DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS. **ACTION:** Final rule.

SUMMARY: This final rule updates the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2009. It also discusses our ongoing analysis of nursing home staff time measurement data collected in the Staff Time and Resource Intensity Verification (STRIVE) project. Finally, this final rule makes technical corrections in the regulations text with respect to Medicare bad debt payments to SNFs and the reference to the definition of urban and rural as applied to SNFs.

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

FOR FURTHER INFORMATION CONTACT:

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

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Abbreviations

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

AIDS Acquired Immune Deficiency Syndrome

- ARD Assessment Reference Date
- BBA Balanced Budget Act of 1997, Public Law 105–33
- BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public Law 106–113
- BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106–554
- CAH Critical Access Hospital
- CARE Continuity Assessment Record and Evaluation
- CBSA Core-Based Statistical Area
- CFR Code of Federal Regulations
- CMI Case-Mix Index
- CMS Centers for Medicare & Medicaid Services
- DRA Deficit Reduction Act of 2005, Public Law 109–171
- FQHC Federally Qualified Health Center
- FR Federal Register
- FY Fiscal Year
- GAO Government Accountability Office
- HAC Hospital-Acquired Condition
- HCPCS Healthcare Common Procedure Coding System
- HIPPS Health Insurance Prospective Payment System
- HIT Health Information Technology
- IFC Interim Final Rule with Comment
- Period IPPS Hospital Inpatient Prospective
- Payment System
- MDS Minimum Data Set
- MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173
- MSA Metropolitan Statistical Area
- MS-DRG Medicare Severity Diagnosis-Related Group
- NRST Non-Resident Specific Time
- NTA Non-Therapy Ancillary
- OBRA Omnibus Budget Reconciliation Act of 1987, Public Law 100–203
- OIG Office of the Inspector General
- OMB Office of Management and Budget

RAI Resident Assessment Instrument

Resident Assessment Protocol

RFA Regulatory Flexibility Act, Public Law

Resident Assessment Validation

- OMRA Other Medicare Required Assessment
- PAC–PRD Post-Acute Care Payment Reform Demonstration
- POA Present on AdmissionPPS Prospective Payment System

RHC Rural Health Clinic

RIA Regulatory Impact Analysis

Mix Classification System RST Resident Specific Time

RUG-III Resource Utilization Groups,

RUG-53 Refined 53-Group RUG-III Case-

SCHIP State Children's Health Insurance

STRIVE Staff Time and Resource Intensity

UMRA Unfunded Mandates Reform Act,

Skilled Nursing Facility

Value-Based Purchasing

STM Staff Time Measurement

TEP Technical Expert Panel

RAP

RAVEN

Entry

96–354

Version III

Program

Verification

Public Law 104-4

SNF

VBP

I. Background

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

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

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

• *Rates.* As discussed in section I.F.1. of this final rule, we established per diem Federal rates for urban and rural areas using allowable costs from FY 1995 cost reports. These rates also included an estimate of the cost of services that, before July 1, 1998, had been paid under Part B but were furnished to Medicare beneficiaries in a SNF during a Part A covered stay. We update the rates annually using a SNF market basket index, and we adjust them by the hospital inpatient wage index to account for geographic variation in wages. We also apply a case-mix adjustment to account for the relative resource utilization of different patient types. This adjustment utilizes a refined, 53-group version of the Resource Utilization Groups, version III

(RUG-III) case-mix classification system, based on information obtained from the required resident assessments using the Minimum Data Set (MDS) 2.0. Additionally, as noted in sections I.C through I.E of this final rule, the payment rates at various times have also reflected specific legislative provisions, including section 101 of the BBRA, sections 311, 312, and 314 of the BIPA, and section 511 of the MMA.

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

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

• Consolidated Billing. The SNF PPS includes a consolidated billing provision that requires a SNF to submit consolidated Medicare bills to its fiscal intermediary or Medicare Administrative Contractor for almost all of the services that its residents receive during the course of a covered Part A stay. In addition, this provision places with the SNF the Medicare billing responsibility for physical, occupational, and speech-language therapy that the resident receives during a noncovered stay. The statute excludes a small list of services from the consolidated billing provision (primarily those of physicians and certain other types of practitioners),

which remain separately billable under Part B when furnished to a SNF's Part A resident. A more detailed discussion of this provision appears in section V. of this final rule.

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

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

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

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

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

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

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

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

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

There were several provisions in the BBRA that resulted in adjustments to the SNF PPS. We described these provisions in detail in the SNF PPS final rule for FY 2001 (65 FR 46770, July 31, 2001). In particular, section 101(a) of the BBRA provided for a temporary 20 percent increase in the per diem adjusted payment rates for 15 specified **46418** Federal Register / Vol. 73, No. 154 / Friday, August 8, 2008 / Rules and Regulations

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

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

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

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

• Section 203 of the BIPA exempted CAH swing-beds from the SNF PPS. We included further information on this provision in Program Memorandum A– 01–09 (Change Request #1509), issued January 16, 2001, which is available online at http://www.cms.hhs.gov/ transmittals/downloads/a0109.pdf.

• Section 311 of the BIPA revised the statutory update formula for the SNF market basket, and also directed us to conduct a study of alternative case-mix classification systems for the SNF PPS. In 2006, we submitted a report to the Congress on this study, which is available online at *http://www.cms.hhs.gov/SNFPPS/Downloads/RC_2006_PC-PPSSNF.pdf.*

• Section 312 of the BIPA provided for a temporary increase of 16.66 percent in the nursing component of the case-mix adjusted Federal rate for services furnished on or after April 1, 2001, and before October 1, 2002; accordingly, this add-on is no longer in effect. This section also directed the Government Accountability Office (GAO) to conduct an audit of SNF nursing staff ratios and submit a report to the Congress on whether the temporary increase in the nursing component should be continued. The report (GAO–03–176), which GAO issued in November 2002, is available online at *http://www.gao.gov/ new.items/d03176.pdf.*

• Section 313 of the BIPA repealed the consolidated billing requirement for services (other than physical, occupational, and speech-language therapy) furnished to SNF residents during noncovered stays, effective January 1, 2001. (A more detailed discussion of this provision appears in section V. of this final rule.)

• Section 314 of the BIPA corrected an anomaly involving three of the RUGs that the BBRA had designated to receive the temporary payment adjustment discussed above in section I.C. of this final rule. (As noted previously, in accordance with section 101(c)(2) of the BBRA, this temporary payment adjustment expired upon the implementation of case-mix refinements on January 1, 2006.)

• Section 315 of the BIPA authorized us to establish a geographic reclassification procedure that is specific to SNFs, but only after collecting the data necessary to establish a SNF wage index that is based on wage data from nursing homes. To date, this has proven to be infeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data.

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

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

The MMA included a provision that resulted in further adjustment to the SNF PPS. Specifically, section 511 of the MMA amended section 1888(e)(12) of the Act, to provide for a temporary increase of 128 percent in the PPS per diem payment for any SNF resident with Acquired Immune Deficiency Syndrome (AIDS), effective with services furnished on or after October 1, 2004. This special AIDS add-on was to remain in effect until "* * * such date as the Secretary certifies that there is an appropriate adjustment in the case mix * *." The AIDS add-on is also discussed in Program Transmittal #160 (Change Request #3291), issued on April 30, 2004, which is available online at

http://www.cms.hhs.gov/transmittals/ downloads/r160cp.pdf. As discussed in the SNF PPS final rule for FY 2006 (70 FR 45028, August 4, 2005), the implementation of the case-mix refinements did not address the certification regarding the AIDS add-on, allowing the temporary add-on payment created by section 511 of the MMA to continue in effect.

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

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

F. Skilled Nursing Facility Prospective Payment—General Overview

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

1. Payment Provisions—Federal Rate

The PPS uses per diem Federal payment rates based on mean SNF costs in a base year updated for inflation to the first effective period of the PPS. We developed the Federal payment rates using allowable costs from hospitalbased and freestanding SNF cost reports for reporting periods beginning in FY 1995. The data used in developing the Federal rates also incorporated an estimate of the amounts that would be payable under Part B for covered SNF services furnished to individuals during the course of a covered Part A stay in a SNF.

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

The Federal rate also incorporates adjustments to account for facility casemix, using a classification system that accounts for the relative resource utilization of different patient types. The RUG–III classification system uses

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

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

Rate Updates Using the Skilled Nursing Facility Market Basket Index

Section 1888(e)(5) of the Act requires us to establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. We use the SNF market basket index to update the Federal rates

on an annual basis. In the FY 2008 SNF PPS final rule (72 FR 43425 through 43430, August 3, 2007), we revised and rebased the market basket, which included updating the base year from FY 1997 to FY 2004. The proposed FY 2009 market basket increase was 3.1 percent. The final FY 2009 market basket increase is 3.4 percent.

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

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

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

* Published in Federal Register; based on second quarter 2006 Global Insight Inc. forecast (97 index).

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

Requirements for Issuance of Regulations

Section 902 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended section 1871(a) of the Act and requires the Secretary, in consultation with the Director of the Office of Management and Budget, to establish and publish timelines for the publication of Medicare final

regulations based on the previous publication of a Medicare proposed or interim final regulation. Section 902 of the MMA also states that the timelines for these regulations may vary but shall not exceed 3 years after publication of the preceding proposed or interim final regulation except under exceptional circumstances.

This final rule finalizes provisions proposed in the May 7, 2008 proposed rule. In addition, this final rule has been

published within the 3-year time limit imposed by section 902 of the MMA. Therefore, we believe that the final rule is in accordance with the Congress' intent to ensure timely publication of final regulations.

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

In the FY 2009 proposed rule (73 FR 25918, May 7, 2008), we proposed to update the Federal payment rates used under the SNF PPS for FY 2009. We also proposed to recalibrate the case-mix indexes so that they would more accurately reflect parity in expenditures related to the implementation of casemix refinements in January 2006. In addition, we discussed our ongoing analysis of nursing home staff time measurement data collected in the Staff Time and Resource Intensity Verification (STRIVE) project. We also proposed to make technical corrections in the regulations text with respect to Medicare bad debt payments to SNFs and the reference to the definition of urban and rural as applied to SNFs.

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

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

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

A. General Comments on the FY 2009 Proposed Rule

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

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

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

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

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

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

1. Federal Prospective Payment System

This final rule sets forth a schedule of Federal prospective payment rates applicable to Medicare Part A SNF services beginning October 1, 2008. The schedule incorporates per diem Federal rates that provide Part A payment for all costs of services furnished to a beneficiary in a SNF during a Medicarecovered stay.

a. Costs and Services Covered by the Federal Rates

In accordance with section 1888(e)(2)(B) of the Act, the Federal rates apply to all costs (routine, ancillary, and capital-related) of covered

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

b. Methodology Used for the Calculation of the Federal Rates

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

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

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

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

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

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

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

2. Case-Mix Adjustments

a. Background

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

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

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

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

b. Development of the Case-Mix Indexes

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

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

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

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

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

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

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

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

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

Comment: A number of comments included references to the discussion of the 2006 case-mix refinements in the SNF PPS proposed rule for FY 2006 (70 FR 29079, May 19, 2005), in which we explained that we were "* * * advancing these proposed changes under our authority in section 101(a) of the BBRA to establish case-mix refinements, and that the changes we are hereby proposing will represent the final adjustments made under this authority" (emphasis added). The commenters stated that this earlier description of the 2006 case-mix refinements as "final" effectively precludes CMS from proceeding with a recalibration, which they characterized as representing a further refinement. Similarly, several commenters also

questioned our authority to recalibrate the case-mix system prior to the completion of the STRIVE staff time measurement (STM) project. In addition, several commenters questioned whether CMS has the authority to impose a budget neutrality requirement on the introduction of a new classification model.

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

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

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

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

We also received a number of technical comments on the potential effects of implementing this recalibration proposal on beneficiaries, providers, and the overall economy. These comments are summarized below.

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

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

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

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

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

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

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

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

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

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

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

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

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

still important to understand that recalibrating CMIs would not change the relative nature of higher payments for patients using more staff resources and services.

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

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

system that were equal to estimated expenditure levels under the RUG-44 system. We then calculated a second adjustment factor to increase the baseline by an amount that served to offset the variability in NTA utilization.

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

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

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

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

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

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

RUG-III category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
IA1 BB2	0.56 0.73		81.18 105.83		16.08 16.08	78.87 78.87	176.13 200.78
BB1 BA2	0.69 0.6		100.03 86.98		16.08 16.08	78.87 78.87	194.98 181.93
BA1	0.52		75.38		16.08	78.87 78.87	170.33
PE1	0.82		118.88		16.08	78.87	213.83
PD2 PD1	0.78		113.08 110.18		16.08 16.08	78.87 78.87	208.03 205.13
PC2 PC1	0.71 0.69		102.93 100.03		16.08 16.08	78.87 78.87	197.88 194.98
PB2	0.55		79.73		16.08	78.87	174.68
РА2	0.53		76.83		16.08	78.87	173.23
PA1	0.5		72.49		16.08	78.87	167.44

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

3. Wage Index Adjustment to Federal Rates

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

Since the implementation of the SNF PPS, as set forth in § 413.337(a)(1)(ii), a SNF's wage index is determined based on the location of the SNF in an urban or rural area as defined in §413.333 and further defined in §412.62(f)(1)(ii) and §412.62(f)(1)(iii) as urban and rural areas, respectively. In the SNF PPS final rule for FY 2006 (70 FR 45041, August 4, 2005), we adopted revised labor market area definitions based on Core-Based Statistical Area (CBSAs). At the time, we noted that these were the same labor market area definitions (based on OMB's new CBSA designations) implemented under the Hospital Inpatient Prospective Payment System (IPPS) at § 412.64(b), which were

effective for those hospitals beginning October 1, 2004, as discussed in the IPPS final rule for FY 2005 (69 FR at 49026 through 49034, August 11, 2004). In the FY 2006 SNF PPS final rule, we inadvertently omitted making a conforming regulation text change to § 413.333. However, this did not alter our decision to follow the IPPS definitions of urban and rural. In the FY 2009 proposed rule, we proposed to make that conforming regulation text change to revise the definitions for rural and urban areas effective for services provided on or after October 1, 2005, to reference the regulations at §§ 412.64(b)(1)(ii)(A) through (C), consistent with the revision under the IPPS.

