancillary services are provided directly by SNFs or under arrangements with suppliers and are, therefore, already billed to Medicare by the SNFs. While there is a possibility that, for those services now being consolidated, a sizeable number of these suppliers would likely be reimbursed at rates lower than the rates at which they were reimbursed under the previous system, this is highly dependent on the reaction each individual supplier has to the new payment system.

In addition, with regard to Consolidated Billing related to services provided to SNF patients who are not in a covered Part A stay, to the extent that these services have been necessary in the past, they will still be required and provided to these patients by suppliers. Accordingly, it is anticipated that the total impact on suppliers will be minimal. However, determining the effect on individual suppliers is not possible due to a lack of data. Therefore we are not able to determine if these new SNF per diem rates will result in a substantial number of suppliers experiencing significant decreases in their total revenues.

Our experience with the inpatient hospital PPS has been that providers will now have incentives to provide the most cost efficient care possible while still providing the level of care necessary for the patient. The SNF PPS system provides some of the same incentives as does the hospital DRG/PPS system, and many of the changes that have taken place in the inpatient hospital system can be expected for these providers.

C. Rural Hospital Impact Statement

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 50 beds.

We have not prepared a rural impact statement since we have determined, and the Secretary certifies, that this rule will not have a significant economic impact on the operations of a substantial number of small rural hospitals.

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

X. Collection of Information Requirements

Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget

Pursuant to sections 3506(c)(2)(A) and 3507(j) of the Paperwork Reduction Act of 1995 (PRA), the Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS), has submitted to the Office of Management and Budget (OMB) a request for emergency review. We are requesting an emergency review because the collection of information described below is needed prior to the expiration of the time limits under OMB's regulations at 5 CFR, Part 1320. The Agency cannot reasonably comply with the normal clearance procedures because of the statutory requirement, as set forth in section 4432 of the BBA 1997, to implement these requirements on July 1, 1998.

HCFA is requesting OMB review and approval of this collection within 11 working days, with a 180-day approval period. Written comments from the public will be accepted and considered if received by the individuals designated below, within 10 working days of publication of this regulation in the **Federal Register**. During this 180-day period, HCFA will pursue OMB clearance of this collection under 5 CFR 1320.5.

In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the information collection requirements discussed below.

Section 413.343 Resident Assessment Data

SNFs are required to submit the resident assessment data as described at § 483.20 of this chapter in the manner necessary to administer the payment rate methodology described in § 413.337. Pursuant to sections 4204(b) and 4214(d) of OBRA 1987, the current requirements related to the submission and retention of resident assessment data are not subject to the PRA, but it has been determined that the new requirement to maintain performance of patient assessment data for the 5th, 30th, and 60th days following admission, necessary to administer the payment rate methodology described in § 413.337, is subject to the PRA. The burden associated with this requirement is the time required to maintain MDS data submitted electronically to a State agency or an agent of the State. We do not believe there is any additional burden associated with the transmission of the data itself, since the supplemental data will be submitted as part of the routine monthly transfer of provider MDS data.

There are an estimated 17,000 facilities that will be required to maintain the minimum data set. It is estimated that it will require 5 minutes per facility, per month, to electronically store the additional MDS data for a total annual burden of 1 hour per facility.

Section 424.32 Basic Requirements For All Claims

The requirements of this section, currently approved under OMB number 0938–0008, are being modified to require that a claim for services furnished to an SNF resident under § 411.15(p)(2)(i) of this chapter must also include the SNF's Medicare provider number and a Part B claim filed by an SNF must include appropriate HCPCS coding.

The burden associated with these requirements is the time required to include the two data elements, as necessary, on a Medicare claim. Given that the burden is minimal and is captured during the completion of a HCFA–1500 common claim form, approved under OMB number 0938–0008, we are assigning 1 token-hour for the annual burden per facility associated with these new requirements. We will include these requirements as part of the supporting requirements for the HCFA–1500, when we resubmit the HCFA–1500 to OMB for reapproval.

We have submitted a copy of this rule to OMB for its review of the information collection requirements above. To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, e-mail your request, including your address, phone number, and HCFA regulation identifier HCFA–1913, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326.

As noted above, comments on these information collection and record keeping requirements must be mailed and/or faxed to the designee referenced below, within 10 working days of publication of this collection in the **Federal Register**:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850; *Attn:* John Burke HCFA–1913; *Fax Number:* (410) 786–1415

And,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, *Attn:* Allison Herron Eydt, HCFA Desk Officer; *Fax Number:* (202) 395–6974 or (202) 395–5167.

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 410

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

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 413

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

42 CFR Part 424

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

42 CFR Part 483

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

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

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

PART 409—HOSPITAL INSURANCE BENEFITS

A. Part 409 is amended as set forth below:

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

Authority: Secs. 1102 and 1871 of the Social Security Act (U.S.C. 1302 and 1895hh).

Subpart C—Posthospital SNF Care

2. In § 409.20, the introductory text to paragraph (a) is revised, paragraphs (a)(6) and (a)(7) are revised, paragraph (a)(8) is removed, and paragraph (b)(2) is revised to read as follows:

§ 409.20 Coverage of services.

(a) *Included services.* Subject to the conditions and limitations set forth in this subpart and subpart D of this part, ''posthospital SNF care'' means the following services furnished to an inpatient of a participating SNF, or of a participating hospital or critical access hospital (CAH) that has a swing-bed approval.

* * * * *

(6) Services furnished by a hospital with which the SNF has a transfer agreement in effect under § 483.75(n) of this chapter; and

(7) Other services that are generally provided by (or under arrangements made by) SNFs.

(b) *Excluded services*—

* * * * *

(2) *Services not generally provided by (or under arrangements made by) SNFs.* Except as specifically listed in §§ 409.21 through 409.27, only those services generally provided by (or under arrangements made by) SNFs are considered as posthospital SNF care. For example, a type of medical or surgical procedure that is ordinarily performed only on an inpatient basis in a hospital is not included as ''posthospital SNF care,'' because such procedures are not generally provided by (or under arrangements made by) SNFs.

* * * * *

3. A new § 409.21 is added to read as follows:

§ 409.21 Nursing care.

(a) *Basic rule.* Medicare pays for nursing care as posthospital SNF care when provided by or under the supervision of a registered professional nurse.

(b) *Exception.* Medicare does not pay for the services of a private duty nurse or attendant. An individual is not considered to be a private duty nurse or attendant if he or she is an SNF employee at the time the services are furnished.

4. Section 409.24 is revised to read as follows:

§ 409.24 Medical social services.

Medicare pays for medical social services as posthospital SNF care, including—

(a) Assessment of the social and emotional factors related to the beneficiary's illness, need for care, response to treatment, and adjustment to care in the facility;

(b) Case work services to assist in resolving social or emotional problems that may have an adverse effect on the beneficiary's ability to respond to treatment; and

(c) Assessment of the relationship of the beneficiary's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from facility care.

