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42 CFR Parts 413 and 424
Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2014; Rules

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 413 and 424

[CMS–1446–F]

RIN 0938–AR65

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2014

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 for skilled nursing facilities (SNFs) for fiscal year (FY) 2014. In addition, it revises and rebases the SNF market basket, revises and updates the labor related share, and makes certain technical and conforming revisions in the regulations text. This final rule also includes a policy for reporting the SNF market basket forecast error in certain limited circumstances and adds a new item to the Minimum Data Set (MDS), Version 3.0 for reporting the number of distinct therapy days. Finally, this final rule adopts a change to the diagnosis code used to determine which residents will receive the AIDS add-on payment, effective for services provided on or after the October 1, 2014 implementation date for conversion to ICD–10–CM.

DATES: *Effective Date:* This final rule is effective on October 1, 2013.

FOR FURTHER INFORMATION CONTACT:

Penny Gershman, (410) 786–6643, for information related to clinical issues.

John Kane, (410) 786–0557, for information related to the development of the payment rates and case-mix indexes.

Kia Sidbury, (410) 786–7816, for information related to the wage index.

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

SUPPLEMENTARY INFORMATION:

Availability of Certain Information Exclusively Through the Internet on the CMS Web site

The Wage Index for Urban Areas Based on CBSA Labor Market Areas (Table A) and the Wage Index Based on CBSA Labor Market Areas for Rural Areas (Table B) are published in the **Federal Register** as an Addendum to the annual SNF PPS rulemaking (that is, the SNF PPS proposed and final rules or, when applicable, the current update notice). However, as of FY 2012, a number of other Medicare payment systems adopted an approach in which such tables are no longer published in the **Federal Register** in this manner, and instead are made available exclusively through the Internet; see, for example, the FY 2012 Hospital Inpatient PPS (IPPS) final rule (76 FR 51476). To be consistent with these other Medicare payment systems and streamline the published content to focus on policy discussion, we proposed to use a similar approach for the SNF PPS as well. We also proposed to revise the applicable regulations text at § 413.345 to accommodate this approach, consistent with the wording of the corresponding statutory authority at section 1888(e)(4)(H)(iii) of the Social Security Act (the Act). We did not receive any comments on this proposal. Therefore, as discussed in greater detail in section V. of this final rule, we are finalizing this proposal and revising the applicable regulations text at § 413.345 to accommodate this approach. Under this approach, effective October 1, 2013, the individual wage index values displayed in Tables A and B of this rule will no longer be published in the **Federal Register** as part of the annual SNF PPS rulemaking, and instead will be made available exclusively through the Internet on CMS's SNF PPS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.* Consistent with the provisions of section 1888(e)(4)(H)(iii) of the Act, we will continue to publish in the **Federal Register** the specific ''factors to be applied in making the area wage adjustment'' (for example, the SNF prospective payment system's use of the hospital wage index exclusive of its occupational mix adjustment) as part of our annual SNF PPS rulemaking process, but that document will no longer include a listing of the individual wage index values themselves, which will instead be made available exclusively through the Internet on the CMS Web site.

In addition, we note that in previous years, each rule or update notice issued under the annual SNF PPS rulemaking cycle has included a detailed reiteration of the various individual legislative provisions that have affected the SNF PPS over the years, a number of which represented temporary measures that have long since expired. That discussion, along with detailed background information on various other aspects of the SNF PPS, will henceforth be made available exclusively on the CMS Web site as well, at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.*

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

Table of Contents

Regulations Text

Acronyms

In addition, because of the many terms to which we refer by acronym 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, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
CAH Critical access hospital
CBSA Core-based statistical area
CFR Code of Federal Regulations
CMI Case-mix index
CMS Centers for Medicare & Medicaid Services
COT Change of therapy
ECI Employment Cost Index
EOT End of therapy
EOT–R End of therapy–resumption
FQHC Federally qualified health center
FR Federal Register
FY Fiscal year
GAO Government Accountability Office
HCPCS Healthcare Common Procedure Coding System
HOMER Home office Medicare records
IGI IHS (Information Handling Services) Global Insight, Inc.
MDS Minimum data set
MFP Multifactor productivity
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MSA Metropolitan statistical area
NAICS North American Industrial Classification System
NTA Non-Therapy Ancillary
OMB Office of Management and Budget
OMRA Other Medicare Required Assessment
PPS Prospective Payment System
RAI Resident assessment instrument
RAVEN Resident assessment validation entry
RFA Regulatory Flexibility Act, Pub. L. 96–354
RHC Rural health clinic
RIA Regulatory impact analysis
RUG–III Resource Utilization Groups, Version 3
RUG–IV Resource Utilization Groups, Version 4
RUG–53 Refined 53-Group RUG–III Case-Mix Classification System
SCHIP State Children's Health Insurance Program
SNF Skilled nursing facility
STM Staff time measurement
STRIVE Staff time and resource intensity verification
UMRA Unfunded Mandates Reform Act, Pub. L. 104–4

I. Executive Summary

A. Purpose

This final rule updates the SNF prospective payment rates for FY 2014 as required under section 1888(e)(4)(E) of the Act. It also responds to section 1888(e)(4)(H) of the Act, which requires the Secretary to ''provide for publication in the **Federal Register**'' before the August 1 that precedes the start of each fiscal year, the unadjusted federal per diem rates, the case-mix classification system, and the factors to be applied in making the area wage adjustment used in computing the prospective payment rates for that fiscal year.