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

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

Response: The regulations that govern the SNF PPS currently do not provide a mechanism for allowing providers to seek geographic reclassification. Moreover, as we have explained in the past (most recently, in the SNF PPS final rule for FY 2008 (72 FR 43420, August 3, 2007)), while section 315 of

the Benefits Improvement and Protection Act of 2000 (BIPA, Pub. L. 106–554) does authorize us to establish such a reclassification methodology under the SNF PPS, it additionally stipulates that such reclassification cannot be implemented until we have collected the data necessary to establish a SNF-specific wage index. This, in turn, has proven to be infeasible due to "* * * the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data" (72 FR 43420, August 3, 2007). We continue to believe that these factors make it unlikely for such an approach to yield meaningful improvements in our ability to determine facility payments, or to justify the significant increase in administrative resources as well as burden on providers that this type of data collection would involve.

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

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

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

a. Clarification of New England Deemed Counties

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

policy to create consistency among provider types.

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

b. Multi-Campus Hospital Wage Index Data

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

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

We also proposed to continue using the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in which there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the FY 2009 SNF PPS wage index. For rural geographic areas that do not have hospitals and, therefore, lack hospital wage data on which to base an area wage adjustment, we would use the average wage index from all contiguous CBSAs as a reasonable proxy. This methodology is used to construct the wage index for rural Massachusetts. However, as discussed in the FY 2008 SNF PPS proposed rule (72 FR 25539, May 4, 2007), we are not applying this

methodology to rural Puerto Rico due to the distinct economic circumstances that exist there, but instead will continue using the most recent wage index previously available for that area. For urban areas without specific hospital wage index data, we will use the average wage indexes of all of the urban areas within the State to serve as a reasonable proxy for the wage index of that urban CBSA. The only urban area without wage index data available is CBSA (25980) Hinesville-Fort Stewart, GA. We received no comments on this issue and are finalizing our policy as proposed without change.

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

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

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

category by multiplying this ratio by the base year (FY 2004) weight. Finally, we add the FY 2009 relative importance for each of the labor-related cost categories

(wages and salaries, employee benefits, non-medical professional fees, laborintensive services, and a portion of capital-related expenses) to produce the FY 2009 labor-related relative importance. Tables 6 and 7 below show the Federal rates by labor-related and non-labor-related components.