5. Section 409.25 is revised to read as follows:

§ 409.25 Drugs, biologicals, supplies, appliances, and equipment.

(a) *Drugs and biologicals.* Except as specified in paragraph (b) of this section, Medicare pays for drugs and biologicals as posthospital SNF care only if—

(1) They represent a cost to the facility;

(2) They are ordinarily furnished by the facility for the care and treatment of inpatients; and

(3) They are furnished to an inpatient for use in the facility.

(b) *Exception.* Medicare pays for a limited supply of drugs for use outside the facility if it is medically necessary to facilitate the beneficiary's departure from the facility and required until he or she can obtain a continuing supply.

(c) *Supplies, appliances, and equipment.* Except as specified in paragraph (d) of this section, Medicare pays for supplies, appliances, and equipment as posthospital SNF care only if they are—

(1) Ordinarily furnished by the facility to inpatients; and

(2) Furnished to inpatients for use in the facility.

(d) *Exception.* Medicare pays for items to be used after the individual leaves the facility if—

(1) The item is one that the beneficiary must continue to use after leaving, such as a leg brace; or

(2) The item is necessary to permit or facilitate the beneficiary's departure from the facility and is required until he or she can obtain a continuing supply, for example, sterile dressings.

6. Section 409.26 is revised to read as follows:

§ 409.26 Transfer agreement hospital services.

(a) *Services furnished by an intern or a resident-in-training.* Medicare pays for medical services that are furnished by an intern or a resident-in-training (under a hospital teaching program approved in accordance with the provisions of § 409.15) as posthospital SNF care, if the intern or resident is in—

(1) A participating hospital with which the SNF has in effect an agreement under § 483.75(n) of this chapter for the transfer of patients and exchange of medical records; or

(2) A hospital that has a swing-bed approval, and is furnishing services to an SNF-level inpatient of that hospital.

(b) *Other diagnostic or therapeutic services.* Medicare pays for other diagnostic or therapeutic services as posthospital SNF care if they are provided—

(1) By a participating hospital with which the SNF has in effect a transfer agreement as described in paragraph (a)(1) of this section; or

(2) By a hospital or a CAH that has a swing-bed approval, to its own SNF-level inpatient.

7. Section 409.27 is revised to read as follows:

§ 409.27 Other services generally provided by (or under arrangements made by) SNFs.

In addition to those services specified in §§ 409.21 through 409.26, Medicare pays as posthospital SNF care for such other diagnostic and therapeutic services as are generally provided by (or under arrangements made by) SNFs, including—

(a) Medical and other health services as described in subpart B of part 410 of this chapter, subject to any applicable limitations or exclusions contained in that subpart or in § 409.20(b); and

(b) Respiratory therapy services prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function.

Subpart D—Requirements for Coverage of Posthospital SNF Care

8. In § 409.30, the introductory text is revised to read as follows:

§ 409.30 Basic requirements.

Posthospital SNF care, including SNF-type care furnished in a hospital or CAH that has a swing-bed approval, is covered only if the beneficiary meets the requirements of this section and only for days when he or she needs and receives care of the level described in § 409.31. A beneficiary in an SNF is also considered to meet the requirements of this section and of § 409.31 when assigned to one of the Resource Utilization Groups that is designated (in the annual publication of Federal prospective payment rates described in § 413.345 of this chapter) as representing the required level of care.

9. In § 409.33, paragraph (a) is removed, and paragraphs (b), (c), and (d) are redesignated as paragraphs (a), (b), and (c), respectively; and newly redesignated paragraphs (a)(1) and (a)(2) are revised to read as follows:

§ 409.33 Examples of skilled nursing and rehabilitation services.

(a) *Services that qualify as skilled nursing services.* (1) Intravenous or intramuscular injections and intravenous feeding.

(2) Enteral feeding that comprises at least 26 per cent of daily calorie requirements and provides at least 501 milliliters of fluid per day.

* * * * *

Subpart F—Scope of Hospital Insurance Benefits

10. In § 409.60, the heading of paragraph (c) is republished, paragraphs (c)(2)(i) through (c)(2)(iii) are redesignated as paragraphs (c)(2)(ii) through (c)(2)(iv), respectively, and a new paragraph (c)(2)(i) is added to read as follows:

§ 409.60 Benefit periods.

* * * * *

(c) *Presumptions.*

* * * * *

(2) * * *

(i) To have met the skilled level of care requirements during any period for which the beneficiary was assigned to one of the Resource Utilization Groups designated as representing the required level of care, as provided in § 409.30.

* * * * *

Part 410—Supplementary Medical Insurance (SMI) Benefits

B. Part 410 is amended as set forth below:

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

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

Subpart B—Medical and Other Health Services

2. In § 410.27, paragraph (a)(1)(i) is revised to read as follows:

§ 410.27 Outpatient hospital services and supplies incident to physicians' services: Conditions.

(a) * * *

(1) * * *

(i) By or under arrangements made by a participating hospital, except in the case of an SNF resident as provided in § 411.15(p) of this chapter; and

* * * * *

3. In § 410.28, paragraph (a)(1) is revised to read as follows:

§ 410.28 Hospital or CAH diagnostic services furnished to outpatients: Conditions.

(a) * * *

(1) They are furnished by or under arrangements made by a participating hospital or participating CAH, except in the case of an SNF resident as provided in § 411.15(p) of this chapter.

* * * * *

4. In § 410.32, the introductory text to paragraph (e) is republished, and a new

paragraph (e)(7) is added to read as follows:

§ 410.32 Diagnostic X-ray texts, diagnostic laboratory tests, and other diagnostic tests: Conditions.

* * * * *

(e) *Diagnostic laboratory tests.* Medicare Part B pays for covered diagnostic laboratory tests that are furnished by any of the following:

* * * * *

(7) An SNF to its resident under § 411.15(p) of this chapter, either directly (in accordance with § 483.75(k)(1)(i) of this chapter) or under an arrangement (as defined in § 409.3 of this chapter) with another entity described in this paragraph.

5. In § 410.40, the introductory text to paragraph (b) is republished, paragraphs (b)(2) and (b)(3)(ii) are revised, and a new paragraph (b)(4) is added to read as follows:

§ 410.40 Ambulance services: Limitations.

* * * * *

(b) *Limits on coverage of ambulance transportation.* Medicare Part B pays for ambulance transportation only if—

* * * * *

(2) Medicare Part A payment is not available for the service;

(3) * * *

(ii) The transportation is furnished by an ambulance service with which the hospital does not have an arrangement (as defined in § 409.3 of this chapter), and the hospital has a waiver (in accordance with § 489.23 of this chapter) under which Medicare Part B payment may be made to the ambulance service; and

(4) In the case of an SNF resident (as defined in § 411.15(p)(3) of this chapter), the transportation is furnished by, or under arrangements made by, the SNF.