B. Summary of Major Provisions

In accordance with sections 1888(e)(4)(E)(ii)(IV) and 1888(e)(5) of the Act, the federal rates in this final rule reflect an update to the rates that we published in the SNF PPS update notice for FY 2013 (77 FR 46214) which reflects the SNF market basket index, adjusted by the forecast error correction, if applicable, and the multifactor productivity adjustment for FY 2014.

C. Summary of Cost, Transfers, and Benefits

Provision description	Total transfers
FY 2014 SNF PPS payment rate update	The economic impact of this final rule is an estimated increase of $470 million in aggregate payments to SNFs during FY 2014.

II. Background

A. Statutory Basis and Scope

As amended by section 4432 of the Balanced Budget Act of 1997 (BBA, Pub. L. 105–33, enacted on August 5, 1997), section 1888(e) of the Act provides for the implementation of a PPS for Medicare payment for covered SNF services. This methodology uses prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services defined in section 1888(e)(2)(A) of the Act. The SNF PPS is effective for cost reporting periods beginning on or after July 1, 1998, and covers all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs) other than costs associated with approved educational activities and bad debts. Under section 1888(e)(2)(A)(i) of the Act, covered SNF services include post-hospital extended care services for which benefits are provided under Part A, as well as those items and services (other than a certain limited number of excluded services described in clauses (ii), (iii), and (iv) of section 1888(e)(2)(A), such as physician services) for which payment may otherwise be made under Part B and which are furnished to Medicare beneficiaries who are residents 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).

B. Initial Transition

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

C. Required Annual Rate Updates

Section 1888(e)(4)(E) of the Act requires the SNF PPS payment rates to be updated annually. The most recent annual update occurred in an update notice that set forth updates to the SNF PPS payment rates for FY 2013 (77 FR 46214).

Under this requirement, section 1888(e)(4)(H) of the Act specifies that we provide for publication annually in the **Federal Register** of the following:

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

Along with other revisions discussed later in this preamble, this final rule also provides the required annual

updates to the per diem payment rates for SNFs for FY 2014.

III. Summary of the Provisions of the FY 2014 SNF PPS Proposed Rule

In the FY 2014 SNF PPS proposed rule (78 FR 26438), we proposed an update to the payment rates used under the PPS for SNFs for FY 2014. Additionally, we proposed to revise and rebase the SNF market basket, to use this revised and rebased SNF market basket to determine the SNF PPS update for FY 2014; to update and revise the labor related share; and to make certain technical and conforming revisions in the regulations text. The proposed rule also included a proposed policy for revising how we report the SNF market basket forecast error in certain limited circumstances. In addition, we proposed a new item to be included on the Minimum Data Set (MDS), Version 3.0. Finally, we proposed to transition to the ICD–10–CM diagnosis code B20 in order to identify those residents for whom it is appropriate to apply the AIDS add-on payment under section 511 of the MMA, effective upon the October 1, 2014 implementation date for conversion to ICD–10–CM.

IV. Analysis of and Responses to Public Comments on the FY 2014 SNF PPS Proposed Rule

In response to the publication of the FY 2014 SNF PPS proposed rule, we received 20 timely public comments from individual providers, corporations, government agencies, private citizens, trade associations, and major organizations. The following are brief summaries of each proposed provision, a summary of the public comments that we received related to that proposal, and our responses to the comments.

A. General Comments on the FY 2014 SNF PPS Proposed Rule

In addition to the comments 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. A discussion of these comments, along with our responses, appears below.

Comment: We received a number of comments about the MDS. Commenters noted the complexity of the MDS 3.0, particularly with regard to several of the newer assessment types, the need to clarify the Resident Assessment Instrument (RAI) Manual, the manual update process, and the time required to become trained on the new MDS 3.0 requirements.

Response: We appreciate these concerns and we recognize that the MDS 3.0 is a complex assessment tool. We provided extensive training and opportunities to assist with questions about the MDS 3.0 both prior to and after its October 1, 2010 implementation on audio conferences, at national training conferences, in the form of the RAI Manual and subsequent clarification updates, and postings to the MDS 3.0 and SNF PPS Web sites.

We have also provided support in response to oral and written inquiries, and issued clarification during Open Door Forums, RAI Manual updates, and through online and telephone technical assistance. We are committed to continuing training on both the MDS 3.0 and RUG–IV systems. Additionally, as we receive provider input through these efforts, we will continue to update and clarify the RAI Manual to ensure that it continues to provide accurate information and guidance on CMS policies in a timely fashion.

Comment: A few commenters raised the issue of Non-Therapy Ancillaries (NTAs). All of the comments we received on this issue supported CMS's broad objective to develop a new method for paying for NTAs received in the SNF. These commenters urged CMS to expedite the research necessary to develop a new model for NTA payment and to implement such a model shortly thereafter.

Response: We appreciate all of the comments on this topic and the broad support for our objective to address this issue. Furthermore, the comments we received provided a number of interesting and creative ideas for consideration during the research process. We look forward to working with providers and stakeholders in the future as we continue to research this possible refinement to the SNF PPS.