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

RUX 62.29 434.70 188.25 RUL 547.06 581.75 156.31 RVX 472.28 329.67 142.71 RVX 440.41 307.33 133.08 RHX 400.35 277.08 187.57 RHL 302.76 277.08 18.86 RMX 483.31 319.82 138.42 RML 20.37 227.05 98.32 RUC 325.77 227.05 98.32 RUA 444.43 33.34 146.50 RUA 462.08 322.45 139.86 RUA 462.08 322.45 139.86 RVA 363.03 228.58 109.70 RVA 363.03 228.55 98.97 RVA 339.95 228.55 98.67 RHA 323.26 228.55 98.67 RVA 339.95 228.55 98.67 RHA 323.26 228.55 98.67 RMA <	RUG–III category	Total rate	Labor portion	Non-labor portion
RUL 547.06 381.75 165.31 RV 447.28 329.57 142.71 RV 440.41 307.33 133.06 RHX 440.35 279.38 120.97 RHL 392.76 274.08 118.66 RMX 458.31 319.82 138.44 RMX 425.37 229.35 127.02 RUC 225.37 227.07 98.32 RUC 484.84 338.34 146.50 RUB 484.00 221.92 122.06 RVA 365.03 253.31 193.70 RVA 365.03 237.23 196.27 RVA 370.12 222.05 11.86 RVA 370.32 222.05 11.86 RVA 370.32 222.05 11.86 RVA 370.32 222.05 188.07 RVA 370.32 222.05 188.07 RVA 370.32 222.05 189.97 RVA	RUX	622.93	434 70	188 23
RV 472.28 329.57 142.71 RH 307.33 133.08 RHX 440.41 307.33 133.08 RHX 440.41 307.33 133.08 RHX 440.41 307.33 133.08 RMM 458.31 319.82 138.49 RML 225.37 227.05 98.32 RUC 528.85 369.05 159.80 RUA 462.06 322.45 139.63 RVA 462.08 324.45 139.63 RVA 462.08 324.45 139.63 RVA 462.08 322.45 139.63 RVA 363.03 253.33 109.70 RVA 363.03 253.33 109.70 RVA 363.03 253.33 109.70 RVA 363.03 253.33 102.72 RVA 363.03 253.33 102.72 RVA 363.04 236.25 98.97 RVA 330.85 237.52 228.56 98.97 RVA 363.03 235	RU	547.06	381.75	165.20
RVL 440.41 307.33 133.08 RHX 440.45 279.38 120.97 RHL 392.76 274.08 118.68 RMM 440.35 293.35 127.02 RLX 325.37 227.05 98.32 RUC 525.87 227.05 98.32 RUC 528.85 369.05 159.80 RUA 448.44 333.44 146.50 RUA 462.08 322.45 139.63 RVA 462.08 322.45 139.63 RVA 363.03 253.33 109.70 RVA 363.03 253.33 109.70 RHE 370.00 258.20 111.80 RHB 339.85 237.23 102.75 RMC 339.95 237.23 102.75 RMM 339.85 233.86 99.97 RMA 322.66 97.66 SE2 318.86 197.96 86.72 SE1 285.57 178.34 172.33 SE2 323.66 197.96 86.	BVX	472.28	329.57	142.71
RHX 400.35 279.38 120.37 RHL 392.76 274.08 118.68 RMM 458.31 319.82 138.44 420.37 293.35 127.02 RLX 325.37 227.05 98.32 RUC 528.86 369.05 159.80 RUB 444.84 338.34 146.50 RVA 442.04 322.53 122.08 RVA 442.04 324.51 198.62 RVA 3363.03 253.33 109.70 RVA 330.30 253.33 109.70 RVA 330.39 527.23 102.72 RVA 330.39 527.23 102.72 RVA 330.39 523.33 109.70 RHA 327.52 228.55 98.69 RMA 323.26 225.58 97.66 RHA 323.26 225.58 97.66 RHA 323.26 225.58 97.64 RHA 285.57 178.34 77.23 SE 285.57 178.34 7	BVI	440.41	307.33	133.08
RHL 382.76 274.08 118.68 RMM 446.83 31.942 138.49 RML 420.37 293.35 127.05 RLX 325.37 227.05 98.32 RUC 528.85 369.05 159.80 RUA 448.44 338.34 146.50 RUA 446.20 322.45 139.63 RVC 452.42 296.75 128.49 RVA 363.03 253.33 109.70 RVA 363.03 253.33 124.655 106.76 RHA 370.00 258.20 111.80 363.31 246.55 106.76 RHA 333.055 230.85 98.97 232.25 98.97 232.25 98.97 262.55 178.34 77.23 227.23 102.72 27.31 127.72 235.5 97.66 90.52 27.34 127.72 235.5 178.34 77.23 25.55 97.66 90.52 178.34 77.23 25.55 97.66 25.97 108.47 79.23 118.22 168.72 118.63 22.19.66 <th>RHX</th> <th>400.35</th> <th>279.38</th> <th>120.97</th>	RHX	400.35	279.38	120.97
RMM 488 31 319 82 138 44 RMM 426 31 238 53 127.02 RLX 325 37 227.05 98.32 RUC 328 85 369 05 159.80 RUA 448 84 338.34 146.50 RUA 446.24 328.33 119.67 RVA 440.00 221.22.08 223.08 RVA 363.03 253.33 109.70 RVA 363.03 253.33 109.70 RVA 363.03 253.33 109.70 RVA 339.95 236.55 106.76 RVA 339.95 236.55 106.76 RVA 339.95 236.55 106.76 RVA 339.95 236.55 106.76 RVA 339.95 237.23 122.76 RVA 339.95 237.23 122.77 RVB 339.95 237.23 122.75 RVB 339.95 238.97 205.95 RVB </th <th>BHI</th> <th>392.76</th> <th>274.08</th> <th>118.68</th>	BHI	392.76	274.08	118.68
RML 220.37 223.35 127.05 RLX 325.37 227.05 98.32 RUC 528.85 369.05 159.40 RUB 448.48 388.34 146.65 RUA 462.08 322.45 128.49 RVC 442.03.07 288.20 128.49 RVA 336.03 253.33 109.70 RVA 336.03 253.33 109.70 RVC 426.25 286.20 111.80 RVA 337.52 228.55 188.49 RVA 333.33 246.55 106.76 RHA 337.52 228.55 198.87 RMC 330.85 230.68 299.47 RMA 232.26 225.56 97.66 RLB 295.7 178.34 77.23 SE2 318.58 222.31 96.27 SE3 286.3 197.96 85.72 SE4 296.40 181.02 78.33 SE2	RMX	458.31	319.82	138.49
RLX 325.37 227.05 98.32 RUC 328.54 369.05 159.80 RUB 448.44 338.34 146.50 RUA 448.44 338.34 146.50 RUC 448.44 338.34 146.50 RVC 425.24 296.75 128.40 RVA 363.03 253.33 109.70 RVA 363.03 253.33 109.70 RVA 363.03 253.33 109.70 RVA 339.95 237.23 102.72 RVA 339.95 237.23 102.72 RVA 339.95 237.23 102.72 RVB 339.95 237.23 102.72 RVB 323.26 255.57 178.34 77.33 SE2 318.86 222.13 193.73 194.79 SE3 255.57 178.34 77.33 186.79 193.79 SE4 255.67 178.34 77.33 196.19 113.23	BMI	420.37	293.35	127.02
RUC 528 85 569 05 153.80 RUB 464 44 388.44 146.50 RUA 462 08 322.45 139.63 RUA 462 08 322.45 139.63 RUA 464 00 281.92 128.49 RVA 363.03 253.33 109.70 RHC 370.00 228.55 98.97 RHC 333.95 237.23 102.72 RHA 322.52 228.55 98.97 RHA 322.26 225.56 97.68 RHB 333.95 237.73 102.77 RHA 229.57 209.05 90.52 RLB 29.957 209.05 90.62 RLA 265.57 178.34 77.23 SE2 316.58 209.05 90.65 SE3 265.94 181.20 79.76 SSC 279.13 194.79 84.34 SSE 269.40 181.02 78.38 SCC	RI X	325.37	227.05	98.32
RUB 444 44 338.34 146.55 RUA 462.08 332.45 139.63 RVC 462.08 322.45 139.63 RVG 464.00 281.92 122.08 RVA 363.03 253.33 109.70 RHC 370.00 258.20 111.80 RHE 353.31 246.55 106.76 RHA 330.95 237.23 228.55 98.97 RMM 322.62 225.58 99.67 209.57 209.05 90.52 RLA 255.57 177.834 77.23 352.23 316.86 222.31 96.27 SE2 318.68 22.31 96.27 27.18.34 79.67 853.33 176.78 78.53 32.33 176.78 78.53 32.52 33.53 134.24 83.99 77.72 33.96 237.73 261.50 113.23 262.25 58 96.67 77.73.34 78.55 77.73.34 77.23 356.23 37.73 261.50	RIC	528.85	369.05	159.80
RUA 462.08 322.45 139.63 RVC 425.24 296.75 128.40 RVB 440.00 281.92 122.08 RVA 363.03 253.33 109.70 RHA 363.03 253.33 109.70 RHC 370.00 256.20 111.80 RHA 327.52 228.55 98.97 RMC 330.85 230.88 99.97 RMM 323.26 225.58 97.68 RLB 296.57 709.04 90.52 RLA 265.57 178.34 77.23 SE2 318.58 222.31 96.77 SSC 277.61 133.72 83.99 SSC 277.61 133.72 83.89 CC1 279.13 194.79 84.34 SSA 289.40 181.02 78.48 SSC 277.61 133.72 83.89 CC2 220.06 158.84 69.22 SSA 289.40 181.02 78.48 CC2 200.57 160.90	RUB	484.84	338.34	146.50
RVC 42524 296.75 128.49 RVB 360.03 281.92 122.06 RVA 360.03 253.33 109.70 RHC 336.03 253.23 119.00 RHC 333.31 245.55 98.87 RHA 337.52 228.55 98.87 RMC 330.85 230.88 99.97 RMA 323.26 225.58 97.68 RHA 232.26 255.57 178.34 77.32 SE2 336.85 229.957 209.05 90.52 SFLA 255.57 178.34 77.23 57.51 SE2 318.58 222.31 96.77 79.68 SSC 277.61 193.72 84.35 78.62 SSA 263.96 184.20 79.76 79.76 SSA 263.96 184.20 79.76 79.76 SSA 263.96 184.20 79.76 79.76 SSA 229.06 150.84 69.22 72.44 78.69 SC2 220.76 160.80	BUA	462.08	322.45	139.63
RVE 404 00 221 92 122 08 RVA 363.03 2253.20 111.80 RHE 353.31 246.55 98.97 RHA 327.52 228.55 98.97 RME 330.95 237.23 102.72 RMM 330.95 230.86 99.97 RMA 322.66 225.56 97.68 RLB 299.57 200.05 90.52 SE3 314.58 222.31 96.27 SE4 283.66 197.96 85.7 SSC 283.66 181.02 78.88 SSC 283.66 181.02 78.88 SSC 283.66 184.20 79.76 SSA 200.57 160.90 69.67 CA1 200.57 160.90 <	BVC	425.24	296.75	128.49
RVA 363.03 253.33 109.70 RHC 370.00 258.20 111.80 RHE 353.31 246.55 106.76 RHA 327.52 228.55 98.37 RMC 339.95 237.23 102.72 RMB 330.95 230.86 99.97 RMA 322.86 295.57 178.34 77.23 SE2 374.73 261.50 113.23 523.23 168.57 SE2 374.73 261.50 113.23 523.58 96.57 SE4 299.57 209.05 113.23 523.58 113.23 SE2 316.68 222.31 96.27 525.57 178.34 77.23 SE1 283.68 197.96 85.72 283.68 197.96 85.72 SE2 271.13 194.79 84.34 79.76 85.72 283.68 197.96 85.72 SE2 200.05 144.20 79.76 85.72 283.68 197.96 86.72 283.68 197.96 86.72 283.68 197.96	BVB	404.00	281.92	122.08
RHC 370.00 258.20 111.80 SB3.31 266.55 106.76 RHA 339.95 227.23 228.55 98.07 RMC 330.95 227.23 102.72 228.56 97.68 RME 330.85 220.68 99.97 229.57 209.05 90.52 RIA 225.57 178.34 77.23 251.50 113.23 SE2 318.58 222.31 96.27 SE1 283.68 197.96 85.72 SSC 279.13 194.79 84.34 SSE 277.61 193.72 83.88 C2 220.6 114.80 79.35 SSC 277.61 193.72 83.88 C2 220.6 184.27 78.68 C2 220.6 159.84 69.27 SSA 250.40 181.02 78.88 C2 220.6 184.27 78.68 C2 220.6 159.84 69.22 SSA 20.6 159.84 69.22 C4 <	RVA		253.33	109.70
RHB 353.31 246.55 106.76 RHA 327.52 228.55 98.97 RMC 330.95 237.23 102.72 RMB 330.88 230.88 99.97 RMA 330.85 230.88 99.97 RMA 285.57 177.83 77.23 SE2 374.73 261.50 113.23 SE2 374.73 261.50 113.23 SE2 374.73 261.50 178.84 SSC 279.13 194.79 84.34 SSE 263.96 184.20 79.76 SSC 277.61 193.72 83.89 CC1 283.33 176.78 76.55 C82 201.74 140.08 69.27 C82 202.77 160.90 69.67 C82 203.57 160.90 69.67 C82 201.74 140.78 86.92 C84 201.74 140.78 69.22 C81 201.74 140.78 69.22 C41 201.74 142.90	BHC	370.00	258.20	111.80
RHA 327.52 228.55 98.97 RMC 339.95 237.23 102.72 RMB 330.88 230.88 99.97 RMA 323.26 225.58 97.68 RLB 299.57 209.05 90.52 RLA 226.557 178.34 77.23 SE3 374.73 261.50 113.23 SE4 228.65 717.8,34 77.23 SE4 286.83 197.96 85.72 SE4 283.68 197.96 85.72 SE4 283.68 197.96 85.72 SE5 263.96 184.20 79.66 SSA 263.96 184.20 79.67 SSA 263.96 184.20 79.67 C2 220.57 160.90 69.67 C2 220.57 160.90 69.67 C2 220.57 178.34 78.28 SSA 220.57 160.90 69.67 C2 220.57 160.90 69.67 C2 220.57 160.90	BHB	353.31	246.55	106.76
RMC 339.95 237.23 102.72 RMB 330.85 230.88 99.97 RMA 332.66 225.58 97.68 RLA 299.57 209.05 90.52 SE3 374.73 261.50 113.23 SE4 318.58 222.31 96.27 SE5 374.73 261.50 113.23 SE4 318.58 222.31 96.27 SSE 279.13 194.79 84.34 SSB 265.96 184.20 77.83 SSC 279.13 194.79 84.34 SSB 263.06 184.20 79.76 SSA 263.96 184.20 79.76 SSB 263.33 176.78 76.55 C2 220.06 158.44 69.22 CA1 283.99 61.88 204.78 44.29 61.88 IB1 204.78 142.90 61.88 61.82 72.48 IB2 204.78 142.90 61.88 61.82 72.48 63.62 74.83 63.62	BHA		228.55	98.97
RMB 330.85 230.88 99.97 RMA 323.26 225.58 97.68 RLB 299.57 209.05 90.52 RLA 255.57 178.34 77.23 SE3 374.73 261.50 1132.32 SE4 318.58 222.31 96.27 SE4 318.58 222.31 96.27 SSC 283.66 197.96 86.57 SSC 283.66 184.20 73.76 SSA 263.96 184.20 73.76 SSA 255.40 181.02 78.38 CC2 277.61 193.72 83.89 CC3 241.20 168.32 72.88 CB1 203.67 160.90 69.67 CA2 229.06 159.84 69.22 CA1 213.88 149.25 64.43 IB2 204.78 142.90 61.88 B2 204.78 142.90 61.88 B4 197.19 137.61 59.58 IB2 204.78 142.90	RMC		237.23	102.72
RMA 323.26 225.58 97.68 RLB 299.57 209.05 90.52 SE3 255.57 178.34 77.23 SE3 374.73 261.50 113.23 SE2 318.58 222.31 96.27 SSC 279.13 194.79 84.34 SSB 263.96 184.20 79.76 SSA 263.96 184.20 79.76 SSA 263.96 184.20 78.38 CC2 259.40 181.02 78.38 CC2 253.33 176.78 76.83 CSB 241.20 168.32 72.88 C21 283.68 149.25 64.63 C22 20.61 159.84 69.67 CA2 213.88 149.25 64.63 IB2 20.57 160.90 66.67 CA1 20.57 160.90 66.67 CA2 213.88 149.25 64.63 IB2 20.57 150.90 65.92 IA1 20.57 160.96 <td< th=""><th>RMB</th><td></td><td>230.88</td><td>99.97</td></td<>	RMB		230.88	99.97
RLB 299.57 209.05 90.52 RLA 255.57 178.34 77.23 SE3 374.73 261.50 113.23 SE2 318.58 222.31 96.27 SSC 279.13 194.79 84.34 SSB 279.13 194.79 84.34 SSB 279.13 194.79 84.34 SC2 277.61 193.72 83.89 CC2 277.61 193.72 83.89 CC1 283.33 176.78 76.55 CR2 241.20 168.32 72.86 CB1 203.57 160.90 66.92 CA2 229.06 159.84 69.22 CA1 201.74 140.78 60.96 RL2 185.05 129.13 55.92 PA 201.74 140.78 60.96 R42 201.74 140.78 60.96 R42 201.74 140.78 60.96 R42 203.26 141.84 61.42 B1 201.74 140.78	RMA		225.58	97.68
RLA 255 57 178.34 7723 SE3 374.73 261.50 113.23 SE2 318.58 222.31 96.27 SE1 283.68 197.96 85.7 SSC 283.68 197.96 85.7 SSA 263.96 184.20 79.63 SSA 263.96 184.20 79.78.38 CC2 277.61 193.72 83.89 CC2 225.33 176.78 76.55 CB2 229.06 159.84 69.27 CA2 229.06 159.84 69.27 CA2 229.06 159.84 69.27 CA2 229.06 159.84 69.27 CA1 229.06 159.84 69.27 RLA 241.20 168.32 72.48 CB1 201.74 140.78 60.96 IA2 177.46 123.84 169.25 IA1 201.74 140.78 60.96 IA2 185.05 129.13 55.26 IA1 201.74 140.78	RLB	299.57	209.05	90.52
SE3 374.73 261.50 113.23 SE2 318.58 222.31 96.27 SSC 279.13 194.79 84.34 SSB 263.96 184.20 79.76 SSA 259.40 181.02 78.38 CC2 277.61 193.72 83.89 CC3 259.40 181.02 78.38 CC4 253.33 176.78 776.55 CA2 229.06 159.84 69.22 CA1 229.06 159.84 69.22 CA1 229.06 159.84 60.92 CA1 229.06 159.84 60.92 CA1 201.74 140.78 60.96 I82 201.74 140.78 60.96 IA2 185.05 129.13 55.92 IA1 201.74 140.78 60.96 IA2 185.05 129.13 55.92 IA1 201.74 140.78 60.96 IA2 185.05 129.13 55.92 IA1 201.74 140.78	RLA		178.34	77.23
SE2 318.58 222.31 96.27 SE1 283.68 197.96 85.72 SSC 279.13 194.79 84.34 SSB 263.96 184.20 79.76 SSA 259.40 181.02 78.38 CC2 277.61 193.72 83.89 CC1 263.96 184.20 76.75 CB2 277.61 193.72 83.89 CC2 241.20 168.32 72.88 CB2 230.57 160.90 69.67 CA2 213.88 149.25 64.63 IB2 213.88 149.25 64.63 IB2 204.78 142.90 61.88 IB1 201.74 140.78 60.96 IA2 177.46 123.84 53.62 IA1 201.74 140.78 60.96 IB2 201.74 140.78 60.96 IB2 201.74 140.78 60.96 IB2 201.74 140.78 60.96 IB2 201.74 145.75	SE3		261.50	113.23
SE1 283.68 197.96 85.72 SSC 279.13 194.79 84.34 SSB 263.96 184.20 77.66 SSA 259.40 181.02 78.38 CC2 277.61 193.72 83.89 CC1 253.33 176.78 77.65 CB2 241.20 168.32 72.88 CB1 229.06 159.84 69.67 CA2 229.06 159.84 69.25 CA1 229.06 159.84 69.22 CA1 213.88 149.25 64.63 IB2 201.74 140.78 60.96 IA2 203.57 160.90 69.67 IB2 201.74 140.78 69.66 IB2 201.74 140.78 69.66 IB2 201.74 140.78 69.66 IB2 203.26 141.84 61.42 IB3 197.19 137.61 55.86 IB4 177.46 123.84 51.62 IB4 197.19 137.61	SE2		222.31	96.27
SSC 279.13 194.79 84.34 SSB 263.96 184.20 79.76 SSA 263.96 184.20 78.38 CC2 277.61 193.72 88.89 CC1 253.33 176.78 76.55 CB2 241.20 168.32 72.88 CB1 230.57 160.90 69.67 CA2 229.06 159.84 69.22 CA1 213.88 149.25 64.63 IB2 204.78 142.90 61.88 IB1 201.74 140.78 60.96 IA2 185.05 129.13 55.92 IA1 177.46 123.84 51.62 IB2 202.6 141.84 61.42 BB1 197.19 137.61 59.58 BA2 197.19 137.61	SE1		197.96	85.72
SSB 263.96 184.20 79.76 SSA 259.40 181.02 78.38 2CC 253.33 176.78 76.55 CB2 241.20 168.32 72.88 CB1 229.06 159.84 69.22 CA1 213.88 149.25 64.63 IB2 201.74 140.78 60.96 CA1 213.88 149.25 64.63 IB2 201.74 140.78 60.96 IA2 185.05 129.13 55.92 IA1 185.05 129.13 55.92 IA1 185.05 129.13 55.92 IA1 197.19 137.61 59.58 BB2 203.26 141.84 61.42 BB1 197.19 137.61 59.56 BA2 197.19 137.61 59.56 PE1 210.85 147.14 63.71 PE2 216.92 151.37 65.55 PD1 207.81 145.02 62.79 PC2 202.33 139.73	SSC		194.79	84.34
SSA 259.40 181.02 78.38 CC2 277.61 193.72 83.89 CC1 253.33 176.78 76.55 CB2 241.20 168.32 72.88 CB1 230.57 160.90 69.67 CA2 229.06 159.84 69.22 CA1 213.88 149.25 64.63 IB2 204.78 142.90 61.88 IB1 201.74 140.78 60.96 IA1 177.46 123.84 53.62 IA2 185.05 129.13 55.92 IA1 177.46 123.84 53.62 IA2 177.46 123.84 53.62 IB3 197.19 137.61 59.58 BB2 203.26 141.84 61.42 BB4 197.19 137.61 59.54 BA2 138.53 128.07 55.46 BA1 21.47 154.55 66.92 PE1 21.47 154.55 66.92 PD2 21.47 154.55 <t< th=""><th>SSB</th><td></td><td>184.20</td><td>79.76</td></t<>	SSB		184.20	79.76
CC2 277.61 193.72 83.89 CC1 253.33 176.78 76.55 CB2 230.57 160.90 69.67 CA1 229.06 159.84 69.22 CA1 213.88 149.25 64.63 IB2 204.78 142.90 61.88 201.74 140.78 60.96 IA2 185.05 129.13 55.92 IA1 177.46 123.84 61.42 BB1 203.26 141.84 61.42 BB2 203.26 141.84 61.42 BA1 197.19 137.61 59.58 BA2 216.92 151.37 65.55 PE2 216.92 151.37 65.55 PD2 210.85 147.14 63.71 PD1 200.23 139.73 60.50 PC2 200.23 139.73 60.50 PC1 200.23 139.73 60.50 PC1 200.23 139.73 60.50 PC1 200.23 139.73 60.50	SSA		181.02	78.38
CC1 253.33 176.78 76.55 CB2 241.20 168.32 72.88 CA2 230.57 160.90 69.67 CA2 213.88 149.25 64.63 IB2 204.78 142.90 61.88 IB1 201.74 140.78 60.96 IA2 185.05 129.13 55.92 IA1 177.46 123.84 63.62 IB2 197.19 137.61 59.58 IB2 202.26 141.84 61.42 IB3.53 128.07 55.46 IB4 177.19 137.61 59.58 IB4 171.39 119.60 51.79 IB4 171.39 119.60 51.79 IB4 171.39 119.60 51.79 IB4 145.02 62.79 62.55 PE1 210.85 147.14 63.71 PD1 200.23 139.73 65.55 PD2 20.23 139.73 65.55 PC2 20.23 139.73 65.55 </th <th>CC2</th> <td> 277.61</td> <td>193.72</td> <td>83.89</td>	CC2	277.61	193.72	83.89
CB2 241.20 168.32 72.88 CB1 230.57 160.90 69.67 CA2 229.06 159.84 69.22 CA1 213.88 149.25 64.63 IB2 204.78 142.90 61.88 IB2 185.05 129.13 55.92 IA2 185.05 129.13 55.92 IA1 185.05 129.13 55.92 IA1 185.05 129.13 55.92 IA1 187.746 123.84 53.62 BB2 203.26 141.84 61.42 BB1 197.19 137.61 59.58 BA2 183.53 128.07 55.46 BA2 183.53 128.07 55.46 BA1 197.19 137.61 59.58 PE1 21.47 154.55 66.92 PE1 21.47 154.55 66.92 PD2 20.23 139.73 60.50 PC2 20.23 139.73 60.50 PC2 20.23 139.73 <td< th=""><th>CC1</th><td> 253.33</td><td>176.78</td><td>76.55</td></td<>	CC1	253.33	176.78	76.55
CB1 230.57 160.90 69.67 CA2 229.06 159.84 69.22 CA1 213.88 149.25 64.63 IB2 204.78 142.90 61.88 IB1 201.74 140.78 60.96 IA2 185.05 129.13 55.92 IA1 177.46 123.84 53.62 BB2 203.26 141.84 61.42 BB1 197.19 137.61 59.58 BA2 183.53 128.07 55.46 BA1 197.19 137.61 59.58 BA2 171.39 119.60 51.79 PE2 221.47 154.55 66.92 PE1 216.92 151.37 65.55 PD2 210.85 147.14 63.71 PD1 207.81 145.02 62.79 PC2 200.23 139.73 60.50 PC1 197.19 137.61 59.58 PB2 197.19 137.61 59.58 PB2 197.19 137.61	CB2		168.32	72.88
CA2 229.06 159.84 69.22 CA1 213.88 149.25 64.63 IB2 204.78 142.90 61.88 1B1 201.74 140.78 60.96 IA2 185.05 129.13 55.92 IA1 177.46 123.84 53.62 BB2 203.26 141.84 61.42 BB1 197.19 137.61 59.58 BA2 197.19 137.61 59.58 BA1 171.39 119.60 51.79 PE1 216.92 151.37 65.55 PD2 210.85 147.14 63.71 PD1 207.81 145.02 62.79 PC2 200.23 139.73 60.50 PC1 207.81 145.02 62.79 PD2 200.23 139.73 60.50 PC2 200.23 139.73 60.50 PC3 197.19 137.61 59.58 PB2 175.95 122.78 53.17 PB4 174.43 121.72	CB1	230.57	160.90	69.67
CA1 213.88 149.25 64.63 IB2 204.78 142.90 61.88 1B1 201.74 140.78 60.96 1A2 185.05 129.13 55.92 IA1 177.46 123.84 53.62 BB2 203.26 141.84 61.42 BB1 197.19 137.61 59.58 BA2 197.19 137.61 59.58 BA1 171.39 119.60 51.79 PE2 221.47 154.55 66.92 PE1 207.81 145.02 62.79 PD2 201.85 147.14 63.71 PD1 207.81 145.02 62.79 PC2 200.23 139.73 60.50 PC1 207.81 145.02 62.79 PD2 200.23 139.73 60.50 PC2 200.23 139.73 60.50 PC1 207.81 145.02 62.79 PD2 200.23 139.73 60.50 PB2 175.95 122.78	CA2	229.06	159.84	69.22
IB2 204.78 142.90 61.88 IB1 201.74 140.78 60.96 IA2 185.05 129.13 55.92 IA1 177.46 123.84 53.62 BB2 203.26 141.84 61.42 BB1 197.19 137.61 59.58 BA2 183.53 128.07 55.46 BA1 171.39 119.60 51.79 PE2 221.47 154.55 66.92 PE1 216.92 151.37 65.55 PD2 210.85 147.14 63.71 PD1 207.81 145.02 62.79 PC2 200.23 139.73 60.50 PC1 197.19 137.61 59.58 PB2 197.19 137.61 59.58 PC2 200.23 139.73 60.50 PC1 197.19 137.61 59.58 PB2 175.95 122.78 53.17 PB1 174.43 121.72 52.71 PA2 172.91 120.66	CA1		149.25	64.63
IB1 201.74 140.78 60.96 IA2 185.05 129.13 55.92 IA1 177.46 123.84 53.62 BB2 203.26 141.84 61.42 BB1 197.19 137.61 59.58 BA2 197.19 137.61 59.58 BA1 171.39 119.60 51.79 PE2 221.47 154.55 66.92 PE1 216.92 151.37 65.55 PD2 210.85 147.14 63.71 PD1 200.23 139.73 60.50 PC2 200.23 139.73 60.50 PC1 207.81 145.02 62.79 PC2 200.23 139.73 60.50 PC1 207.81 145.02 62.79 PC2 197.19 137.61 59.58 PB2 175.95 122.78 53.17 PB1 174.43 121.72 52.71 PA2 172.91 120.66 52.25 PA1 168.36 117.49	IB2		142.90	61.88
IA2 185.05 129.13 55.92 IA1 177.46 123.84 53.62 BB2 203.26 141.84 61.42 BB1 197.19 137.61 59.58 BA2 197.19 137.61 59.58 BA1 177.46 123.84 61.42 BA1 197.19 137.61 59.58 BA1 210.85 128.07 55.46 BA1 214.7 154.55 66.92 PE1 216.92 151.37 65.55 PD2 210.85 147.14 63.71 PD1 207.81 145.02 62.79 PC2 202.3 139.73 60.50 PC1 207.81 145.02 62.79 PC2 200.23 139.73 60.50 PC1 197.19 137.61 59.58 PB2 175.95 122.78 53.17 PB1 174.43 121.72 52.71 PA2 172.91 120.66 52.25 PA1 168.36 117.49 <	IB1	201.74	140.78	60.96
IA1 177.46 123.84 53.62 BB2 203.26 141.84 61.42 BB1 197.19 137.61 59.58 BA2 183.53 128.07 55.46 BA1 171.39 119.60 51.79 PE2 221.47 154.55 66.92 PE1 216.92 151.37 65.55 PD2 200.23 139.73 60.50 PC2 200.23 139.73 60.50 PC1 197.19 137.61 59.58 PB2 197.19 137.61 59.58 PB4 197.19 137.61 59.58 PB2 197.19 137.61 59.58 PB2 197.19 137.61 59.58 PB2 175.95 122.78 53.17 PB1 174.43 121.72 52.71 PA2 172.91 120.66 52.25 PA1 168.36 117.49 50.87	IA2	185.05	129.13	55.92
BB2 203.26 141.84 61.42 BB1 197.19 137.61 59.58 BA2 183.53 128.07 55.46 BA1 171.39 119.60 51.79 PE2 221.47 154.55 66.92 PE1 216.92 151.37 65.55 PD1 207.81 1445.02 62.79 PC2 200.23 139.73 60.50 PC1 197.19 137.61 59.58 PB2 175.95 122.78 53.17 PB4 175.95 122.78 53.17 PA2 172.91 120.66 52.25 PA1 168.36 117.49 50.87	IA1	177.46	123.84	53.62
BB1 197.19 137.61 59.58 BA2 183.53 128.07 55.46 BA1 171.39 119.60 51.79 PE2 221.47 154.55 66.92 PE1 216.92 151.37 65.55 PD2 210.85 147.14 63.71 PD1 200.23 139.73 60.50 PC1 197.19 137.61 59.58 PB2 197.19 137.61 59.58 PA2 175.95 122.78 53.17 PA2 172.91 120.66 52.25 PA1 168.36 117.49 50.87	BB2	203.26	141.84	61.42
BA2 183.53 128.07 55.46 BA1 171.39 119.60 51.79 PE2 221.47 154.55 66.92 PE1 216.92 151.37 65.55 PD2 207.81 145.02 62.79 PC2 200.23 139.73 60.50 PC1 197.19 137.61 59.58 PB2 175.95 122.78 53.17 PB1 174.43 121.72 52.71 PA2 172.91 120.66 52.25 PA1 06.36 117.49 50.87	BB1	197.19	137.61	59.58
BA1 171.39 119.60 51.79 PE2 221.47 154.55 66.92 PE1 216.92 151.37 65.55 PD2 20.85 147.14 63.71 PC1 207.81 145.02 62.79 PC1 200.23 139.73 60.55 PB2 197.19 137.61 59.58 PB2 175.95 122.78 53.17 PB1 174.43 121.72 52.71 PA2 172.91 120.66 52.25 PA1 0.68.36 117.49 50.87	BA2	183.53	128.07	55.46
PE2 221.47 154.55 66.92 PE1 216.92 151.37 65.55 PD2 210.85 147.14 63.71 PD1 207.81 145.02 62.79 PC2 200.23 139.73 60.50 PP1 197.19 137.61 59.58 PB2 175.95 122.78 53.17 PB1 174.43 121.72 52.71 PA2 172.91 120.66 52.25 PA1 168.36 117.49 50.87	BA1	171.39	119.60	51.79
PE1 216.92 151.37 65.55 PD2 210.85 147.14 63.71 PD1 207.81 145.02 62.79 PC2 200.23 139.73 60.50 PC1 197.19 137.61 59.58 PB2 175.95 122.78 53.17 PB1 174.43 121.72 52.71 PA2 172.91 120.66 52.25 PA1 168.36 117.49 50.87	PE2	221.47	154.55	66.92
PD2 210.85 147.14 63.71 PD1 207.81 145.02 62.79 PC2 200.23 139.73 60.50 PC1 197.19 137.61 59.58 PB2 175.95 122.78 53.17 PB1 174.43 121.72 52.71 PA2 172.91 120.66 52.25 PA1 168.36 117.49 50.87	PE1	216.92	151.37	65.55
PD1 207.81 145.02 62.79 PC2 200.23 139.73 60.50 PC1 197.19 137.61 59.58 PB2 175.95 122.78 53.17 PB1 174.43 121.72 52.71 PA2 172.91 120.66 52.25 PA1 168.36 117.49 50.87	PD2	210.85	147.14	63.71
PC2 200.23 139.73 60.50 PC1 197.19 137.61 59.58 PB2 175.95 122.78 53.17 PB1 174.43 121.72 52.71 PA2 172.91 120.66 52.25 PA1 168.36 117.49 50.87	PD1	207.81	145.02	62.79
PC1 197.19 137.61 59.58 PB2 175.95 122.78 53.17 PB1 174.43 121.72 52.71 PA2 172.91 120.66 52.25 PA1 168.36 117.49 50.87	PC2	200.23	139.73	60.50
PB2 175.95 122.78 53.17 PB1 174.43 121.72 52.71 PA2 172.91 120.66 52.25 PA1 168.36 117.49 50.87	PC1	197.19	137.61	59.58
PB1 174.43 121.72 52.71 PA2 172.91 120.66 52.25 PA1 168.36 117.49 50.87	PB2	175.95	122.78	53.17
PA2 172.91 120.66 52.25 PA1 168.36 117.49 50.87	PB1	174.43	121.72	52.71
PA1 168.36 117.49 50.87	PA2	172.91	120.66	52.25
	PA1	168.36	117.49	50.87