* * * * *

Subpart I—Payment of SMI Benefits

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

§ 410.150 To whom payment is made.

(a) *General rules.*

* * * * *

(2) The services specified in paragraphs (b)(5) through (b)(14) of this section must be furnished by a facility that has in effect a provider agreement or other appropriate agreement to participate in Medicare.

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

* * * * *

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

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

C. Part 411 is amended as set forth below:

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

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

Subpart A—General Exclusions and Exclusion of Particular Services

2. In § 411.15, the introductory text is republished; in the heading to paragraph (m) of this section, the word ''furnished'' is added before the word ''to''; and a new paragraph (p) is added to read as follows:

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage.

* * * * *

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

(i) Any physical, occupational, or speech-language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional; and

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

(2) *Exceptions.* The following services are not excluded from coverage:

(i) Physicians' services that meet the criteria of § 415.102(a) of this chapter for payment on a fee schedule basis, provided that the claim for payment includes the SNF's Medicare provider number in accordance with § 424.32(a)(2) of this chapter.

(ii) Services performed under a physician's supervision by a physician assistant who meets the applicable definition in section 1861(aa)(5) of the Act.

(iii) Services performed by a nurse practitioner or clinical nurse specialist who meets the applicable definition in section 1861(aa)(5) of the Act and is working in collaboration (as defined in section 1861(aa)(6) of the Act) with a physician.

(iv) Services performed by a certified nurse-midwife, as defined in section 1861(gg) of the Act.

(v) Services performed by a qualified psychologist, as defined in section 1861(ii) of the Act.

(vi) Services performed by a certified registered nurse anesthetist, as defined in section 1861(bb) of the Act.

(vii) Dialysis services and supplies, as defined in section 1861(s)(2)(F) of the Act.

(viii) Erythropoietin (EPO) for dialysis patients, as defined in section 1861(s)(2)(O) of the Act.

(ix) Hospice care, as defined in section 1861(dd) of the Act.

(x) An ambulance trip that initially conveys an individual to the SNF to be admitted as a resident, or that conveys an individual from the SNF in connection with one of the circumstances specified in paragraphs (p)(3)(i) through (p)(3)(iv) of this section as ending the individual's status as an SNF resident.

(xi) *For services furnished during 1998 only.* The transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS code R0076).

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

(i) The beneficiary is admitted as an inpatient to a Medicare-participating hospital or CAH, or as a resident to another SNF;

(ii) The beneficiary receives services from a Medicare-participating home health agency under a plan of care;

(iii) The beneficiary receives outpatient services from a Medicare-participating hospital or CAH (but only

with respect to those services that are not furnished pursuant to the comprehensive care plan required under § 483.20 of this chapter); or

(iv) The beneficiary is formally discharged (or otherwise departs) from the SNF, unless the beneficiary is readmitted (or returns) to that or another SNF within 24 consecutive hours.

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

D. Part 413 is amended as set forth below:

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

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

Subpart A—Introduction and General Rules

2. In § 413.1, paragraph (g) is revised to read as follows:

§ 413.1 Introduction.

* * * * *

(g) *Payment for services furnished in SNFs.* (1) Except as specified in paragraph (g)(2)(ii) of this section, the amount paid for services furnished in cost reporting periods beginning before July 1, 1998, is determined on a reasonable cost basis or, where applicable, in accordance with the prospectively determined payment rates for low-volume SNFs established under section 1888(d) of the Act, as set forth in subpart I of this part.

(2) The amount paid for services (other than those described in § 411.15(p)(2) of this chapter)—

(i) That are furnished in cost reporting periods beginning on or after July 1, 1998, to a resident who is in a covered Part A stay, is determined in accordance with the prospectively determined payment rates for SNFs established under section 1888(e) of the Act, as set forth in subpart J of this part.

(ii) That are furnished on or after July 1, 1998, to a resident who is not in a covered Part A stay, is determined in accordance with any applicable Part B fee schedule or, for a particular item or service to which no fee schedule applies, by using the existing payment methodology utilized under Part B for such item or service.

3. The heading for subpart I of part 413 is revised to read as follows:

Subpart I—Prospectively Determined Payment Rates for Low-Volume Skilled Nursing Facilities, for Cost Reporting Periods Beginning Prior to July 1, 1998

4. A new subpart J, consisting of §§ 413.330, 413.333, 413.335, 413.337, 413.340, 413.343, 413.345, and 413.348, is added to part 413 to read as follows:

Subpart J—Prospective Payment for Skilled Nursing Facilities

Sec.
413.330 Basis and scope.
413.333 Definitions.
413.335 Basis of payment.
413.337 Methodology for calculating the prospective payment rates.
413.340 Transition period.
413.343 Resident assessment data.
413.345 Publication of Federal prospective payment rates.
413.348 Limitation on review.

Subpart J—Prospective Payment for Skilled Nursing Facilities

§ 413.330 Basis and scope.

(a) *Basis.* This subpart implements section 1888(e) of the Act, which provides for the implementation of a prospective payment system for SNFs for cost reporting periods beginning on or after July 1, 1998.

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for SNFs, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules.

§ 413.333 Definitions.

As used in this subpart—

Case-mix index means a scale that measures the relative difference in resource intensity among different groups in the resident classification system.

Market basket index means an index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing services.

Resident classification system means a system for classifying SNF residents into mutually exclusive groups based on clinical, functional, and resource-based criteria. For purposes of this subpart, this term refers to the current version of the Resource Utilization Groups, as set out in the annual publication of Federal prospective payment rates described in § 413.345.

Rural area means any area outside of an urban area.

Urban area means a metropolitan statistical area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Office of Management and Budget, or a New England county deemed to be an urban area, as listed in § 412.62(f)(1)(ii)(B) of this chapter.

§ 413.335 Basis of payment.

(a) *Method of payment.* Under the prospective payment system, SNFs receive a per diem payment of a predetermined rate for inpatient services furnished to Medicare beneficiaries. The per diem payments are made on the basis of the Federal payment rate described in § 413.337 and, during a transition period, on the basis of a blend of the Federal rate and the facility-specific rate described in § 413.340. These per diem payment rates are determined according to the methodology described in § 413.337 and § 413.340.

(b) *Payment in full.* 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 operating approved educational activities as described in § 413.85.

§ 413.337 Methodology for calculating the prospective payment rates.