B. SNF PPS Rate Setting Methodology and FY 2014 Update

In the FY 2014 SNF PPS proposed rule (78 FR 26441 through 26463), we outlined the basic methodology used to set the rates for the SNF PPS. We also discussed several proposals associated with our rate setting methodology, including proposals associated with revising and rebasing the SNF market basket for FY 2014, using the revised and rebased SNF market basket to update the SNF payment rates, and updating and revising the labor-related share, as well as a proposal associated with how CMS reports the SNF forecast error correction for a given year. Our discussion of the rate setting methodology, our proposed changes associated with this methodology, and the comments, along with our responses, on these proposals appear below.

1. Federal Base Rates

Under section 1888(e)(4) of the Act, the SNF PPS uses per diem federal payment rates based on mean SNF costs in a base year (FY 1995) updated for inflation to the first effective period of the PPS. We developed the federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in FY 1995. The data used in developing the federal rates also incorporated a ''Part B add-on,'' which is an estimate of the amounts that, prior to the SNF PPS, would have been 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 from FY 1995 to the first effective year of the PPS (which was the 15-month period beginning July 1, 1998) using a SNF market basket index, and then standardized for geographic variations in wages and for the costs of facility differences in case mix. 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, and adjusted the portion of the federal rate attributable to wage-related costs by a wage index to reflect geographic variations in wages.

2. SNF Market Basket Update

Section 1888(e)(5)(A) 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. 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. 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 midpoint of the

previous FY to the midpoint of the current FY. For the federal rates set forth in this final rule, we use the percentage change in the SNF market basket index to compute the update factor for FY 2014, based on the IGI second quarter 2013 forecast (with historical data through first quarter of 2013) of the FY 2014 percentage increase in the FY 2010-based SNF market basket for routine, ancillary, and capital related expenses. In the FY 2014 SNF PPS proposed rule, the FY 2014 SNF market basket percentage was based on the IGI first quarter 2013 forecast (with historical data through the fourth quarter 2012) of the FY 2014 percentage increase in the FY 2010-based SNF market basket index for routine, ancillary, and capital-related expenses. The final SNF market basket update is discussed in section IV.B.5 of this final rule. As discussed in sections IV.B of this final rule, this market basket percentage change is reduced by the forecast error correction (§ 413.337(d)(2)), and by the MFP adjustment as required by section 1888(e)(5)(B)(ii) of the Act.

a. Revising and Rebasing the SNF Market Basket Index

In the FY 2008 SNF PPS final rule (72 FR 43425 through 43430), we revised and rebased the SNF market basket, which included updating the base year from FY 1997 to FY 2004. For FY 2014, we proposed to rebase the market basket to reflect FY 2010 Medicare allowable total cost data (routine, ancillary, and capital-related) and to revise the cost categories, cost weights, and price proxies used to determine the market basket (78 FR 26451 through 26461).

Specifically, we proposed to develop cost category weights for the FY 2010-based SNF market basket in two stages. First, we proposed to derive base weights for seven major categories (wages and salaries, employee benefits, contract labor, pharmaceuticals, professional liability insurance, capital-related, and a residual ''all other'') from the FY 2010 Medicare cost report (MCR) data for freestanding SNFs. Second, we proposed to divide the residual ''all other'' cost category into subcategories, using U.S. Department of Commerce Bureau of Economic Analysis' (BEA) 2002 Benchmark Input-Output (I–O) tables for the nursing home industry aged forward using price changes. Furthermore, we proposed to continue to use the same overall methodology as was used for the FY 2004-based SNF market basket to develop the capital related cost weights of the FY 2010-based SNF market basket.

We proposed to include five new cost categories in the FY 2010-based SNF market basket: (1) Medical Instruments and Supplies; (2) Apparel; (3) Machinery and Equipment; (4) Administrative and Facilities Support Services; and (5) Financial Services. We also proposed to divide the Nonmedical Professional Fees cost category into Nonmedical Professional Fees: Labor-Related and Nonmedical Professional Fees: Nonlabor-Related; and to revise our labels for the Labor-Intensive Services and Nonlabor-Intensive Services cost categories to All Other: Labor-Related Services and All Other: Nonlabor-Related Services, respectively.

In addition, we proposed to revise several price proxies, including using the ECI for Wages and Salaries for Nursing Care Facilities (NAICS 6231) to measure price growth of the Wages and Salaries cost category, and using the ECI for Benefits for Nursing Care Facilities (NAICS 6231) to measure price growth of the Benefits cost category.

We refer readers to the FY 2014 SNF PPS proposed rule (78 FR 26450–26461) for a complete discussion of our proposals and associated rationale related to revising and rebasing the SNF market basket. We received a number of public comments on the proposed revising and rebasing of the SNF market basket. A discussion of these comments, with our responses, appears below.

Comment: Several commenters were in agreement with our efforts to revise and rebase the SNF Market Basket. One commenter recommended that we forgo rebasing the SNF market basket index until cost data that adequately reflects recent and upcoming changes to the SNF cost structure are available. Furthermore, the commenter stated that the expenses reflected in the proposed FY 2010 base year do not account for system-wide and industry-wide changes that have occurred since FY 2010, which impose additional costs on SNFs. Specifically, they stated the following changes have occurred since 2010 or are about to occur: (1) Effective beginning FY 2011, CMS implemented changes to the reporting of therapy minutes on the MDS; (2) effective beginning FY 2012, CMS implemented a new therapy-related assessment and reporting changes; and (3) significant new requirements and costs on SNFs as employers due to the implementation of the Affordable Care Act.