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

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

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

	RUG-III category	Total rate	Labor portion	Non-labor portion
RMX		460.15	321.11	139.04
RMI		423.91	295.82	128.09
RIX		325.45	227 11	98.34
BUC		560.98	391.47	169 51
RUB		518 94	362 13	156.81
RUA		497 19	346.95	150.24
RVC		443.02	309 15	133.87
RVR		422 73	294.99	100.07
RVA		383 50	267.68	115.01
BHC		370.62	26/ 01	11/ 71
		262.62	204.31	100.90
		220.02	233.79	109.09
		247.09	230.39	102.44
		347.00	242.20	104.00
		001.00	230.13	102.25
		331.13	231.07	100.06
RLB		300.81	209.91	90.90
RLA		258.76	180.57	/8.19
SE3		364.59	254.42	110.17
SE2		310.96	217.00	93.96
SE1		277.61	193.72	83.89
SSC		273.26	190.69	82.57
SSB		258.77	180.58	78.19
SSA		254.42	177.54	76.88
CC2		271.81	189.68	82.13
CC1		248.62	173.49	75.13
CB2		237.02	165.40	71.62
CB1		226.87	158.32	68.55
CA2		225.42	157.30	68.12
CA1		210.93	147.19	63.74
IB2 .		202.23	141.12	61.11
IB1 .		199.33	139.10	60.23
IA2 .		183.38	127.97	55.41
IA1 .		176.13	122.91	53.22
BB2		200.78	140.11	60.67
BB1		194.98	136.06	58.92
BA2		181.93	126.96	54.97
BA1		170.33	118.86	51.47
PE2		218.17	152.25	65.92
PE1		213.83	149.22	64.61
PD2		208.03	145.17	62.86
PD1		205.13	143.15	61.98
PC2		197.88	138.09	59.79
PC1		194.98	136.06	58.92
PB2		174.68	121.90	52.78
PB1		173.23	120.89	52.34
PA2		171 78	119.87	51 91
PA1		167 44	116.84	50 60
1 7 1		107.44	110.04	55.00

Section 1888(e)(4)(G)(ii) of the Act also requires that we apply this wage index in a manner that does not result in aggregate payments that are greater or less than would otherwise be made in the absence of the wage adjustment. For FY 2009 (Federal rates effective October 1, 2008), we apply an adjustment to fulfill the budget neutrality requirement. We meet this requirement by multiplying each of the components of the unadjusted Federal rates by a budget neutrality factor equal to the ratio of the weighted average wage adjustment factor for FY 2008 to the weighted average wage adjustment factor for FY 2009. For this calculation, we use the same 2006 claims utilization data for

both the numerator and denominator of this ratio. We define the wage adjustment factor used in this calculation as the labor share of the rate component multiplied by the wage index plus the non-labor share of the rate component. The final budget neutrality factor for this year is 1.0009. The wage index applicable to FY 2009 appears in Tables 8 and 9, which are included in the Addendum of this final rule.