(a) *Data used.* (1) To calculate the prospective payment rates, HCFA uses—

(i) Medicare data on allowable costs from freestanding and hospital-based SNFs for cost reporting periods beginning in fiscal year 1995. SNFs that received ''new provider'' exemptions under § 413.30(e)(2) are excluded from the data base used to compute the Federal payment rates. In addition, allowable costs related to exceptions payments under § 413.30(f) are excluded from the data base used to compute the Federal payment rates;

(ii) An appropriate wage index to adjust for area wage differences;

(iii) The most recent projections of increases in the costs from the SNF market basket index;

(iv) Resident assessment and other data that account for the relative resource utilization of different resident types; and

(v) Medicare Part B SNF claims data reflecting amounts payable under Part B for covered SNF services (other than those services described in § 411.15(p)(2) of this chapter) furnished during SNF cost reporting periods beginning in fiscal year 1995 to individuals who were residents of SNFs and receiving Part A covered services.

(b) *Methodology for calculating the per diem Federal payment rates.* (1) *Determining SNF costs.* In calculating the initial unadjusted Federal rates

applicable for services provided during the period beginning July 1, 1998 through September 30, 1999, HCFA determines each SNF's costs by summing its allowable costs for the cost reporting period beginning in fiscal year 1995 and its estimate of Part B payments (described in paragraphs (a)(1)(i) and (a)(1)(v) of this section).

(2) *Use of market basket index.* The SNF market basket index is used to adjust the SNF cost data to reflect cost increases occurring between cost reporting periods represented in the data and the initial period (beginning July 1, 1998 and ending September 30, 1999) to which the payment rates apply. For each year, the cost data are updated by a factor equivalent to the annual market basket index percentage minus 1 percentage point.

(3) *Calculation of the per diem cost.* For each SNF, the per diem cost is computed by dividing the cost data for each SNF by the corresponding number of Medicare days.

(4) *Standardization of data for variation in area wage levels and case-mix.* The cost data described in paragraph (b)(2) of this section are standardized to remove the effects of geographic variation in wage levels and facility variation in case-mix. The cost data are standardized for geographic variation in wage levels using the wage index. The cost data are standardized for facility variation in case-mix using the case-mix indices and other data that indicate facility case-mix.

(5) *Calculation of unadjusted Federal payment rates.* HCFA calculates the national per diem unadjusted payment rates by urban and rural classification in the following manner:

(i) By computing the average per diem standardized cost of freestanding SNFs weighted by Medicare days.

(ii) By computing the average per diem standardized cost of freestanding and hospital-based SNFs combined weighted by Medicare days.

(iii) By computing the average of the amounts determined under paragraphs (b)(5)(i) and (b)(5)(ii) of this section.

(c) *Calculation of adjusted Federal payment rates for case-mix and area wage levels.* The Federal rate is adjusted to account for facility case-mix using a resident classification system and associated case-mix indices that account for the relative resource utilization of different patient types. This classification system utilizes the resident assessment instrument completed by SNFs as described at § 483.20 of this chapter, according to the assessment schedule described in § 413.343(b). The Federal rate is also adjusted to account for geographic differences in area wage levels using an appropriate wage index.

(d) *Annual updates of Federal unadjusted payment rates.* HCFA updates the unadjusted Federal payment rates on a fiscal year basis.

(1) For fiscal years 2000 through 2002, the unadjusted Federal rate is equal to the rate for the previous period or fiscal year increased by a factor equal to the SNF market basket index percentage minus 1 percentage point.

(2) For subsequent fiscal years, the unadjusted Federal rate is equal to the rate for the previous fiscal year increased by the applicable SNF market basket index amount.

§ 413.340 Transition period.

(a) *Duration of transition period and proportions for the blended transition rate.* Beginning with an SNF's first cost reporting period beginning on or after July 1, 1998, there is a transition period covering three cost reporting periods. During this transition phase, SNFs receive a payment rate comprising a blend of the adjusted Federal rate and a facility-specific rate. For the first cost reporting period beginning on or after July 1, 1998, payment is based on 75 percent of the facility-specific rate and 25 percent of the Federal rate. For the subsequent cost reporting period, the rate is comprised of 50 percent of the facility-specific rate and 50 percent of the Federal rate. In the final cost reporting period of the transition, the rate is comprised of 25 percent of the facility-specific rate and 75 percent of the Federal rate. For all subsequent cost reporting periods, payment is based entirely on the Federal rate.

(b) *Calculation of facility-specific rate for the first cost reporting period.* The facility-specific rate is computed based on the SNF's Medicare allowable costs from its fiscal year 1995 cost report plus an estimate of the amounts payable under Part B for covered SNF services (other than those services described in § 411.15(p)(2) of this chapter) furnished during fiscal year 1995 to individuals who were residents of SNFs and receiving Part A covered services. Allowable costs associated with exceptions, as described in § 413.30(f), are included in the calculation of the facility-specific rate. Allowable costs associated with exemptions, as described in § 413.30(e)(2), are included in the calculation of the facility-specific rate but only to the extent that they do not exceed 150 percent of the routine cost limit. Low Medicare volume SNFs that were paid a prospectively determined rate under § 413.300 for their cost reporting period beginning in fiscal year 1995 will utilize that rate as the basis for the allowable costs of routine (operating and capital-related) expenses in determining the facility-specific rate. Each SNF's allowable costs are updated to the first cost reporting period to which the payment rates apply using annual factors equal to the SNF market basket percentage minus 1 percentage point.

(c) *SNFs participating in the Multistate Nursing Home Case-Mix and Quality Demonstration.* SNFs that participated in the Multistate Nursing Home Case-Mix and Quality Demonstration in a cost reporting period that began in calendar year 1997 will utilize their allowable costs from that cost reporting period, including prospective payment amounts determined under the demonstration payment methodology.

(d) *Update of facility-specific rates for subsequent cost reporting periods.* The facility-specific rate for a cost reporting period that is subsequent to the first cost reporting period is equal to the facility-specific rate for the first cost reporting period (described in paragraph (a) of this section) updated by the market basket index.

(1) For a subsequent cost reporting period beginning in fiscal years 1998 and 1999, the facility-specific rate is equal to the facility-specific rate for the previous cost reporting period updated by the applicable market basket index percentage minus one percentage point.

(2) For a subsequent cost reporting period beginning in fiscal year 2000, the facility-specific rate is equal to the facility-specific rate for the previous cost reporting period updated by the applicable market basket index percentage.

(e) *SNFs excluded from the transition period.* SNFs that received their first payment from Medicare, under present or previous ownership, on or after October 1, 1995, are excluded from the transition period, and payment is made according to the Federal rates only.

§ 413.343 Resident assessment data.

(a) *Submission of resident assessment data.* SNFs are required to submit the resident assessment data described at § 483.20 of this chapter in the manner necessary to administer the payment rate methodology described in § 413.337. This provision includes the frequency, scope, and number of assessments required.