Response: We last rebased and revised the SNF market basket in the FY 2008 SNF PPS final rule (72 FR 43412, 43425–29), reflecting a FY 2004 base year. In the FY 2014 SNF PPS proposed rule, we proposed to rebase and revise the SNF market basket to reflect FY 2010 data as these were the most recent Medicare cost report data available; a decision that was supported by numerous commenters. We do not agree with the commenter's suggestion to postpone the rebasing of the SNF market basket and continue to use a FY 2004-based SNF market basket, which is less relevant with regard to the costs faced by SNFs and, thus, is not as technically appropriate as the FY 2010-based index. We will actively monitor the MCR data to determine if the cost structure changes in a meaningful way as future years of data become available and will propose any appropriate revisions or rebasing of the SNF market basket in future rulemaking.

Comment: One commenter supported our efforts to improve payment accuracy by rebasing and revising the market basket. However, they expressed concern about the accuracy of the Medicare SNF cost reports on which we rely. They stated that since payments are now based on the SNF PPS, and have for an increasing time been divorced from an individual facility's costs, less attention has been given to assuring their accuracy.

The commenter also expressed concern that there has not been a recent federal study on the accuracy of the SNF Medicare Cost Reports. They recommended that we commission a study of the accuracy of SNF Medicare cost reports and commit to revising applicable parts of the new market basket index, if the study shows that such changes are warranted.

The commenter also stated that there may be accuracy issues with the SNF cost reports, as evidenced by MedPAC's use of unpublished screens to select SNF cost reports for its analyses. Therefore, they recommended that we explain what, if any, screens, exclusions, or other mechanisms were used in the selection of the FY 2010 SNF cost reports on which the new market basket weights are computed.

Response: We appreciate the commenter's concern over the accuracy of the Medicare cost report data. Similar to MedPAC, we do apply edits to the MCR data to remove reporting errors and outliers. Specifically, MCR data are excluded if total facility costs, total operating costs, Medicare general inpatient routine service costs, and Medicare payments are less than or equal to zero. Additionally, for each of the major cost weights (wages and salaries, employee benefits, contract labor, pharmaceuticals, professional liability insurance, capital-related expenses) the data are trimmed by: (1) Requiring that major expenses (such as salary costs) and total Medicare

allowable costs are greater than zero; and (2) excluding the top and bottom 5 percent of the major cost weight (for example, salary costs as a percent of total Medicare allowable costs). These are the same types of edits utilized for the FY 2004-based SNF market basket, as well as other PPS market baskets (including but not limited to IPPS and HHA). We believe this trimming process considerably improves the accuracy of the data used to compute the major cost weights.

In response to the commenters' recommendation that we commission a study of the accuracy of Medicare SNF cost reports, we note that implementing such a recommendation would require significant resources and approval through OMB's standard survey and auditing process (see ''Standards and Guidelines for Statistical Surveys'' *http://www.whitehouse.gov/sites/default/files/omb/assets/omb/inforeg/statpolicy/standards_stat_surveys.pdf* and ''Guidance on Agency Survey and Statistical Information Collections'' *http://www.whitehouse.gov/sites/default/files/omb/assets/omb/inforeg/pmc_survey_guidance_2006.pdf*). In the past, cost report audits have been conducted but were limited to specific fields and a small sample of providers. At this time, we believe this approach is the most efficient and appropriate way to identify and address cost report errors and to improve the accuracy of the MCR data used to develop the SNF market basket cost weights. We would appreciate industry representatives communicating to their members the importance of completing the cost reports as accurately as possible, the implications of misreported data, and the possible impacts on their future payments.

Comment: One commenter was supportive of periodic rebasing and revisions to the SNF market basket, but recommended that we hold off on updating the weights and price proxies this year pending refinements to the underlying Medicare cost reports to correct data issues that they believe may bias the major cost categories weights. Their concerns included:

(1) The effect of excluding cost reports where the Medicare General Inpatient Routine. Service Costs are less than or equal to zero. They expressed concern about the effect of the exclusion of providers whose Medicare general inpatient routine service costs (as reported on Worksheet D1 of the SNF MCR) are less than or equal to zero, noting that this edit alone is responsible for excluding over 4,000 Medicare cost reports (approximately 30 percent of all SNFs filing a Medicare cost report) from the analytic database and the subsequent weight calculations. They acknowledged that the exclusion makes sense on its face and that clearly facilities with zero or negative inpatient routine service costs should be excluded. Upon reviewing the cost reports, however, they asserted that the issue is not that inpatient routine service costs are zero or negative, but rather that the Worksheet D1 is an optional worksheet. They also encouraged CMS to examine, develop, and evaluate other exclusion criteria that target the same issue that CMS seeks to address with the Medicare inpatient routine services cost exclusion.

(2) Some of the cost category methodology descriptions in the proposed rule were unclear and requested that CMS in both this year's final rule and future proposed rules provide more specificity in the precise methodology for estimating the market basket cost weights using the Medicare cost reports. The commenter requested that CMS make available a detailed item-by-item description of the formulas used in the calculation of the major cost category weights in the final rule and that CMS provide the analytic databases used to support the major cost category weight calculations on the CMS Web site.