In the FY 2006 SNF PPS final rule (70 FR 45026, August 4, 2005), we adopted the changes discussed in the Office of Management and Budget (OMB) Bulletin No. 03–04 (June 6, 2003), available online at *http://*

www.whitehouse.gov/omb/bulletins/ b03-04.html, which announced revised definitions for Metropolitan Statistical Areas (MSAs), and the creation of Micropolitan Statistical Areas and Combined Statistical Areas. In addition, OMB published subsequent bulletins regarding CBSA changes, including changes in CBSA numbers and titles. As indicated in the FY 2008 SNF PPS final rule (72 FR 43423, August 3, 2007), this and all subsequent SNF PPS rules and notices are considered to incorporate the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage data used to determine the current SNF PPS wage index. The OMB bulletins may be

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

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

4. Updates to the Federal Rates

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

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

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

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

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

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

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

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

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

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

7. Other Issues

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

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

The SNF PPS proposed rule for FY 2009 (73 FR 25930, May 7, 2008) included a more detailed discussion of the current status of the STRIVE project. Specific comments on this issue, and our responses to those comments, are as follows: *Comment:* Specifically referencing the STRIVE Technical Expert Panel (TEP) described in the proposed rule, one commenter expressed concern about whether registered nurses (RNs) have been adequately represented in the STRIVE process.

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

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

Response: STRIVE collected all nursing staff time over 2 days using personal digital assistants (PDAs). In each PDA, the name of each nursing staff member was linked to his or her individual job title (including RN, LPN, and CNA). STRIVE does not represent the first instance in which CMS (or, rather, its predecessor, HCFA) has separately tracked different nursing staff positions as it collected time data. In the FY 2006 refinements that added nine new RUG categories, CMS calculated case-mix indexes based on nursing staff time collected in the prior time studies. That data accounted for three different disciplines: RNs, LPNs, and Aides. In fact, CMS published on its Web site a spreadsheet containing populationweighted time for each of those three positions. These data appear on the RUG refinement page of the SNF PPS Web site: http://www.cms.hhs.gov/ SNFPPS/09_RUG

Refinement.asp#TopOfPage. Under "Downloads" near the bottom of the page, that data can be unzipped after linking to Unadjusted nursing weights [Zip, 15kb].

b. Minimum Data Set (MDS) 3.0

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

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

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

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

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

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

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

c. Integrated Post Acute Care Payment

In the proposed rule, we discussed our ongoing examination of possible steps toward achieving a more seamless system for the delivery and payment of

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

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

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

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

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

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

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

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

Response: We appreciate the commenters' thoughtful input about application of the principal embodied in the IPPS HAC payment provision to the SNF setting. While we acknowledge that infections, dementia, and falls are among the selected HACs in the IPPS acute care setting that potentially have relevance for the SNF setting as well, we agree that these and other conditions may have different implications in the SNF setting. We agree with the commenters that it would be unfair to penalize a SNF financially for a condition that developed in another care setting. We note that the IPPS HAC payment provision uses Present on Admission (POA) indicator data to exclude from payment those conditions that develop outside of the IPPS acute

care stay, and a similar mechanism would be needed to apply this type of payment provision to the SNF setting should such an approach be adopted there. Regarding the commenters' concerns about the difficulty of determining which adverse events are "reasonably preventable," we would expect to work closely with stakeholders to determine which conditions could reasonably be prevented through the application of evidence-based guidelines. With regard to the comments that questioned the existing legal authority for expanding the HAC payment provision beyond the IPPS hospital setting, we note that in this final rule, we are not establishing any new Medicare policies in this area. However, we will keep the commenters' concerns in mind as our implementation of VBP for all Medicare payment systems proceeds. We look forward to working with stakeholders in continuing to explore possible ways to reduce the occurrence of these preventable conditions in various care settings. Finally, we note that in addition to the comments on those aspects of PAC payment reform and VBP that we discussed in the proposed rule, we also received some comments on the current Nursing Home VBP Demonstration (referenced previously in the SNF PPS update notice for FY 2007 (71 FR 43172, July 31, 2006); however, those comments, which offered specific suggestions about the design and conduct of the demonstration, are beyond the scope of this rulemaking.

8. Miscellaneous Technical Corrections and Clarifications

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

a. Bad Debt Payments

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

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

b. Additional Clarifications

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

• The circumstances under which a SNF is paid at the "default rate," a reduced payment made in lieu of the full SNF PPS rate that would have been payable had the SNF's resident been assessed in a timely manner; and

• The role of rehabilitation services evaluations in SNFs. The comments that we received, and

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

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

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

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

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

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

• When the stay is less than 8 days within a spell of illness (that is, benefit period);

• The SNF is notified on an untimely basis or is unaware of a Medicare Secondary Payer denial;

• The SNF is notified on an untimely basis of the revocation of a payment ban;

• The beneficiary requests a demand bill; or,

• The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage program.

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

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

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

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

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

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

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

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

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

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

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

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

Comment: One commenter wanted to know, if a SNF can demonstrate that an ARD was determined on a document other than the MDS, whether the SNF could use such documentation to "set" the ARD in order to avoid payment at the default rate. *Response:* It is not acceptable to backdate an MDS or to use any documentation other than the MDS itself to establish the ARD.

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

Response: In situations where the SNF fails to assess the beneficiary and fails to issue the proper Notification of Non-Coverage, the SNF is liable for all services normally covered under the Medicare Part A benefit. Since the beneficiary is receiving benefits, the days will be considered Part A days and charged against the beneficiary's benefit period. The SNF may collect any applicable copayment amounts. Services that would have been payable to the SNF as Part A benefits cannot be billed to either the FI or the carrier as Part B services. *Comment:* A commenter questioned why CMS was issuing a technical clarification regarding the requirement for a therapy evaluation before therapy minutes can be counted in Section P and Section T of the MDS. The commenter was concerned that while the proposed change appears to be consistent with the practices of its therapy members, questions have been raised as to whether in making this clarification, CMS inadvertently may be changing the instructions for Subpart T as they relate to projected therapy services.

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

IV. The Skilled Nursing Facility Market Basket Index

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

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

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

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

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

A. Use of the Skilled Nursing Facility Market Basket Percentage

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

transition period from facility-specific to full Federal rates that started with cost reporting periods beginning in July 1998 has expired.

B. Market Basket Forecast Error Adjustment

As discussed in the FY 2004 supplemental proposed rule (68 FR 34768, June 10, 2003) and finalized in the FY 2004 final rule (68 FR 46067, August 4, 2003), regulations at §413.337(d)(2) provide for an adjustment to account for market basket forecast error. The initial adjustment applied to the update of the FY 2003 rate for FY 2004, and took into account the cumulative forecast error for the period from FY 2000 through FY 2002. Subsequent adjustments in succeeding FYs take into account the forecast error from the most recently available FY for which there is final data, and apply whenever the difference between the

forecasted and actual change in the market basket exceeds a specified threshold. We originally used a 0.25 percentage point threshold for this purpose; however, for the reasons specified in the FY 2008 SNF PPS final rule (72 FR 43425, August 3, 2007), we adopted a 0.5 percentage point threshold effective with FY 2008. As discussed previously in section I.F.2. of this final rule, as the difference between the estimated and actual amounts of increase in the market basket index for FY 2007 (the most recently available FY for which there is final data) does not exceed the 0.5 percentage point threshold, the payment rates for FY 2009 do not include a forecast error adjustment.

The following is a specific comment that we received on the market basket forecast error adjustment, and our response: *Comment:* A few commenters suggested that CMS apply a cumulative forecast error to account for all of the variations in the market basket forecasts since FY 2004 (that is, as of when CMS implemented the market basket forecast error correction policy.)

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

C. Federal Rate Update Factor

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

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

V. Consolidated Billing

Section 4432(b) of the BBA established a consolidated billing requirement that places with the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive, except for a small number of services that the statute specifically identifies as being excluded from this provision. Section 103 of the BBRA amended this provision by further excluding a number of individual "high-cost, low-probability" services, identified by the Healthcare Common Procedure Coding System

(HCPCS) codes, within several broader categories (chemotherapy and its administration, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA amendment in greater detail in the FY 2001 SNF PPS proposed rule (65 FR 19231 through 19232, April 10, 2000), and the FY 2001 SNF PPS final rule (65 FR 46790 through 46795, July 31, 2000), as well as in Program Memorandum AB-00-18 (Change Request #1070), issued March 2000, which is available online at http://www.cms.hhs.gov/ transmittals/downloads/ab001860.pdf.

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

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

To date, the Congress has enacted no further legislation affecting the consolidated billing provision. However, as noted above and explained in the FY 2001 SNF PPS proposed rule (65 FR 19232, April 10, 2000), the amendments enacted in section 103 of the BBRA not only identified for exclusion from this provision a number of particular service codes within four specified categories (that is, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices), but also gave the Secretary "* * * the authority to designate additional, individual services for exclusion within each of the specified service categories." In the FY 2001 SNF PPS proposed rule, we also noted that the BBRA Conference report (H.R. Rep. No. 106-479 at 854 (1999) (Conf. Rep.)) characterizes the individual services

that this legislation targets for exclusion as, "* * high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment [SNFs] receive under the prospective payment system* * *." According to the conferees, section 103(a) "* * * is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs * * * For example, * * * chemotherapy drugs [that] are not typically administered in a SNF, or are exceptionally expensive, or are given as infusions, thus requiring special staff expertise to administer." By contrast, we noted that the Congress declined to designate for exclusion any of the remaining services within those four categories (thus leaving all of those services subject to SNF consolidated billing), because they "* * * are relatively inexpensive and are administered routinely in SNFs".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VII. Provisions of the Final Rule

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

• Revise the existing SNF PPS definitions of "urban" and "rural" areas that appear in § 413.333 to include updated cross-references to the corresponding IPPS definitions in Part 412, subpart D.

• Make a technical revision at § 413.335(b) to reflect Medicare bad debt payments to SNFs.

VIII. Collection of Information Requirements

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

IX. Regulatory Impact Analysis

A. Overall Impact

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

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

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

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

This final rule updates the SNF PPS rates published in the FY 2008 SNF PPS final rule (72 FR 43412, August 3, 2007) and the associated correction notices published on September 28, 2007 (72 FR 55085) and on November 30, 2007 (72 FR 67652), resulting in a net change in payments of an estimated \$780 million for FY 2009. As indicated in Table 12, the effect on facilities will be a net positive impact of 3.4 percent. We note that while all providers will experience an overall net increase in payments, some providers may experience larger increases than others due to the distributional impact of the FY 2009 wage indexes and the degree of Medicare utilization.

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

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

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

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

B. Anticipated Effects

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

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

In accordance with section 1888(e)(4)(E) of the Act, we update the payment rates for FY 2008 by a factor equal to the full market basket index percentage increase plus the FY 2007 forecast error adjustment to determine the payment rates for FY 2009. The special AIDS add-on established by section 511 of the MMA remains in effect until "* * * such date as the Secretary certifies that there is an appropriate adjustment in the case mix * *." We have not provided a separate impact analysis for this MMA provision. Our latest estimates indicate that there are less than 2,700 beneficiaries who qualify for the AIDS add-on payment. The impact on Medicare is included in the "total" column of Table 12. In updating the

rates for FY 2009, we made a number of standard annual revisions and clarifications mentioned elsewhere in this final rule (for example, the update to the wage and market basket indexes used for adjusting the Federal rates). These revisions would increase payments to SNFs by approximately \$780 million for FY 2009.

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

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

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

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

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

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

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

TABLE 12—PROJECTED IMPACT TO THE SNF PPS FOR FY 20	009
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	Number of facilities	Updated wage data (percent)	Total FY 2009 change (percent)
Total	15,373	0.0	3.4
Urban	10,497	0.0	3.4
Rural	4,876	0.0	3.4
Hospital based urban	1,528	-0.1	3.3
Freestanding urban	8,969	0.0	3.4
Hospital based rural	1,154	0.0	3.4
Freestanding rural	3,722	0.0	3.4
Urban by region:			
New England	840	0.2	3.6
Middle Atlantic	1,490	-0.5	2.9
South Atlantic	1,734	-0.3	3.1
East North Central	2,010	-0.5	2.9
East South Central	530	0.0	3.4
West North Central	827	0.6	4.0
West South Central	1,166	0.2	3.6
Mountain	472	0.0	3.4
Pacific	1,420	1.5	4.9
Outlying	8	0.6	4.0
Rural by region:			
New England	150	- 1.8	1.6
Middle Atlantic	257	-0.2	3.2
South Atlantic	603	0.0	3.4
East North Central	940	-0.6	2.8
East South Central	552	0.3	3.7
West North Central	1,144	0.5	4.0
West South Central	821	0.5	3.9
Mountain	259	-0.1	3.3
Pacific	148	1.1	4.5
Outlying	2	0.4	3.9
Ownership:			
Government	665	-0.1	3.3
Proprietary	11,286	0.0	3.4
Voluntary	3,422	-0.1	3.3

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

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

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

C. Alternatives Considered

Section 1888(e) of the Act establishes the SNF PPS for the payment of Medicare SNF services for cost reporting periods beginning on or after July 1, 1998. This section of the statute prescribes a detailed formula for calculating payment rates under the SNF PPS, and does not provide for the use of any alternative methodology. It specifies that the base year cost data to be used for computing the SNF PPS payment rates must be from FY 1995 (October 1, 1994, through September 30, 1995). In accordance with the statute, we also incorporated a number of elements into the SNF PPS (for example, case-mix classification methodology, the MDS assessment schedule, a market basket index, a wage index, and the urban and rural distinction used in the development or adjustment of the

Federal rates). Further, section 1888(e)(4)(H) of the Act specifically requires us to disseminate the payment rates for each new FY through the **Federal Register**, and to do so before the August 1 that precedes the start of the new FY. Accordingly, we are not pursuing alternatives with respect to the payment methodology as discussed above.

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

Although the 2001 data were the best source available at the time the FY 2006 refinements were introduced, the distribution of paid days, a key component in adjusting the RUG–53 case-mix weights, was based solely on estimated utilization. The 2006 data provide a more recent and a more accurate source of RUG–53 utilization based on actual utilization, and are an appropriate source to use for case-mix adjustment. However, in light of the potential ramifications of this proposal and the complexity of the issues involved, we believe that it would be prudent to take additional time to evaluate the proposal in order to further consider consequences that may result from it. Accordingly, we are not proceeding with the proposed recalibration at this time, pending further analysis. We note that as we continue to evaluate this issue, we fully expect to implement such an adjustment in the future.