(b) *Assessment schedule.* In accordance with the methodology described in § 413.337(c) related to the adjustment of the Federal rates for case-mix, SNFs must submit assessments according to an assessment schedule. This schedule must include

performance of patient assessments on the 5th, 14th, 30th, 60th, and 90th days following admission and such other assessments that are necessary to account for changes in patient care needs.

(c) *Noncompliance with assessment schedule.* HCFA pays a default rate for the Federal rate when a SNF fails to comply with the assessment schedule in paragraph (b) of this section. The default rate is paid for the days of a patient's care for which the SNF is not in compliance with the assessment schedule.

§ 413.345 Publication of Federal prospective payment rates.

HCFA publishes information pertaining to each update of the Federal payment rates in the **Federal Register**. This information includes the standardized Federal rates, the resident classification system that provides the basis for case-mix adjustment (including the designation of those specific Resource Utilization Groups under the resident classification system that represent the required SNF level of care, as provided in § 409.30 of this chapter), and the wage index. This information is published before May 1 for the fiscal year 1998 and before August 1 for the fiscal years 1999 and after.

§ 413.348 Limitation on review.

Judicial or administrative review under sections 1869 or 1878 of the Act or otherwise is prohibited with regard to the establishment of the Federal rates. This prohibition includes the methodology used in the computation of the Federal standardized payment rates, the case-mix methodology, and the development and application of the wage index. This prohibition on judicial and administrative review also extends to the methodology used to establish the facility-specific rates but not to determinations related to reasonable cost in the fiscal year 1995 cost reporting period used as the basis for these rates.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

E. Part 424 is amended as set forth below:

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

Authority: Secs. 1102 and 1871 of the Social Security Act (U.S.C. 1302 and 1895hh).

Subpart A—General Provisions

2. In § 424.3, the following definition is added, in alphabetical order, to read as follows:

§ 424.3 Definitions.

* * * * *

HCPCS means HCFA Common Procedure Coding System.

* * * * *

Subpart B—Certification and Plan of Treatment Requirements

3. In § 424.20, the introductory text and paragraph (a) are revised to read as follows:

§ 424.20 Requirements for posthospital SNF care.

Medicare Part A pays for posthospital SNF care furnished by an SNF, or a hospital or CAH with a swing-bed approval, only if the certification and recertification for services are consistent with the content of paragraph (a) or (c) of this section, as appropriate.

(a) *Content of certification*—(1) *General requirements.* Posthospital SNF care is or was required because—

(i) The individual needs or needed on a daily basis skilled nursing care (furnished directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services that, as a practical matter, can only be provided in an SNF or a swing-bed hospital on an inpatient basis, and the SNF care is or was needed for a condition for which the individual received inpatient care in a participating hospital or a qualified hospital, as defined in § 409.3 of this chapter; or

(ii) The individual has been correctly assigned to one of the Resource Utilization Groups designated as representing the required level of care, as provided in § 409.30 of this chapter.

* * * * *

4. In § 424.32, the introductory text to paragraph (a) is republished, paragraph (a)(2) is revised, and a new paragraph (a)(5) is added, to read as follows:

§ 424.32 Basic requirements for all claims.

(a) A claim must meet the following requirements:

* * * * *

(2) A claim for physician services must include appropriate diagnostic coding using ICD–9–CM and, for services furnished to an SNF resident under § 411.15(p)(2)(i) of this chapter, must also include the SNF's Medicare provider number.

* * * * *

(5) A Part B claim filed by an SNF must include appropriate HCPCS coding.

* * * * *

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

F. Part 483 is amended as set forth below:

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

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

Subpart B—Requirements for Long Term Care Facilities

2. In § 483.20, paragraph (b)(4) is revised to read as follows:

§ 483.20 Resident assessment.

* * * * *

(b) *Comprehensive assessments.*

* * * * *

(4) *Frequency.* Subject to the timeframes prescribed in § 413.343(b) of this chapter, assessments must be conducted—

(i) No later than 14 days after the date of admission;

(ii) Promptly after a significant change in the resident's physical or mental condition; and

(iii) In no case, less often than once every 12 months.

* * * * *

3. In § 483.75, paragraph (h)(1) is revised to read as follows:

§ 483.75 Administration.

* * * * *

(h) *Use of outside resources.* (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or (with respect to services furnished to NF residents and dental services furnished to SNF residents) an agreement described in paragraph (h)(2) of this section.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

G. Part 489 is amended to read as follows:

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

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

Subpart B—Essentials of Provider Agreements

2. In § 489.20, the introductory text is republished, and a new paragraph (s) is added to read as follows:

§ 489.20 Basic commitments.

The provider agrees to the following:

* * * * *

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

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

(2) Services performed under a physician's supervision by a physician assistant who meets the applicable definition in section 1861(aa)(5) of the Act.

(3) Services performed by a nurse practitioner or clinical nurse specialist who meets the applicable definition in section 1861(aa)(5) of the Act and is working in collaboration (as defined in section 1861(aa)(6) of the Act) with a physician.

(4) Services performed by a certified nurse-midwife, as defined in section 1861(gg) of the Act.

(5) Services performed by a qualified psychologist, as defined in section 1861(ii) of the Act.

(6) Services performed by a certified registered nurse anesthetist, as defined in section 1861(bb) of the Act.

(7) Dialysis services and supplies, as defined in section 1861(s)(2)(F) of the Act.

(8) Erythropoietin (EPO) for dialysis patients, as defined in section 1861(s)(2)(O) of the Act.

(9) Hospice care, as defined in section 1861(dd) of the Act.

(10) An ambulance trip that initially conveys an individual to the SNF to be admitted as a resident, or that conveys an individual from the SNF in connection with one of the circumstances specified in § 411.15(p)(3)(i) through (p)(3)(iv) of this chapter as ending the individual's status as an SNF resident.

(11) *For services furnished during 1998 only.* The transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS code R0076).

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

Dated: April 22, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Approved: April 28, 1998.

Donna E. Shalala,

Secretary.

Note: The following Appendix will not appear in the Code of Federal Regulations.

Appendix A—Technical Features of the 1992 Skilled Nursing Facility Total Cost Market Basket Index

As discussed in the preamble of this rule, we are revising and rebasing the SNF market basket. This appendix describes the technical aspects of the 1992-based index that we are implementing in this rule. We present this description of the market basket in three steps:

- A synopsis of the structural differences between the 1977- and the 1992-based market baskets.
- A description of the methodology used to develop the cost category weights in the 1992-based market basket.
- A description of the data sources used to measure price change for each component of the 1992-based market basket, making note of the differences from the price proxies used in the 1977-based market basket.

I. Synopsis of Structural Changes Adopted in the Revised and Rebased 1992 Skilled Nursing Facility Total Cost Market Basket

Four major structural differences exist between the current 1977-based and the 1992-based SNF market baskets.