(3) The commenter claims that the CMS methodology for wages and salaries (specifically the numerator for wages and salaries), benefits, contract labor, and pharmaceuticals is inaccurate. The commenter based this conclusion on their own estimates, which were an attempt to re-create the CMS methodology and were provided in their comments. Additionally, the commenter requested more information be provided in the final rule to ensure that the results and analysis are valid and accurate.

Response: We disagree with the commenter's recommendation to hold off on updating the weights and price proxies this year. We believe our methodology is technically sound and does not have any of the data issues that the commenter suggests may bias the major cost category weights. We are using the same general methodology used to develop the FY 2004-based SNF market basket, as finalized in the FY 2008 SNF PPS final rule (72 FR 43412, 43425–43429) . In our response below, we address the three main concerns identified by the commenter.

The commenter suggested that we explore alternative edits and examine, develop, and evaluate other exclusion criteria that target the same issue that we seek to address with the Medicare inpatient services routine cost exclusion. However, we continue to believe that this edit (exclusion of providers whose Medicare general inpatient routine service costs are less than or equal to zero) is appropriate as our goal is to create a market basket that is representative of freestanding SNF providers serving Medicare patients.

Worksheet D1 is ''optional'' to those provider's filing a low Medicare utilization cost report (See Provider Reimbursement Manual, part II, Section 110 *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html*). The cost structure of these providers would reflect the expenses required to serve predominately non-Medicare patients. Therefore, we believe excluding these providers is appropriate.

Our market basket sample, which included approximately 10,000 providers, represents 70 percent of all freestanding SNF providers that submitted a Medicare cost report for FY 2010. In addition, we note that a sensitivity analysis that removed the Medicare general inpatient routine service cost edit had a minor impact on the salary cost weight of −0.2 percentage point. Therefore, we believe the resulting cost weights are representative of the average across all SNFs serving Medicare patients, even though we exclude some reports. The final sample of SNF Medicare Cost Reports used to calculate the market basket cost weights excluded any providers that reported costs less than or equal to zero for the following categories: total facility costs, total operating costs, Medicare general inpatient routine service costs, and Medicare payments. Therefore, the final sample used included roughly 10,000 of the 14,000 providers that submitted a Medicare cost report for FY 2010.

After we apply these edits, we calculate the cost weights as specified in the FY 2014 SNF PPS proposed rule (78 FR 26451 through 26461); this method is further clarified below. For each of the major cost weights (wages and salaries, employee benefits, contract labor, pharmaceuticals, professional liability insurance, and capital-related expenses), the data are trimmed by: (1) Requiring that major expenses (such as wages and salary costs) and total Medicare allowable costs are greater than zero; and (2) excluding the top and bottom 5 percent of the major cost weight (for example, salary costs as a percent of total Medicare allowable costs). We would note that this trimming process is done for each cost weight individually. For example,

providers excluded from the drug cost weight calculation are not automatically excluded from the other cost weight calculations and trimming process. These are the same types of edits utilized for the FY 2004-based SNF market basket as well as other PPS market baskets (including but not limited to IPPS and HHA). We believe this trimming process considerably improves the accuracy of the data used to compute the major cost weights.

For all of the cost weights, Medicare allowable total costs were equal to total expenses from Worksheet B, lines 16, 21 through 30, 32, 33, and 48 plus Medicaid drug costs as defined below.

We included estimated Medicaid drug costs in the pharmacy cost weight as well as the denominator for total Medicare allowable costs. This is the same methodology used for the FY 2004-based SNF market basket revision and rebasing. During that revision and rebasing, commenters expressed concern over the exclusion of these Medicaid drug expenses. In response, we revised the market basket drug cost weight methodology to include these costs in the Medicare allowable methodology. We finalized this methodology in the FY 2008 SNF PPS final rule (72 FR 43425 through 43430), and for the same reasons set forth in that final rule, we believe it is appropriate to continue to use this methodology in the proposed FY 2010-based SNF market basket. The methodology used in the FY 2010-based SNF market basket includes Medicaid drug costs in the Medicare allowable MCR total costs (as calculated using Worksheet B, lines 16, 21 through 30, 32, 33, 48) for each of the cost weights prior to trimming them as specified above. An alternative methodology would be to calculate and trim the nondrug cost weights using only Medicare allowable total costs from Worksheet B and then adjust the resulting cost weights for the inclusion of Medicaid drug costs. We believe our approach is technically appropriate as it allows for this adjustment to be applied at the individual (that is, provider) level, which is preferable.

Finally, we would clarify that the final weights of the proposed FY 2010-based SNF market basket are based on weighted means. For example, the final salary cost weight after trimming is equal to the sum of total Medicare allowable wages and salaries divided by the sum of total Medicare allowable costs (including Medicaid drug costs) where providers with larger wages and salary costs have a larger weight in the final wages and salaries cost weight. This methodology is consistent with the methodology used to calculate the FY 2004-based SNF market basket cost weights and other PPS market basket cost weights.

We believe the proposed rule included sufficient information regarding CMS's methodology and the underlying data used for revising and rebasing the SNF market basket. As stated in the FY 2014 SNF PPS proposed rule, the cost category weights for the proposed rebased and revised market basket were derived using freestanding Skilled Nursing Facility Medicare Cost Reports and Bureau of Economic Analysis 2002 Input-Output data. Both databases are publicly available on the CMS and BEA Web sites, respectively. We would note that the databases used for the other market basket rebasings (such as, the hospital Medicare cost report data for the IPPS market basket) are also publicly available on the CMS and BEA Web sites, as well.