D. Accounting Statement

As required by OMB Circular A–4 (available at *http://*

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

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

[In millions]

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

E. Conclusion

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

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

List of Subjects in 42 CFR Part 413

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

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

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

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

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

Subpart J—Prospective Payment for Skilled Nursing Facilities

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

§413.333 Definitions.

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

§413.335 [Amended]

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

§413.335 Basis of payment.

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

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

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

Dated: July 18, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: July 31, 2008.

Michael O. Leavitt,

Secretary.

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

Addendum—FY 2009 CBSA Wage Index Tables

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

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

CBSA code	Urban area (constituent counties)	Wage index
	Moca Municipio, PR	
	Rincón Municipio, PR	
10420	San Sebastian Municipio, PR	0.8017
10420	Portage County, OH	0.0917
	Summit County, OH	
10500	Albany, GA	0.8703
	Baker County, GA	
	Lee County, GA	
	Terrell County, GA	
10590	Worth County, GA	0.0707
10580	Albany County NY	0.8707
	Rensselaer County, NY	
	Saratoga County, NY	
	Schenectady County, NY	
10740	Albuquerque NM	0.9210
10740	Bernalillo County, NM	0.0210
	Sandoval County, NM	
	Torrance County, NM	
10780	Valencia County, NM Alexandria I A	0.8130
10700	Grant Parish, LA	0.0100
	Rapides Parish, LA	
10900	Allentown-Bethlehem-Easton, PA-NJ	0.9499
	Warren County, NJ	
	Lehigh County, PA	
	Northampton County, PA	
11020	Altoona, PA	0.8521
11100	Blair County, PA	0.0007
11100	Amarillo, TX	0.8927
	Carson County, TX	
	Potter County, TX	
11100	Randall County, TX	0.0407
11180	Ames, IA	0.9487
11260	Anchorage, AK	1.1931
	Anchorage Municipality, AK	
11000	Matanuska-Susitna Borough, AK	0.0700
11300	Anderson, IN	0.8760
11340	Anderson, SC	0.9570
	Anderson County, SC	
11460	Ann Arbor, MI	1.0445
11500	Washtenaw County, MI	0 7007
11500	Calhoun County Al	0.7927
11540	Appleton, WI	0.9440
	Calumet County, WI	
11700	Outagamie County, WI	0.0140
11700	Asneville, NC	0.9142
	Haywood County, NC	
	Henderson County, NC	
	Madison County, NC	
12020	Athens-Clarke County, GA	0.9591
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	
12060	Atlanta-Sandy Springs-Marietta, GA	0.9754
	Barrow County, GA	
	Bartow County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	i oob oounty, GA	1

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

CBSA code	Urban area (constituent counties)	Wage index
13460	Bend, OR	1.1375
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD	1.0548
13740	Montgomery County, MD Billings, MT Carbon County, MT	0.8805
13780	Yellowstone County, MT Binghamton, NY Broome County, NY	0.8574
13820	Tioga County, NY Birmingham-Hoover, AL Bibb County, Al	0.8792
	Blount County, AL Chilton County, AL	
	St. Clair County, AL Shelby County, AL	
13900	Walker County, AL Bismarck, ND Burleich County, ND	0.7148
13980	Morton County, ND Blacksburg-Christiansburg-Radford, VA	0.8155
	Giles County, VA Montgomery County, VA Pulaski County, VA	
14020	Radford City, VA Bloomington, IN Greene County, IN	0.8979
14060	Monroe County, IN Owen County, IN Bloomington-Normal, II	0 9323
14000	McLean County, IL	0.0020
14260	Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owvhee County, ID	0.9268
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA	1.1897
14500	Suttolk County, MA Boulder, CO	1.0302
14540	Boulder County, CO Bowling Green, KY Edmonson County, KY	0.8388
14600	Warren County, KY Bradenton-Sarasota-Venice, FL Manatee County, FL	0.9900
14740	Sarasota County, FL Bremerton-Silverdale, WA Kitsap County, WA	1.0770
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County. CT	1.2868
15180	Brownsville-Harlingen, TX Cameron County. TX	0.8916
15260	Brunswick, GA Brantley County, GA Glynn County, GA	0.9567
15380	McIntosh County, GA Buffalo-Niagara Falls, NY Erie County, NY	0.9537
15500	Niagara County, NY Burlington, NC	0.8736
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT	0.9254
15764	Grand Isle County, VT Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1086

CBSA code	Urban area (constituent counties)	Wage index
15804	Camden, NJ	1.0346
	Burlington County, NJ	
	Camden County, NJ	
15940	Canton-Massillon. OH	0.8841
	Carroll County, OH	
15000	Stark County, OH	0.0006
15980	Lee County, Fl	0.9396
16180	Carson City, NV	1.0128
	Carson Čity, NV	
16220	Casper, WY	0.9579
16300	Cedar Rapids, IA	0.8919
	Benton County, IA	
	Jones County, IA	
16580	Champaign-Urbana II	0.9461
10000	Champaign County, IL	0.0101
	Ford County, IL	
16620	Platt County, IL	0.9275
10020	Boone County. WV	0.0275
	Clay County, WV	
	Kanawha County, WV	
	Lincoln County, WV Butnam County, WV	
16700	Charleston-North Charleston-Summerville, SC	0.9209
	Berkeley County, SC	
	Charleston County, SC	
16740	Dorchester County, SC Charlotte-Gastonia-Concord NC-SC	0 9595
107 10	Anson County, NC	0.0000
	Cabarrus County, NC	
	Gaston County, NC	
	Union County, NC	
	York County, SC	
16820	Charlottesville, VA	0.9816
	Albemarie County, VA	
	Greene County, VA	
	Nelson County, VA	
16960	Charlottesville City, VA	0 0070
10000	Clatoosa County, GA	0.0070
	Dade County, GA	
	Walker County, GA	
	Hamilton County, TN Marion County, TN	
	Seguatchie County, TN	
16940	Cheyenne, WY	0.9276
10074	Laramie County, WY	1 0000
16974	Chicago-Naperville-Joliet, IL	1.0399
	DeKalb County, IL	
	DuPage County, IL	
	Grundy County, IL	
	Kane County, IL Kendall County, IL	
	McHenry County, IL	
	Will County, IL	
17020	Chico, CA	1.0897
17140	Duite County, CA Cincinnati-Middletown, OH-KY-IN	0.9687
	Dearborn County, IN	
	Franklin County, IN	
	Ohio County, IN Boong County, KX	
	Bracken County, KY	
	Campbell County, KY	
	Gallatin County, KY	

CBSA code	Urban area (constituent counties)	Wage index
	Grant County, KY	
	Kenton County, KY	
	Penaleton County, KY Brown County, OH	
	Brown County, OH Butler County, OH	
	Clermont County, OH	
	Hamilton County, OH	
17200	Warren County, OH	0 0000
17300	Christian County KY	0.8298
	Trig County, KY	
	Montgomery County, TN	
17100	Stewart County, TN	0.0040
17420	Cieveland, TN	0.8010
	Polk County, TN	
17460	Cleveland-Elyria-Mentor, OH	0.9241
	Cuyahoga County, OH	
	Geauga County, OH	
	Lorain County, OH	
	Medina County, OH	
17660	Coeur d'Alene, ID	0.9322
17700	Kootenai County, ID	0.0040
17780	College Station-Bryan, TX	0.9346
	Burleson County, TX	
	Robertson County, TX	
17820	Colorado Springs, CO	0.9977
	El Paso County, CO	
17860	Columbia. MO	0.8540
	Boone County, MO	
	Howard County, MO	
17900	Columbia, SC	0.8933
	Fairfield County, SC	
	Kershaw County, SC	
	Lexington County, SC	
	Richland County, SC	
17980	Saluda County, SC Columbus GA-Al	0.8739
17000	Russell County, AL	0.0700
	Chattahoochee County, GA	
	Harris County, GA	
	Manon County, GA Muscogee County, GA	
18020	Columbus, IN	0.9739
	Bartholomew County, IN	
18140	Columbus, OH	0.9943
	Delaware County, OH	
	Franklin County, OH	
	Licking County, OH	
	Madison County, OH	
	Morrow County, OH	
	Linion County, OH	
18580	Corpus Christi, TX	0.8598
	Aransas County, TX	
	Nueces County, TX	
19700	San Patricio County, TX	1 1 2 0 4
10/00	Benton County, OR	1.1304
19060	Cumberland, MD-WV	0.7816
	Allegany County, MD	
10104	Mineral County, WV	0.0045
19124	Collin County TX	0.9945
	Dallas County, TX	
	Delta County, TX	
	Denton County, TX	l

CBSA code	Urban area (constituent counties)	Wage index
	Ellis County, TX	
	Hunt County, TX Kaufman County, TX	
	Rockwall County, TX	
19140	Dalton, GA	0.8705
	Whitfield County, GA	
19180	Danville, IL	0.9374
19260	Vermilion County, IL Danville, VA	0.8395
10200	Pittsylvania County, VA	0.0000
10240	Danville City, VA	0.0405
19340	Henry County, IL	0.6435
	Mercer County, IL	
	Rock Island County, IL	
19380	Davton, OH	0.9203
	Greene County, OH	
	Miami County, OH	
	Preble County, OH	
19460	Decatur, AL	0.7803
	Lawrence County, AL Morgan County, AL	
19500	Decatur, IL	0.8145
	Macon County, IL	
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.8890
19740	Denver-Aurora, CO	1.0818
	Adams County, CO	
	Arapanoe County, CO Broomfield County, CO	
	Clear Creek County, CO	
	Denver County, CO	
	Douglas County, CO	
	Gilpin County, CO	
	Jefferson County, CO	
19780	Park County, CO Des Moines-West Des Moines IA	0 9535
10700	Dallas County, IA	0.0000
	Guthrie County, IA	
	Madison County, IA Polk County, IA	
	Warren County, IA	
19804	Detroit-Livonia-Dearborn, MI	0.9958
20020	Wayne County, MI Dothan Al	0 7613
20020	Geneva County, AL	
	Henry County, AL	
20100	Houston County, AL Dover DE	1 0325
	Kent County, DE	
20220	Dubuque, IA	0.8380
20260	Dubuque County, IA Duluth MN-WI	1 0363
_0_00	Carlton County, MN	
	St. Louis County, MN	
20500	Durbam, NC	0.9732
20000	Chatham County, NC	0.0702
	Durham County, NC	
	Person County, NC	
20740	Eau Claire, WI	0.9668
	Chippewa County, WI	
20764	Eau Claire County, WI Edison-New Brunswick NJ	1 1283
_0,0+	Middlesex County, NJ	1.1200
	Monmouth County, NJ	
	Ocean County, NJ	I

CBSA code	Urban area (constituent counties)	Wage index
	Somerset County, NJ	
20940	El Centro, CA	0.8746
21060	Elizabethtown, KY	0.8525
	Hardin County, KY	
21140	Larue County, KY Fikhart-Goshen, IN	0 9568
21110	Elkhart County, IN	0.0000
21300	Elmira, NY	0.8247
21340	El Paso, TX	0.8694
04500	El Paso County, TX	0.0740
21500	Erie, PA	0.8713
21660	Eugene-Springfield, OR	1.1061
01790	Lane County, OR	0 9600
21700	Gibson County, IN	0.8690
	Posey County, IN	
	Vanderburgh County, IN Warrick County, IN	
	Henderson County, KY	
01000	Webster County, KY	4 4 0 0 7
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1297
21940	Fajardo, PR	0.4061
	Ceiba Municipio, PR	
	Fajardo Municipio, PR	
22020	Fargo, ND-MN	0.8166
	Cass County, ND	
22140	Farmington, NM	0.8051
	San Juan County, NM	
22180	Fayetteville, NC	0.9340
	Hoke County, NC	
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8970
	Benton County, AR Madison County, AB	
	Washington County, AR	
00000	McDonald County, MO	1 17/9
22300	Coconino County, AZ	1.1743
22420	Flint, MI	1.1425
22500	Genesee County, MI	0.9120
22500	Darlington County, SC	0.0130
	Florence County, SC	
22520	Florence-Muscle Shoals, AL	0.7871
	Lauderdale County, AL	
22540	Fond du Lac, WI	0.9293
22660	Fond du Lac County, Wi Fort Collins-Loveland, CO	0.9867
	Larimer County, CO	0.0007
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	0.9946
22900	Fort Smith. AR-OK	0.7697
	Crawford County, AR	
	Franklin County, AR	
	Le Flore County, OK	
	Sequoyah County, OK	c
23020	Fort Walton Beach-Crestview-Destin, FL	0.8769
23060	Fort Wayne, IN	0.9176
	Allen County, IN	
	Weils County, IN Whitley County, IN	
23104	Fort Worth-Arlington, TX	0.9709
	Johnson County, TX	

CBSA code	Urban area (constituent counties)	Wage index
	Parker County, TX	
	Tarrant County, TX	
23420	Fresno, CA	1.1009
	Fresho County, CA	
23460	Gadsden, AL	0.7983
23540	Gainesville, FL	0.9312
	Alachua County, FL	
23580	Gilchrist County, FL	0.9109
20000	Hall County, GA	0.9109
23844	Gary, IN	0.9250
	Jasper County, IN	
	Newton County, IN	
0.4000	Porter County, IN	0.0470
24020	Giens Falls, NY	0.8473
	Washington County, NY	
24140	Goldsboro, NC	0.9143
24220	Grand Forks, ND-MN	0.7565
	Polk County, MN	
24200	Grand Forks County, ND	0.0910
24300	Mesa County. CO	0.9012
24340	Grand Rapids-Wyoming, MI	0.9184
	Barry County, MI	
	Kent County, MI	
	Newaygo County, MI	
24500	Great Falls, MT	0.8784
24540	Greeley, CO	0.9684
	Weld County, CO	
24580	Green Bay, WI	0.9709
	Kewaunee County, WI	
0.4000	Oconto County, WI	0.0014
24660	Greensboro-High Point, NC	0.9011
	Randolph County, NC	
04700	Rockingham County, NC	0.0449
24780	Greenville, NC	0.9448
	Pitt County, NC	
24860	Greenville-Mauldin-Easley, SC	0.9961
	Laurens County, SC	
	Pickens County, SC	
25020	Guayama, PR	0.3249
	Guavama Municipio, PR	
	Patillas Municipio, PR	
25060	Gulfport-Biloxi, MS	0.9029
	Harrison County, MS	
	Stone County, MS	
25180	Hagerstown-Martinsburg, MD-WV	0.8997
	Berkeley County, WV	
	Morgan County, WV	
25260	Hantord-Corcoran, CA	1.0870
25420	Harrisburg-Carlisle, PA	0.9153
	Cumberland County, PA	
	Dauphin County, PA	
25500	Harrisonburg, VA	0.8894
	Rockingham County, VA	
	Harrisonburg City, VA	I