- The 1992-based market basket has total costs (routine, ancillary, and capital-related) whereas the 1977-based market basket had only routine costs.
- More recent SNF cost data are used in the revised and rebased SNF market basket.

The 1977-based market basket contained cost shares that were derived from 1977 National Center for Health Statistics data. The 1992-based market basket uses data from the PPS–9 Medicare Cost Reports for freestanding SNFs with Medicare expenses greater than 1 percent of total expenses for five major categories of cost. PPS–9 cost reports have cost reporting periods beginning after September 30, 1991 and before October 1, 1992. Cost allocations with the six major cost categories use two Department of Commerce data sources, the 1992 Asset and Expenditure Survey, Bureau of the Census, Economics and Statistics Administration, and the 1992 Bureau of Economic Analysis Input-Output Tables.

- Some cost categories have been disaggregated and some cost categories have been combined. These category changes reflect the availability of data in the cost reports, the Asset and Expenditure Survey, and the Input-Output Tables. The cost categories for Fuel Oil, Coal, etc. and Natural Gas have been combined into Fuels, Nonhighway. The Supplies category has been disaggregated into several subcategories: Paper, Rubber and Plastics, and Chemicals. The 1977-based Miscellaneous Costs cost category was disaggregated into Miscellaneous Products and Other Services, which was then further disaggregated into Telephone, Labor-intensive Services, and Non Labor-intensive Services. The Capital-related Expenses major cost category was added, and then disaggregated into five subcategories, including Depreciation expenses for Building and Fixed Equipment and for Movable Equipment, Interest expenses for Government and Nonprofit SNFs and for For-profit SNFs, and Other Capital-related expenses.
- Some new price proxies have been incorporated in the revised and rebased market basket.

II. Methodology for Developing the Cost Category Weights

Cost category weights for the 1992-based market basket were developed in two stages. First, base weights for six main categories (wages and salaries, employee benefits, contract labor, pharmaceuticals, capital-related expenses, and a residual all other) were derived from the SNF Medicare Cost Reports described above. The residual ''all other'' cost category was divided into subcategories, using U.S. Department of Commerce data sources for the nursing home industry. Relationships from the 1992 Input-Output Tables were used to allocate the ''all other'' cost category.

Below we describe the source of the six main category weights and their subcategories in the 1992-based market basket.

- Wages and Salaries: The wages and salaries cost category is one of the six base weights derived from using 1992 SNF Medicare Cost Reports.
- Employee Benefits: The ratio used in the employee benefits cost category is derived from 1993 SNF Medicare cost reports. The 1993 cost reports contained information from which to derive the ratio of employee benefits to wages and salaries that was not available in the 1992 SNF cost reports.
- Pharmaceuticals: The ratio used in the pharmaceuticals cost category was derived from 1993 SNF Medicare cost reports. The 1993 cost reports contained information from which to derive the ratio of pharmaceuticals costs to that cost that was not available in the 1992 cost reports.
- Capital-related: The weight for the overall capital-related expenses cost category was derived using 1992 SNF Medicare Cost Reports. The subcategory and vintage weights within the overall capital-related expenses were derived using additional data sources. The methodology for deriving these weights is described below.

In determining the subcategory weights, we used a combination of information from the 1992 and 1993 SNF Medicare Cost Reports, the 1992 Census Asset and Expenditure Survey, and the 1992 hospital Medicare Cost Reports. We estimated the depreciation expense share of capital-related expenses, including the distribution between building and fixed equipment and movable equipment, from the 1992 Asset and Expenditure Survey. Depreciation expenses cannot be disaggregated from the Medicare Cost Reports due to multiple reporting methods. From these calculations, depreciation expenses, not including

depreciation expenses implicit from leases, were estimated to be 50.7 percent of total capital-related expenditures in 1992.

The interest expense share of capital-related expenses was derived from a special file of the 1993 SNF Medicare Cost Reports. Interest expenses are not identifiable in the 1992 SNF Medicare Cost Reports and not reported in the 1992 Asset and Expenditure Survey. We determined the split between for-profit interest expense and not-for profit interest expense based on the distribution of long-term debt outstanding by type of SNF (for-profit or not-for-profit) from the 1992 SNF Medicare Cost Reports. Interest expense, not including interest expenses from leases, was estimated to be 27.3 percent of total capital-related expenditures in 1992.

A small category, other capital-related expenses (insurance, taxes, other), was calculated using a ratio from the 1992 hospital Medicare Cost Reports. We determined the ratio of other capital-related expenses to book values for hospital depreciable assets by type of hospital control (for-profit, not-for-profit, and government) from the 1992 hospital Medicare Cost Reports. We then applied this ratio by type of SNF control to the book values of SNF depreciable assets from the 1992 SNF Medicare Cost Reports to determine other capital-related expenses for SNFs. This methodology assumes that by type of control, hospitals and SNFs have the same proportion of other capital-related expenses to depreciable assets. This assumption was necessary since other capital-related expenses not including leases were not directly available from the SNF Medicare Cost Reports. Other capital-related expenses, not including other capital-related expenses implicit from leases, were estimated to be 4.5 percent of total capital-related expenditures in 1992.

Consistent with the methodology from the hospital PPS capital input price index, we calculated lease expenses as a residual by subtracting depreciation, interest, and other capital-related expenses from total capital-related expenses. We then assumed that roughly 10 percent of lease expenses were overhead, the same assumption used in the hospital PPS capital input price index, and included them in the other capital-related expense category. The remaining 90 percent of lease expenses were distributed across the depreciation (61.5 percent = 50.7/82.5), interest (33.1 percent = 27.3/82.5), and other capital-related expenses (5.4 percent = 4.5/82.5) categories using the shares determined by the methodology described above. The amount of lease expenses applied to the depreciation subcategories, building and fixed equipment (93.9 percent) and movable equipment (6.1 percent), were determined using the 1992 Asset and Expenditure Survey distribution of lease expenses. The table below shows the final capital-related expense distribution, including expenses from leases, in the SNF PPS market basket:

	SNF capital-related expenses*	SNF capital-related expenses**
Total	100.0	9.8
Depreciation	60.5	5.9
Building and Fixed Equipment.	42.1	4.1
Movable Equipment	18.4	1.8
Interest	32.6	3.2
Other capital-related expense	6.9	0.7

*As a percent of total capital-related expenses.
**As percent of total SNF expenses.

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

The expected life of capital must be determined for both building and fixed equipment and movable equipment. The expected life for each of these cost categories is determined by dividing end of year book value amounts by annual depreciation expenses for SNFs from the 1992 Asset and Expenditure Survey. This calculation produced an expected life of 23 years for building and fixed equipment and 10 years for movable equipment. Implicit in this calculation is the assumption that all book values are currently depreciable. In the absence of data on capital debt instruments held by SNFs, the expected life of capital debt instruments is assumed to be 22 years for both for-profit and not-for-profit debt instruments, the same as for the hospital PPS capital input price index.