However, in order to respond to the commenter's suggestion for more information on the detailed methodology for calculating the proposed FY 2010-based SNF market basket major cost weights, we have provided a detailed discussion of the methodology, as requested. These clarifications should allow the commenter to adequately re-create the market basket weights so that discrepancies between their results and the proposed FY 2010-based SNF market basket cost weights (that they believed produced inaccurate results) can be reconciled. We believe that the commenter's estimates and conclusions were based on a misunderstanding of the formulas used to calculate the major cost weights for the FY 2010-based SNF market basket, and thus we believe the additional clarification provided below should address commenter's concerns.

Specifically, we provide additional clarification on the specific Medicare cost report fields used to calculate the major cost weights: (1) The wages and salaries; (2) employee benefits; (3) contract labor; (4) pharmaceutical; (5) professional liability insurance; (6) capital; and (7) All Other ''residual'':

(1) Wages and Salaries (before the allocation of contract labor): We derived the wages and salaries cost category using the FY 2010 SNF MCRs. We determined Medicare allowable wages and salaries mostly from Worksheet S–3, part II data. Medicare allowable wages and salaries are equal to total wages and salaries (Worksheet S3, part II, line 1, column 3) minus: (1) Excluded salaries from Worksheet S–3, part II; and (2) nursing facility and non-reimbursable salaries from Worksheet A, lines 18, 34 through 36. Specifically, we determined excluded salaries in three steps: (1) Sum of data from Worksheet S3, part II, lines 3–5, and 8–14; Worksheet A, lines 18, 31, 34–36, 51, and 56; (2) estimated overhead salaries attributable to the non-Medicare allowable cost centers defined as (total overhead salaries (Worksheet S3, Part III, line 14) as a percent of total salaries Worksheet S3, Part II, line 1, column 3) * excluded salaries as defined in step (1); (3) total excluded salaries is equal to the sum of (1) and (2).

(2) Employee Benefits (before the allocation of contract labor): We determined the weight for employee benefits using FY 2010 SNF MCR data. We derived Medicare allowable benefit costs from Worksheet S–3, part II. Medicare allowable benefits are equal to total benefits from Worksheet S–3, part II, (lines 19–21) minus excluded (non-Medicare allowable) benefits. Non-Medicare allowable benefits are derived by multiplying non-Medicare allowable salaries (otherwise referred to as excluded salaries above) times the ratio of total benefit costs for the SNF to the total wage costs for the SNF.

(3) Contract Labor: We determined the weight for contract labor using 2010 SNF MCR data. We derived Medicare allowable contract labor costs from Worksheet S–3, part II line 17 minus Nursing Facility (NF) contract labor costs, and Medicare allowable total costs from Worksheet B. (Worksheet S–3, part II line 17 includes only those costs attributable to services rendered in the SNF and/or NF for contracted direct patient care services, that is, nursing, therapeutic, rehabilitative, or diagnostic services furnished under contract rather than by employees, and management contract services costs, defined as those individuals who are working at the facility in the capacity of chief executive, chief operating officer, chief financial officer, or nursing administrator.) NF contract labor costs, which are not reimbursable under Medicare, are derived by multiplying total contract labor costs by the ratio of NF wages and salaries (Worksheet A, column 1, line 18), to the sum of NF and SNF wages and salaries (Worksheet A, column 1, line 16).

(4) Pharmaceuticals: First, we calculated pharmaceutical costs using the non-salary costs from the Pharmacy cost center (Worksheet B, column 0, line 11 less Worksheet A, column 1, line 11) and the Drugs Charged to Patients' cost center (Worksheet B, column 0, line 30 less Worksheet A, column 1, line 30), both found on Worksheet B of the SNF MCRs. Since these drug costs were attributable to the entire SNF and not limited to Medicare allowable services,

we adjusted the drug costs by the ratio of Medicare allowable pharmacy total costs to total pharmacy costs from Worksheet B, part I, column 11. Worksheet B, part I allocates the general service cost centers, which are often referred to as ''overhead costs'' (in which pharmacy costs are included) to the Medicare allowable and non-Medicare allowable cost centers.

Second, for the FY 2010-based SNF market basket, we proposed to continue to adjust the drug expenses reported on the MCR to include an estimate of total Medicaid drug costs, which are not represented in the Medicare-allowable drug cost weight. Similar to the last rebasing, we are estimating Medicaid drug costs based on data representing dual-eligible Medicaid beneficiaries. Medicaid drug costs are estimated by multiplying Medicaid dual-eligible drug costs per day times the number of Medicaid days as reported in the Medicare allowable skilled nursing cost center in the SNF MCR. Medicaid dual-eligible drug costs per day (where the day represents an unduplicated drug supply day) were estimated using a sample of 2010 Part D claims for those dual-eligible beneficiaries who had a Medicare SNF stay during the year. Medicaid dual-eligible beneficiaries would receive their drugs through the Medicare Part D benefit, which would work directly with the pharmacy, and therefore, these costs would not be represented in the Medicare SNF MCRs. A random 20 percent sample of Medicare Part D claims data yielded a Medicaid drug cost per day of $17.39. We note that the FY 2004-based SNF market basket relied on data from the Medicaid Statistical Information System, which yielded a dual-eligible Medicaid drug cost per day of $13.65 for 2004. For the revised and rebased FY 2010-based SNF market basket, we used Part D claims to estimate total Medicaid drug costs as this provides drug expenditure data for dual-eligible beneficiaries for 2010. The Medicaid Statistical Information system is no longer a comprehensive database for dual-eligible beneficiaries' drug costs.