CBSA code	Urban area (constituent counties)	Wage index
25540	Hartford-West Hartford-East Hartford, CT	1.1069
	Hartford County, CT Middlesex County, CT	
	Tolland County, CT	
25620	Hattiesburg, MS	0.7337
	Forrest County, MS Lamar County, MS	
	Perry County, MS	
25860	Hickory-Lenoir-Morganton, NC	0.8976
	Alexander County, NC Burke County, NC	
	Caldwell County, NC	
25090	Catawba County, NC	0.0110
25960	Liberty County. GA	0.9110
	Long County, GA	
26100	Holland-Grand Haven, MI	0.9008
26180	Honolulu, HI	1.1811
	Honolulu County, HI	
26300	Hot Springs, AK	0.9113
26380	Houma-Bayou Cane-Thibodaux, LA	0.7758
	Lafourche Parish, LA	
26420	Terrebonne Parish, LA Houston-Sugar Land-Baytown, TX	0 9838
20120	Austin County, TX	0.0000
	Brazoria County, TX	
	Fort Bend County, TX	
	Galveston County, TX	
	Harris County, TX	
	Montgomery County, TX	
	San Jacinto County, TX	
26580	Waller County, TX Huntington-Ashland, WV-KY-OH	0 9254
20000	Boyd County, KY	0.0204
	Greenup County, KY	
	Lawrence County, OH Cabell County, WV	
	Wayne County, WV	
26620	Huntsville, AL	0.9082
	Madison County, AL	
26820	Idaho Falls, ID	0.9080
	Bonneville County, ID	
26900	Indianapolis-Carmel, IN	0.9908
	Boone County, IN	
	Brown County, IN Hamilton County, IN	
	Hancock County, IN	
	Hendricks County, IN	
	Jonnson County, IN Marion County, IN	
	Morgan County, IN	
	Putnam County, IN	
26980	Iowa City, IA	0.9483
	Johnson County, IA	
27060	Washington County, IA	0.0614
27000	Tompkins County, NY	0.9014
27100	Jackson, MI	0.9309
27140	Jackson County, MI	0 0067
2/140	Copiah County, MS	0.8087
	Hinds County, MS	
	Madison County, MS Bankin County, MS	
	Simpson County, MS	

CBSA code	Urban area (constituent counties)	Wage index
27180	Jackson, TN	0.8523
	Chester County, TN	
27260	Madison County, TN	0 8000
27200	Baker County, FL	0.0999
	Clay County, FL	
	Duval County, FL	
	Nassau County, FL St. Johns County, Fl	
27340	Jacksonville, NC	0.8177
	Onslow County, NC	
27500	Janesville, WI	0.9662
27620	Jefferson City, MO	0.8775
	Callaway County, MO	
	Cole County, MO	
	Moniteau County, MO	
27740	Johnson City. TN	0.7971
	Carter County, TN	
	Unicoi County, TN	
27780	Washington County, TN	0 7020
27700	Cambria County, PA	0.7920
27860	Jonesboro, AR	0.7916
	Craighead County, AR	
27900	Poinsett County, AR	0.9406
27900	Jasper County, MO	0.9400
	Newton County, MO	
28020	Kalamazoo-Portage, MI	1.0801
	Kalamazoo County, Mi Van Buran County, Mi	
28100	Kankakee-Bradlev. IL	1.0485
	Kankakee County, IL	
28140	Kansas City, MO-KS	0.9610
	Franklin County, KS Johnson County, KS	
	Leavenworth County, KS	
	Linn County, KS	
	Miami County, KS	
	Bates County, NO	
	Caldwell County, MO	
	Cass County, MO	
	Clay County, MO	
	Jackson County, MO	
	Lafayette County, MO	
	Platte County, MO	
00400	Ray County, MO	0.0011
26420	Renton County WA	0.9911
	Franklin County, WA	
28660	Killeen-Temple-Fort Hood, TX	0.8765
	Bell County, TX	
	Lampasas County, TX	
28700	Kingsport-Bristol-Bristol, TN-VA	0.7743
	Hawkins County, TN	
	Sullivan County, TN Briatel City, MA	
	Scott County, VA	
	Washington County, VA	
28740	Kingston, NY	0.9375
20040	Ulster County, NY	0 7001
20940	Anderson County, TN	0.7881
	Blount County, TN	
	Knox County, TN	
	Loudon County, TN	
	Union County, IN	I

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CBSA code	Urban area (constituent counties)	Wage index
29020	Kokomo, IN Howard County, IN	0.9349
29100	La Crosse, WI-MN Houston County, MN	0.9758
29140	La Crosse County, WI Lafayette, IN Benton County, IN	0.9221
	Carroll County, IN Tippecanoe County, IN	
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8374
29340	Lake Charles, LA Calcasieu Parish, LA	0.7556
29404	Lake County-Kenosha County, IL-WI Lake County, IL	1.0389
29420	Kenosha County, WI Lake Havasu City-Kingman, AZ	0.9797
29460	Mohave County, AZ Lakeland-Winter Haven, FL	0.8530
29540	Polk County, FL Lancaster, PA	0.9363
29620	Lancaster County, PA Lansing-East Lansing, MI	0.9931
	Clinton County, MI Eaton County, MI Jonham County, MI	
29700	Laredo, TX Webb County, TX	0.8366
29740	Las Cruces, NM	0.8929
29820	Las Vegas-Paradise, NV	1.1971
29940	Lawrence, KS	0.8343
30020	Lawton, OK Comanche County, OK	0.8211
30140	Lebanon, PA Lebanon County, PA	0.8954
30300	Lewiston, ID-WA	0.9465
30340	Asotin County, WA Lewiston-Auburn, ME	0.9200
30460	Androscoggin County, ME Lexington-Favette, KY	0.9110
	Bourbon County, KY Clark County, KY	
	Fayette County, KY Jessamine County, KY	
	Scott County, KY Woodford County, KY	
30620	Lima, OH	0.9427
30700	Lincoln, NE Lancaster County, NE	0.9759
30780	Seward County, NE Little Rock-North Little Rock-Conway, AR Faulkner County, AR	0.8672
	Grant County, AR Lonoke County, AR	
	Perry County, AR Pulaski County, AB	
30860	Saline County, AR	0 8765
	Franklin County, ID Cache County, IT	0.0705
30980	Longview, TX	0.8370
	Rusk County, TX Upshur County, TX	

CBSA code	Urban area (constituent counties)	Wage index
31020	Longview, WA	1.1207
31084	Los Angeles-Long Beach-Santa Ana, CA	1.2208
31140 31180 31340	Los Angeles County, CA Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Shelby County, KY Spencer County, KY Lubbock, TX Crosby County, TX Lubbock, TX Lynchburg, VA Amherst County, VA Bedford County, VA	0.9249
31420	Campbell County, VA Bedford City, VA Lynchburg City, VA Macon, GA Bibb County, GA Crawford County, GA	0.9570
31460	Monroe County, GA Twiggs County, GA Madera, CA	0.7939
01540	Madera County, CA	1.0007
31540	Columbia County, WI Dane County, WI Iowa County, WI	1.0907
31700	Manchester-Nashua, NH	1.0359
31900	Mansfield, OH	0.9330
32420	Hichland County, OH Mayagüez, PR Hormigueros Municipio, PR	0.3940
32580	McAllen-Edinburg-Mission, TX	0.9009
32780	Medford, OR	1.0244
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tinton County, TN	0.9232
32900	Merced, CA	1.2243
33124	Miercea County, CA Miami-Miami Beach-Kendall, FL	0.9830
33140	Miami-Dade County, FL Michigan City-La Porte, IN	0.9159
33260	LaPorte County, IN Midland, TX	0.9827
33340	Midland County, TX Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0080

CBSA code	Urban area (constituent counties)	Wage index
33460	Minneapolis-St. Paul—Bloomington, MN-WI	1.1150
	Anoka County, MN	
	Carver County, MN	
	Dakota County, MN	
	Hennepin County, MN	
	Isanti County, MN	
	Ramsey County, MN Scott County, MN	
	Sherburne County, MN	
	Washington County, MN	
	Wright County, MN	
	St. Croix County, WI	
33540	Missoula, MT	0.8973
	Missoula County, MT	
33660	Mobile, AL	0.7908
33700	Modesto, CA	1,2194
	Stanislaus County, CA	
33740	Monroe, LA	0.7900
	Ouachita Parish, LA	
33780	Monroe, MI	0.8941
	Monroe County, MI	
33860	Montgomery, AL	0.8283
	Autauga County, AL Elmore County, Al	
	Lowndes County, AL	
	Montgomery County, AL	
34060	Morgantown, WV	0.8528
	Preston County, WV	
34100	Morristown, TN	0.7254
	Grainger County, TN	
	Hamblen County, TN	
34580	Mount Vernon-Anacortes. WA	1.0292
	Skagit County, WA	
34620	Muncie, IN	0.8489
34740	Delaware County, IN Muskegon-Norton Shores, MI	1 0055
	Muskegon County, MI	1.0000
34820	Myrtle Beach-North Myrtle Beach-Conway, SC	0.8652
24000	Horry County, SC	1 4500
34900	Napa, CA	1.4520
34940	Naples-Marco Island, FL	0.9672
	Collier County, FL	
34980	Nashville-Davidson-Murfreesboro-Franklin, TN	0.9504
	Cheatham County, TN	
	Davidson County, TN	
	Dickson County, TN	
	Hickman County, IN Macon County, TN	
	Robertson County, TN	
	Rutherford County, TN	
	Smith County, TN	
	Sumner County, TN Trousdale County, TN	
	Williamson County, TN	
	Wilson County, TN	
35004	Nassau-Suffolk, NY	1.2453
	Nassau County, NY Suffolk County, NY	
35084	Newark-Union, NJ-PA	1.1731
	Essex County, NJ	
	Hunterdon County, NJ	
	Sussex County, NJ	
	Union County, NJ	

CBSA code	Urban area (constituent counties)	Wage index
05000	Pike County, PA	4 4740
35300	New Haven-Milford, CT	1.1742
35380	New Orleans-Metairie-Kenner, LA	0.9103
	Jefferson Parish, LA	
	Orleans Parish, LA Plaquemines Parish, LA	
	St. Bernard Parish, LA	
	St. Charles Parish, LA	
	St. John the Baptist Parish, LA	
35644	New York-White Plains-Wavne. NY-NJ	1.2885
	Bergen County, NJ	
	Hudson County, NJ	
	Passaic County, NJ Bronx County, NY	
	Kings County, NY	
	New York County, NY	
	Putnam County, NY Queens County, NY	
	Richmond County, NY	
	Rockland County, NY	
25660	Westchester County, NY	0.0066
35000	Berrien County. MI	0.9000
35980	Norwich-New London, CT	1.1398
26094	New London County, CT	1 6000
36084	Alameda County CA	1.6092
	Contra Costa County, CA	
36100	Ocala, FL	0.8512
36140	Marion County, FL Ocean City, NJ	1 1496
00140	Cape May County, NJ	1.1400
36220	Odessa, TX	0.9475
36260	Ector County, TX	0.9153
00200	Davis County, UT	0.0100
	Morgan County, UT	
26420	Weber County, UT	0 9724
30420	Canadian County, OK	0.0724
	Cleveland County, OK	
	Grady County, OK	
	Lincoln County, OK	
	McClain County, OK	
00500	Oklahoma County, OK	4 4 5 0 7
36500	Olympia, WA	1.1537
36540	Omaha-Council Bluffs, NE-IA	0.9441
	Harrison County, IA	
	Mills County, IA Pottawattamie County, IA	
	Cass County, NE	
	Douglas County, NE	
	Sarpy County, NE	
	Washington County, NE	
36740	Orlando-Kissimmee, FL	0.9111
	Lake County, FL	
	Orange County, FL Osceola County, FL	
	Seminole County, FL	
36780	Oshkosh-Neenah, WI	0.9474
36980	winnebago Gounty, wi Owenshoro, KY	0 8685
	Daviess County, KY	0.0000
	Hancock County, KY	
37100	McLean County, KY Oxnard-Thousand Oaks-Ventura, CA	1 1051
	Ventura County, CA	1.1001

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CBSA code	Urban area (constituent counties)	Wage index
37340	Palm Bay-Melbourne-Titusville, FL	0.9332
37380	Palm Coast, FL	0.8963
37460	Panama City-Lynn Haven, FL	0.8360
37620	Bay County, FL Parkersburg-Marietta-Vienna, WV-OH	0.7867
	Washington County, OH Pleasants County, WV	
	Wirt County, WV Wood County, WV	
37700	Pascagoula, MS	0.8102
	Jackson County, MS	
37764	Peabody, MA Essex County. MA	1.0747
37860	Pensacola-Ferry Pass-Brent, FL	0.8242
	Santa Rosa County, FL	
37900	Peoria, IL Marshall County, IL	0.9038
	Peoria County, IL	
	Tazewell County, IL	
37964	Woodford County, IL Philadelphia. PA	1.0979
	Bucks County, PA	
	Delaware County, PA	
	Montgomery County, PA Philadelphia County, PA	
38060	Phoenix-Mesa-Scottsdale, AZ	1.0379
	Pinal County, AZ	
38220	Pine Bluff, AR Cleveland County, AR	0.7926
	Jefferson County, AR	
38300	Pittsburgh, PA	0.8678
	Allegheny County, PA Armstrong County, PA	
	Beaver County, PA	
	Fayette County, PA	
	Washington County, PA	
38340	Pittsfield, MA	1.0445
38540	Berkshire County, MA Pocatello, ID	0.9343
	Bannock County, ID Bower County, ID	
38660	Ponce, PR	0.4289
	Juana Diaz Municipio, PR Ponce Municipio, PR	
20060	Villalba Municipio, PR Portland South Portland Riddeford, ME	0.0042
30000	Cumberland County, ME	0.9942
	Sagadahoc County, ME York County, ME	
38900	Portland-Vancouver-Beaverton, OR-WA	1.1456
	Columbia County, OR	
	Multnomah County, OR Washington County, OB	
	Yamhill County, OR	
	Clark County, WA Skamania County, WA	
38940	Port St. Lucie, FL	0.9870
	St. Lucie County, FL	
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY	1.0920