Given the expected life of capital and debt instruments as determined from the methodology above, we must determine the proportion of capital expenditures attributable to each year of the expected life by cost category. These proportions represent the vintage weights. We were not able to find historical time-series of capital expenditures by SNFs. Therefore, we approximated the capital expenditure patterns of SNFs over time using alternative SNF data sources. For building and fixed equipment, we used the stock of beds in nursing homes from the HCFA's National Health Accounts for 1962 through 1991. We then used the change in the stock of beds each year to approximate building and fixed equipment purchases for that year. This procedure assumes that bed growth reflects the growth in capital-related costs in SNFs for building and fixed equipment. We believe this assumption is reasonable since the number of beds reflects the size of the SNF, and as the SNF adds beds, it also adds fixed capital.

For movable equipment, we used available SNF data to capture the changes in intensity of SNF services that would cause SNFs to purchase movable equipment. We estimated the change in intensity as the trend in the ratio of non-therapy ancillary costs to routine costs from the 1989 through 1993 SNF Medicare Cost Reports. We estimated this ratio for 1962 through 1988 using regression analysis. The time series of non-therapy ancillary costs to routine costs for SNFs measures changes in intensity in SNF services, which are assumed to be associated with movable equipment purchase patterns. The assumption here is that as non-therapy ancillary costs increase compared with routine costs, the SNF caseload is more complex and would require more movable equipment. Again, the lack of direct movable equipment purchase data for SNFs over time required us to use alternative SNF data sources. The resulting two time series, determined from beds and the ratio of non-therapy ancillary to routine costs, reflect real capital purchases of building and fixed equipment and movable equipment over time, respectively.

To obtain nominal purchases, which are used to determine the vintage weights for interest, we converted the two real capital purchase series from 1963 through 1991 determined above to nominal capital purchase series using their respective price proxies (Boeckh institutional construction index and PPI for machinery and equipment). We then combined the two nominal series into one nominal capital purchase series for 1963 through 1991. Nominal capital purchases are needed for interest vintage weights to capture the value of the debt instrument.

Once these capital purchase time series were created for 1963 through 1991, we averaged different periods to obtain an average capital purchase pattern over time. For building and fixed equipment we

averaged seven 23-year periods, for movable equipment we averaged twenty 10-year periods, and for interest we averaged eight 22-year periods. The vintage weight for a given year is calculated by dividing the capital purchase amount in any given year by the total amount of purchases during the expected life of the equipment or debt instrument. For example, for the 23-year period of 1963 through 1985 for building and fixed equipment, the vintage weight for year 1 is calculated by dividing the real annual capital purchase amount of building and fixed equipment in 1963 into the total amount of real annual capital purchases of building and fixed equipment over the entire 1963 through 1985 period. We performed this calculation for each year in the 23-year period, and for each of the seven 23-year periods. We then calculated an average of the seven 23-year periods. The resulting vintage weights for each of these cost categories are shown in Table A–1 below:

Appendix Table A–1—Vintage Weights for SNF PPS Capital-Related Price Proxies

Year	Building and fixed equipment	Movable equipment	Interest
1	0.059	0.089	0.038
2	0.078	0.093	0.046
3	0.086	0.096	0.046
4	0.079	0.101	0.047
5	0.074	0.104	0.051
6	0.071	0.104	0.054
7	0.073	0.104	0.060
8	0.075	0.114	0.064
9	0.064	0.101	0.062
10	0.056	0.097	0.055
11	0.052	.....	0.056
12	0.048	.....	0.056
13	0.041	.....	0.055
14	0.034	.....	0.050
15	0.026	.....	0.042
16	0.019	.....	0.044
17	0.017	.....	0.039
18	0.016	.....	0.036
19	0.013	.....	0.025
20	0.004	.....	0.027
21	0.003	.....	0.023
22	0.005	.....	0.026
23	0.009	.....	.....
Total	1.000	1.000	1.000

Sources: 1992 SNF Medicare Cost Reports; HCFA, National Health Accounts.

Note: Totals may not sum to 1.000 due to rounding.

In developing the capital-related expenses portion of the SNF input price index, we considered numerous alternatives for developing the cost category and vintage weights. Our analysis showed that using any of these alternatives would have a minimal impact on the capital-related expense portion of the SNF index. Since the capital-related expense share of the total SNF market basket is just 9.777 percent, these minimal differences have no effect on the total SNF market basket percent change.

We compared the price change in the capital-related expense component to changes in other relevant price indexes to evaluate our methodology. The table below shows the four-quarter moving-average percent change in the SNF PPS capital-related expense component, the hospital PPS capital input price index, the Boeckh institutional construction index, and the CPI-all items for FY 1992 to FY 1997. Since the two HCFA capital indexes include an adjustment for interest rates that have been declining in recent years, the capital-related expense component of the SNF PPS market basket appears to be within a reasonable range of the other price indexes.

APPENDIX TABLE A–2—PERCENT CHANGE IN HCFA CAPITAL-RELATED EXPENSE SHARE OF SNF PPS INPUT PRICE INDEX COMPARED TO OTHER PRICE INDEXES

	HCFA capital-related expense share of SNF PPS input price index	HCFA hospital PPS capital input price index	Boeckh institutional construction index	CPI—all items
FY92	2.4	1.5	2.6	3.0
FY93	2.0	1.1	2.4	3.0
FY94	1.8	1.1	2.8	2.6
FY95	1.8	1.3	3.1	2.8
FY96	1.6	1.0	2.3	2.8
FY97	1.4	0.9	2.4	2.7

• Contract labor: The weight for the contract labor cost category was derived using 1992 Medicare Cost Reports. It was then distributed among the wages and salaries, employee benefits, and ''all other'' cost categories, so that contract costs will have the same price proxies as direct cost categories.

• All Other: Subcategory weights for the All Other category were derived using information from a U.S. Department of Commerce data source. The 1992 Input-

Output Tables were used to apportion all other costs within the SNF Medicare Cost Reports.

III. Price Proxies Used To Measure Cost Category Growth

• Wages and Salaries: For measuring price growth in the wages and salaries cost component of the 1992-based market basket, the percentage change in the ECI for wages and salaries for private nursing homes is used. This is a revision from the 1977-based market basket, in which the AHE for Nursing and Personal Care Facilities was used to measure the percentage change in wages and salaries. The ECI for wages and salaries for private nursing homes is a fixed-weight index that measures the rate of change in employee wage rates per hour worked. It measures pure price change and is not affected by shifts among occupations. The previous measure, AHE, confounds changes in the proportion of different occupations with changes in earnings levels for a given occupation.