(5) Professional Liability Insurance: We calculated the professional liability insurance costs from Worksheet S–2 of the MCRs as the sum of premiums, paid losses, and self-insurance (Worksheet S–2, column 1, line 45 plus Worksheet S–2, column 2, line 45 plus Worksheet S–2, column 3, line 45).

(6) Capital-Related: We derived the capital-related costs using the FY 2010 SNF MCRs. We calculated the Medicare allowable capital-related cost weight from Worksheet B, part II (Worksheet B, part II, column 18, line 16 plus Worksheet B, part II, column 18, lines 21 to 30 plus Worksheet B, part II, column 18, line 32 plus Worksheet B, part II, column 18, line 33 plus Worksheet B, part II, column 18, line 48 plus Worksheet B, part II, column 18, lines 52 to 54).

(7) All Other Expenses: The ''all other'' cost weight is a residual, calculated by subtracting the major cost weights (wages and salaries, employee benefits, contract labor, pharmaceuticals, professional liability insurance, and capital-related expenses) from 100. As stated in the FY 2014 SNF proposed rule (78 FR 26451), we then proposed to divide the residual ''all other'' cost category (21.534 percent) into subcategories, using U.S. Department of Commerce Bureau of Economic Analysis' (BEA) 2002 Benchmark Input–Output (I–O) tables for the nursing home industry aged forward to FY 2014 using price changes. We also proposed that if more recent BEA Benchmark I–O data for 2007 were released between the proposed and final rule with sufficient time to incorporate such data into the final rule that we would incorporate these data, as appropriate, into the FY 2010-based SNF PPS market basket for the final rule, so that the SNF market basket reflects the most recent BEA data available.

Comment: One commenter had questions on our methodology for the proposed FY 2010-based SNF market basket contract labor cost weight. They stated that the contract labor in a nursing facility is primarily comprised of agency nursing (commonly called nursing pool) and contracted therapy. They further stated that we calculate Allowable Contract Labor by multiplying total contract labor cost by the ratio of SNF salaries and wages to SNF and NF salaries and wages, which they indicated is reasonable to assume because agency nursing would provide services to patients in skilled units and in NF units. However, they asserted that while this allocation approach is reasonable for agency nursing, it is not appropriate for contracted therapy. They further stated that contract therapy costs relate almost exclusively to skilled patients and are reported as ancillary costs (Worksheet B Part I, lines 25–27), which are Medicare allowable expenses. They indicated that allocating these costs on the ratio of SNF and NF salaries results in a percentage of these costs being considered as non-allowable, which is inaccurate. Therefore, they proposed that prior to determining the Allowable Contract Labor using the ratio methodology described above, that contract therapy costs (which they calculate as Worksheet A, lines 25–27, column 2) be removed. Total Medicare allowable contract labor would be equal to the Allowable Contract Labor plus the contract therapy costs.

Response: We appreciate the commenter bringing to our attention a potential issue with contracted therapy costs weight methodology. While the commenter has raised an issue that would require further analysis, our preliminary analysis indicates that the impact to the cost weight for a change like this would be negligible (0.001 percentage points to the cost weight). Therefore, we will continue to use our current methodology but will conduct further analysis and communicate any findings in future rulemaking.

Comment: One commenter suggested that we should provide the public with a meaningful opportunity to comment on the incorporation of more recent BEA Benchmark Input–Output (I–O) data into the FY 2014 market basket update before using this data as proposed.

Response: The 2007 Benchmark I–O data has not been published by the BEA and, therefore, we will not be incorporating this data into the FY 2010-based SNF market basket. The 2007 Benchmark I–O data is expected to be published in December 2013. Any future use of this 2007 data in the SNF market basket will be proposed in rulemaking, which will provide the public with a meaningful opportunity to comment.

Comment: Several commenters disagreed with our proposal in the FY 2014 SNF PPS proposed rule (78 FR 26458) to use the ECI for Nursing Care Facilities (Private Industry) (NAICS 6231; BLS series code CIU2026231000000I) to measure price growth of the wages and salaries and employee benefit cost category. They stated that the proposed wages and salaries price proxy index may be too heavily weighted with a lower-skilled labor mix to be adequately representative of the mix of labor skills necessary to deliver care to Medicare SNF patients. In addition, they stated that according to the Census Bureau, there were 16,320 establishments classified in NAICS 6231 in 2007. For that year, 13,841 SNFs submitted cost reports, suggesting that approximately 15 percent of establishments in this industry classification are facilities providing care to residents who are less complex and resource-intensive than SNF residents, especially SNF post-acute care patients. These commenters stated that if these facilities have a less-skilled workforce whose wages and salaries increase at a slower rate than higher-skilled occupations, using the

ECI for NAICS 6231 as the price proxy for wages and salaries in the SNF market basket index could bias the SNF market basket update downward. Furthermore, one commenter proposed that we use a blended price proxy based on 25 percent of the ECI for wages and salaries for nursing and residential care facilities (NAICS 623) and 75 percent of the ECI for wages and salaries for hospital workers (NAICS 622). The commenter suggested that we collect data for a sample of Medicare SNFs to determine the appropriate weighting.