CBSA code	Urban area (constituent counties)	Wage index
00110	Orange County, NY	1 0001
39140	Prescott, AZ	1.0221
39300	Providence-New Bedford-Fall River, RI-MA	1.0696
	Bristol County, MA Bristol County, PL	
	Kent County, RI	
	Newport County, RI	
	Providence County, RI Weshington County, RI	
39340	Provo-Orem, UT	0.9381
	Juab County, UT	
39380	Utah County, UT Pueblo, CO	0.8713
00000	Pueblo County, CO	0.0710
39460	Punta Gorda, FL	0.8976
39540	Charlotte County, FL Bacine, WI	0 9054
00040	Racine County, WI	0.0004
39580	Raleigh-Cary, NC	0.9817
	Johnston County, NC	
	Wake County, NC	
39660	Rapid City, SD	0.9598
	Pennington County, SD	
39740	Reading, PA	0.9242
20220	Berks County, PA	1 0701
39820	Shasta County. CA	1.3731
39900	Reno-Sparks, NV	1.0317
	Storey County, NV	
40060	Richmond, VA	0.9363
	Amelia County, VA	
	Caroline County, VA	
	Chesterfield County, VA	
	Cumberland County, VA	
	Dinwiddie County, VA Goochland County, VA	
	Hanover County, VA	
	Henrico County, VA	
	King and Queen County, VA King William County, VA	
	Louisa County, VA	
	New Kent County, VA	
	Pownatan County, VA Prince George County, VA	
	Sussex County, VA	
	Colonial Heights City, VA	
	Petersburg City, VA	
	Richmond City, VA	
40140	Riverside-San Bernardino-Ontario, CA	1.1468
	San Bernardino County, CA	
40220	Roanoke, VA	0.8660
	Botetourt County, VA	
	Franklin County, VA	
	Roanoke County, VA	
	Roanoke City, VA	
40340	Rochester, MN	1.1214
	Dodge County, MN	
	Olmsted County, MN Wabasha County, MN	
40380	Rochester, NY	0.8811
	Livingston County, NY	
	Monroe County, NY	
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CBSA code	Urban area (constituent counties)	Wage index
	Orleans County, NY	
	_ Wayne County, NY	
40420	Rockford, IL	0.9835
	Winnebago County, IL	
40484	Rockingham County, NH	0.9926
40500	Strafford County, NH	0.0004
40580	Rocky Mount, NC	0.9031
	Nash County, NC	
40660	Rome, GA	0.9134
10000	Floyd County, GA	4 0570
40900	Sacramento—Arden-Arcade—Roseville, CA	1.3572
	Placer County, CA	
	Sacramento County, CA	
40000	Yolo County, CA	0.0700
40980	Saginaw-Saginaw Township North, MI	0.8702
41060	St. Cloud. MN	1.0976
	Benton County, MN	
	Stearns County, MN	
41100	St. George, UI	0.9021
41140	St. Joseph. MO-KS	1.0380
	Doniphan County, KS	
	Andrew County, MO	
	Buchanan County, MO	
41180	St Louis MO-II	0 9006
	Bond County, IL	0.0000
	Calhoun County, IL	
	Clinton County, IL	
	Macounin County II	
	Madison County, IL	
	Monroe County, IL	
	St. Clair County, IL	
	Franklin County, MO	
	Jefferson County, MO	
	Lincoln County, MO	
	St. Charles County, MO	
	St. Louis County, MO Warren County, MO	
	Washington County, MO	
	St. Louis City, MO	
41420	Salem, OR	1.0884
	Marion County, OR Bolk County, OR	
41500	Salinas. CA	1.4987
	Monterey County, CA	
41540	Salisbury, MD	0.9246
	Somerset County, MD Wicomics County, MD	
41620	Salt Lake City, UT	0.9158
	Salt Lake County, UT	
	Summit County, UT	
41000	Tooele County, UT	0.0404
41660	San Angelo, TX	0.8424
	Tom Green County, TX	
41700	San Antonio, TX	0.8856
	Atascosa County, TX	
	Bandera County, TX Bexar County, TX	
	Comal County, TX	
	Guadalupe County, TX	
	Kendall County, TX	
	Medina County, TX	
41740	San Diego-Carlsbad-San Marcos, CA	1.1538
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CBSA code	Urban area (constituent counties)	Wage index
	San Diego County, CA	
41780	Sandusky, OH	0.8870
41884	Erie County, OH San Francisco-San Mateo-Bedwood City, CA	1 5529
41004	Marin County, CA	1.5525
	San Francisco County, CA	
41000	San Mateo County, CA	0.4750
41900	San German-Cabo Rojo, PR	0.4756
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
	San Germán Municipio, PR	
41940	San Jose-Sunnyvale-Santa Clara, CA	1.6141
	Santa Clara County, CA	
41980	San Juan-Caguas-Guaynabo, PR	0.4393
	Aguas Buenas Municipio, PR	
	Aibonito Municipio, PR	
	Arecibo Municipio, PR Barcolonata Municipio, PR	
	Barceloneta Municipio, PR	
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Carolina Municipio, PR	
	Cayey Municipio, PR	
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Guaynabo Municipio, PR	
	Gurado Municipio, PR Hatillo Municipio, PB	
	Humacao Municipio, PR	
	Juncos Municipio, PR	
	Las Piedras Municipio, PR	
	Loiza Municipio, PR Magatí Municipia, DD	
	Manah Municipio, PR Maunabo Municipio, PR	
	Morovis Municipio, PR	
	Naguabo Municipio, PR	
	Naranjito Municipio, PR	
	Orocovis Municipio, PR	
	Río Grande Municipio, PR	
	San Juan Municipio, PR	
	San Lorenzo Municipio, PR	
	Toa Alta Municipio, PR	
	Truiillo Alto Municipio, PR	
	Vega Alta Municipio, PR	
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	
42020	San Luis Obispo-Paso Robles, CA	1.2441
42044	Santa Ana-Anabeim-Invine CA	1 1 9 9 3
.2077	Orange County, CA	1.1000
42060	Santa Barbara-Santa Maria-Goleta, CA	1.1909
10100	Santa Barbara County, CA	
42100	Santa Cruz-Watsonville, CA	1.6429
42140	Santa Giuz Courity, CA Santa Fe, NM	1 0610
72170	Santa Fe County. NM	1.0010
42220	Santa Rosa-Petaluma, CA	1.5528
(Sonoma County, CA	_
42340	Savannah, GA	0.9152
	Chatham County, GA	

CBSA code	Urban area (constituent counties)	Wage index
	Effingham County, GA	
42540	Scranton—Wilkes-Barre, PA	0.8333
	Lackawanna County, PA	
	Wyoming County, PA	
42644	Seattle-Bellevue-Everett, WA	1.1755
	King County, WA	
	Snohomish County, WA	
42680	Sebastian-Vero Beach, FL	0.9217
43100	Indian Hiver County, FL	0.8920
40100	Sheboyaan County, WI	0.0020
43300	Sherman-Denison, TX	0.9024
	Grayson County, TX	
43340	Shreveport-Bossier City, LA	0.8442
	Bossier Parisn, LA	
	De Soto Parisi, LA	
43580	Sioux City, IA-NE-SD	0.8915
	Woodbury County, IA	
	Dakota County, NE	
	Dixon County, NE	
13620		0.0354
43020	Lincounty SD	0.3034
	McCook County, SD	
	Minnehaha County, SD	
	Turner County, SD	
43780	South Bend-Mishawaka, IN-MI	0.9761
	St. Joseph County, IN	
43900	Spartaburg, Min	0.9025
	Spartanburg County, SC	0.0020
44060	Spokane, WA	1.0559
	Spokane County, WA	
44100	Springfield, IL	0.9102
	Sangamon County II	
44140	Springfield, MA	1.0405
	Franklin County, MA	
	Hampden County, MA	
44100	Hampshire County, MA	0.0404
44160	Christian County, MO	0.8424
	Dallas County, MO	
	Greene County, MO	
	Polk County, MO	
	Webster County, MO	
44220	Springfield, OH	0.8876
44300	Clark County, OH State College PA	0.8937
44000	Centre County, PA	0.0007
44700	Stockton, CA	1.2015
	San Joaquin County, CA	
44940	Sumter, SC	0.8257
45000	Sumter County, SC	0.0707
45060	Maduse, NT	0.9767
	Onondaga County, NY	
	Oswego County, NY	
45104	Tacoma, WA	1.1241
	Pierce County, WA	
45220	Iailahassee, FL	0.8964
	Jefferson County FL	
	Leon County, FL	
	Wakulla County, FL	
45300	Tampa-St. Petersburg-Clearwater, FL	0.8852
	Hernando County, FL	
	Hillsborough County, FL	
	Pasco County, FL Pinellas County, FL	
	r inclias obuilty, I L	1

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

CBSA code	Urban area (constituent counties)	Wage index
47380	Waco, TX	0.8596
	McLennan County, TX	
47580	Warner Robins, GA	0.8989
47644	Warren-Trov-Earmington Hills, MI	0.9904
	Lapeer County, MI	
	Livingston County, MI	
	Macomb County, MI	
	St. Clair County, MI	
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	1.0827
	District of Columbia, DC	
	Calvert County, MD	
	Prince George's County, MD	
	Arlington County, VA	
	Clarke County, VA	
	Fairfax County, VA	
	Loudour County, VA	
	Prince William County, VA	
	Spotsylvania County, VA	
	Stafford County, VA	
	Warren County, VA Alexandria City, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fredericksburg Čity, VA	
	Manassas City, VA	
	Manassas Park Oily, VA Jefferson County WV	
47940	Waterloo-Cedar Falls, IA	0.8490
	Black Hawk County, IA	
	Bremer County, IA	
19110	Grundy County, IA	0.0615
40140	Marathon County, WI	0.9015
48260	Weirton-Steubenville, WV-OH	0.8079
	Jefferson County, OH	
	Brooke County, WV	
48300	Hancock County, WV Wenatchee, WA	0.0544
40000	Chelan County, WA	0.0044
	Douglas County, WA	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	0.9757
19510	Palm Beach County, FL	0 6055
40540	Belmont County, OH	0.0955
	Marshall County, WV	
	Ohio County, WV	
48620	Wichita, KS	0.9069
	Buller County, KS Harvey County, KS	
	Sedgwick County, KS	
	Sumner County, KS	
48660	Wichita Falls, TX	0.8832
	Archer County, 1X	
	Wichita County, TX	
48700	Williamsport, PA	0.8096
	Lycoming County, PA	
48864	Wilmington, DE-MD-NJ	1.0696
	INEW CASHE COUNTY, DE	
	Salem County, MD	
48900	Wilmington, NC	0.9089
	Brunswick County, NC	
	New Hanover County, NC	
49020	Pender County, NC Winchester VA-WV	0 0801
-3020	Frederick County. VA	0.5001
	Winchester City, VA	

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

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

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

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

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

State	Nonurban area	vvage						
code		index	State code	Nonurban area	Wage index	State code	Nonurban area	Wage index
1	Alabama	0.7587						
2	Alaska	1.1898	25	Mississippi	0.7584	46	Utah	0.8267
3	Arizona	0.8453	26	Missouri	0.7982	47	Vermont	1.0079
4	Arkansas	0.7473	27	Montana	0.8658	48	Virgin Islands	0.6971
5	California	1.2275	28	Nebraska	0.8730	10 10	Virginia	0 7861
<u>6</u>	Colorado	0.9570	29	Nevada	0.9382	F0	Washington	1 0191
1	Connecticut	1.1016	30	New Hampshire	1.0182	50	Washington	0.7502
8	Delaware	0.9962	31	New Jersev ¹		51		0.7503
10	Florida	0.8504	32	New Mexico	0.8812	52	Wisconsin	0.9373
11	Georgia	0.7612	33	New York	0.8145	53	Wyoming	0.9315
12	Hawali	1.0999	34	North Carolina	0.8576	65	Guam	0.9611
13	Idano	0.7651	35	North Dakota	0 7205	1 4 11 -		- I : 6 I
14		0.8386	36	Obio	0.7200	' All C	ounties within the State are	classified
15	Indiana	0.8473	37	Oklahoma	0.0000	and Puerto Rico. Massachusetts and Puerto Rico have areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for FY 2009. The rural Massa- chusetts wage index is calculated as the aver- age of all contiguous CBSAs. The Puerto Rico wage index is the same as FY 2008.		
16	Iowa	0.8804	38	Oregon	1 0218			
17	Kansas	0.8052	20	Bonnovlyonia	0.0210			
18	Kentucky	0.7803	39 40	Puorto Dioo 1	0.0305			
19	Louisiana	0.7447	40	Dhada Jaland 1	0.4047			
20	Maine	0.8644	41	Courte Corolina	0.0500			
21	Maryland	0.8883	42	South Dalasta	0.8538			
22	Massachusetts 1	1.1670	43	South Dakota	0.8603	[FR Doc	E8-17948 Filed 7-31-08.	1·15 nml
23	Michigan	0.8887	44	I ennessee	0.7789	LI IC DOG	. 10 17 540 i fieu 7-51-60,	rito biii)
24	Minnesota	0.9059	45	I exas	0.7894	BILLING C	CODE 4120-01-P	