• Employee Benefits: For measuring price growth in the 1992-based market basket, the percentage change in the ECI for benefits for private nursing homes is used. This is a revision from the 1977-based market basket, in which the BEA Supplement to Wages and Salaries per employee (BLS) was used to measure this component. The ECI for benefits for private nursing homes is also a fixed-weight index that measures pure price change and is not affected by shifts in occupation. In contrast to the ECI, the BEA Supplement to Wages and Salaries per employee (BLS) is not specific to the nursing home industry and is not as conceptually sound for our purpose.

• All Other Expenses:

+ Nonmedical professional fees: The ECI for compensation for Private Industry Professional, Technical, and Specialty Workers is used to measure price changes in nonmedical professional fees. This is a revision from the 1977-based index in which the cost of nonmedical professional fees was not specifically measured.

+ Electricity: For measuring price change in the Electricity cost category, the PPI for Commercial Electric Power is used. This is a revision from the 1977-based index in which the Implicit Price Deflator-Electricity (PCE) was used.

+ Fuels, nonhighway: For measuring price change in the Fuels, Nonhighway cost category, the PPI for Commercial Natural Gas is used. This is a revision from the 1977-based market basket, in which the Implicit Price Deflator-Fuel Oil (PCE) and the Implicit Price Deflator-Natural Gas (PCE) were used for separate cost categories.

+ Water and Sewerage: For measuring price change in the Water and Sewerage cost category, the CPI–U (Consumer Price Index for All Urban Consumers) for Water and Sewerage is used. The same price proxy was used in the 1977-based index.

+ Food-wholesale purchases: For measuring price change in the Food-wholesale purchases cost category, the PPI for Processed Foods is used. The same price proxy was used in the 1977-based index.

+ Food-retail purchases: For measuring price change in the Food-retail purchases cost category, the CPI–U for Food Away From Home is used. This is a change from the 1977-based index, when the CPI–U for Food and Beverages was used, and reflects the use of contract food service by some SNFs.

+ Pharmaceuticals: For measuring price change in the Pharmaceuticals cost category, the PPI for Prescription Drugs is used. The same price proxy was used for this cost category in the 1977-based index.

+ Chemicals: For measuring price change in the Chemicals cost category, the PPI for Industrial Chemicals is used. This is a revision from the 1977-based index, in which the cost of chemicals was not specifically measured.

+ Rubber and Plastics: For measuring price change in the Rubber and Plastics cost category, the PPI for Rubber and Plastic Products is used. This too is a revision from the 1977-based index, in which the cost of rubber and plastic products was not specifically measured.

+ Paper Products: For measuring price change in the Paper Products cost category, the PPI for Converted Paper and Paperboard is used. The cost of paper products was not specifically measured in the 1977-based index.

+ Miscellaneous Products: For measuring price change in the Miscellaneous Products cost category, the PPI for Finished Goods is used. The cost of miscellaneous products was not specifically measured in the 1977-based index.

+ Telephone Services: The percentage change in the price of Telephone service as measured by the CPI-U is applied to this component. This is a revision from the 1977-based index, in which the cost of telephone services was not specifically measured.

+ Labor-intensive Services: For measuring price change in the Labor-intensive Services cost category, the ECI for Compensation for Private Service Occupations is used. The cost of Labor-intensive Services was not specifically measured in the 1977-based index.

+Non Labor-intensive Services: For measuring price change in the Non Labor-intensive Services cost category, the CPI-U for All Items is used. The 1977-based index did not specifically measure the cost of Non Labor-intensive Services.

• Capital-related: All capital-related expense categories are new cost categories in the revised SNF market basket. The price proxies chosen are the same as those used for the hospital PPS capital input price index described in the August 30, 1996 **Federal Register** (61 FR 46326). The price proxies for the SNF capital-related expenses are described below:

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

+ Depreciation—Movable Equipment: The PPI for Machinery and Equipment.

+ Interest—Government and Nonprofit SNFs: The Average Yield for Municipal Bonds from the Bond Buyer Index of 20 bonds. HCFA input price indexes, including this rebased SNF index, are concerned with the rate of change in the price proxy and not the level of the price proxy. While SNFs may face different interest rate levels than hospitals, the rate of change in most interest rates is not significantly different. Our research on this issue regarding hospitals has been presented in the August 30, 1996 **Federal Register** (61 FR 46201).

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

+ Other Capital-related Expenses: The CPI-U for Residential Rent.

Appendix Table A–3—A Comparison of Price Proxies Used in the 1992-Based and 1977-Based Skilled Nursing Facility Market Baskets

Cost category	1992-based price proxy	1977-based price proxy
Wages and Salaries	ECI for Wages and Salaries for Private Nursing Homes.	AHE—Private Nursing and Personal Care Facilities
Employee Benefits	ECI for Benefits for Private Nursing Homes	BEA Supplement to Wages and Salaries per worker (BLS)
Nonmedical professional fees	ECI for Compensation for Private Professional and Technical Workers.	n/a
Electricity	PPI for Commercial Electric Power	Implicit Price Deflator—Electricity (PCE)
Fuels	PPI for Commercial Natural Gas	Implicit Price Deflator—Fuel Oil (PCE) and Implicit Price Deflator—Natural Gas (PCE)
Water and sewerage	CPI-U for Water and Sewerage	CPI-U for Water and Sewerage
Food—Wholesale purchases	PPI—Processed Foods	PPI—Processed Foods
Food—Retail purchases	CPI-U—Food Away From Home	CPI-U—Food and Beverages
Pharmaceuticals	PPI for Prescription Drugs	PPI—Prescription Drugs

Appendix Table A–3—A Comparison of Price Proxies Used in the 1992-Based and 1977-Based Skilled Nursing Facility Market Baskets—Continued

Cost category	1992-based price proxy	1977-based price proxy
Chemicals	PPI for Industrial Chemicals	n/a
Rubber and plastics	PPI for Rubber and Plastic Products	n/a
Paper products	PPI for Converted Paper and Paperboard	n/a
Miscellaneous products	PPI for Finished Goods	n/a
Telephone services	CPI-U for Telephone Services	n/a
Labor-intensive services	ECI for Compensation for Private Service Occupations.	n/a
Non labor-intensive services	CPI-U for All Items	n/a
Depreciation: Building and Fixed Equipment.	Boeckh Institutional Construction Index	n/a
Depreciation: Movable Equipment	PPI for Machinery and Equipment	n/a
Interest: Government and Nonprofit SNFs.	Average Yield Municipal Bonds (Bond Buyer Index-20 bonds).	n/a
Interest: For-profit SNFs	Average Yield Moody's AAA Bonds	n/a
Other Capital-related Expenses	CPI-U for Residential Rent	n/a

[FR Doc. 98–12208 Filed 5–5–98; 12:57 pm]

BILLING CODE 4120–01–P