Response: We do not agree with the commenter's suggestion to continue to use a blended price proxy similar to that used for the FY 2004-based SNF market basket to measure the price growth of wages and salaries and employee benefit cost category. The FY 2004-based SNF market basket used a blended index of a more general nursing home ECI for Nursing and Residential Facilities (NAICS 623, representing facilities that provide a mix of health and social services) and the ECI for wages and salaries of hospital workers (NAICS 622) as a result of the discontinuation of an ECI for Nursing and Personal Care Facilities based on the Standard Industrial Classification (SIC) 805. The blended index was proposed and finalized in the FY 2008 SNF PPS rulemaking (72 FR 25550–51 and 72 FR 43425–29, respectively) to address the industry's and CMS's concern about the lack of an ECI that best represented Medicare-certified SNFs. After requests from CMS and the SNF industry, BLS began publishing the ECI for Nursing Care Facilities (6231) in 2006. Because BLS had just begun publishing ECI data for Nursing Care Facilities (NAICS 6231) at the time of the last SNF market revision and rebasing, IGI, the economic forecasting firm, was unable to forecast this price proxy at that time.

As stated by the commenter, according to the 2007 Economic Census there were 16,320 establishments classified in NAICS 6231 in 2007; however, 15,335 establishments operated for the entire year (as also reported in the 2007 Economic Census). Of the 13,841 SNF providers submitting a Medicare cost report, 13,830 were open for an entire year. Therefore, 85–90 percent of the 2007 NAICS 6231 establishments are likely Medicare-certified SNFs. The commenter proposes that we continue to use NAICS 623 (Nursing and Residential Facilities), which is less representative of Medicare-certified SNFs since it also includes other types of facilities such as Residential care facilities, in the blended price proxy.

Because we believe the ECI for Nursing Care Facilities (NAICS 6231) is representative of the SNF industry as discussed above, we continue to believe it is the most technically appropriate proxy for the compensation price inflation faced by Medicare-certified SNFs. As such, we believe that a blended price proxy is no longer necessary.

After considering the comments we received, for the reasons discussed above and in the FY 2014 SNF PPS proposed rule, we are finalizing without modification our proposals as presented in the FY 2014 SNF PPS proposed rule (78 FR 26451 through 26461) to revise the FY 2004-based SNF market basket and to rebase it to reflect a base year of FY 2010, effective October 1, 2013. Table 1 presents the final revised and rebased FY 2010-based SNF market basket index.

TABLE 1—FY 2010-BASED SNF MARKET BASKET

Cost category	Weight	Proposed price proxy
Compensation	62.093	
Wages and Salaries	50.573	ECI for Wages and Salaries for Nursing Care Facilities.
Employee Benefits	11.520	ECI for Benefits for Nursing Care Facilities.
Utilities	2.223	
Electricity	1.411	PPI for Commercial Electric Power.
Fuels, Nonhighway	0.667	PPI for Commercial Natural Gas.
Water and Sewerage	0.145	CPI–U for Water and Sewerage Maintenance.
Professional Liability Insurance	1.141	CMS Hospital Professional Liability Insurance Index.
All Other	27.183	
Other Products	16.148	
Pharmaceuticals	7.872	PPI for Pharmaceuticals for Human Use, Prescription.
Food, Wholesale Purchase	3.661	PPI for Processed Foods and Feeds.
Food, Retail Purchases	1.190	CPI–U for Food Away From Home.
Chemicals	0.166	Blend of Chemical PPIs.
Medical Instruments and Supplies	0.764	PPI for Medical, Surgical, and Personal Aid Devices.
Rubber and Plastics	0.981	PPI for Rubber and Plastic Products.
Paper and Printing Products	0.838	PPI for Converted Paper and Paperboard Products.
Apparel	0.195	PPI for Apparel.
Machinery and Equipment	0.190	PPI for Machinery and Equipment.
Miscellaneous Products	0.291	PPI for Finished Goods Less Food and Energy.
All Other Services	11.035	
Labor-Related Services	6.227	
Nonmedical Professional Fees: Labor-related	3.427	ECI for Total Compensation for Professional and Related Occupations.
Administrative and Facilities Support	0.497	ECI for Total Compensation for Office and Administrative Support.
All Other: Labor-Related Services	2.303	ECI for Total Compensation for Service Occupations.
Non Labor-Related Services	4.808	
Nonmedical Professional Fees: Non Labor-Related.	2.042	ECI for Total Compensation for Professional and Related Occupations.
Financial Services	0.899	ECI for Total Compensation for Financial Activities.
Telephone Services	0.572	CPI–U for Telephone Services.
Postage	0.240	CPI–U for Postage and Delivery Services.
All Other: Nonlabor-Related Services	1.055	CPI–U for All Items Less Food and Energy.
Capital-Related Expenses	7.360	
Total Depreciation	3.180	

TABLE 1—FY 2010-BASED SNF MARKET BASKET—Continued

Cost category	Weight	Proposed price proxy
Building and Fixed Equipment	2.701	BEA chained price index for nonresidential construction for hospitals and special care facilities—vintage weighted (25 years).
Movable Equipment	0.479	PPI for Machinery and Equipment—vintage weighted (6 years).
Total Interest	2.096	
For-Profit SNFs	0.869	Average yield on municipal bonds (Bond Buyer Index 20 bonds)—vintage weighted (22 years).
Government and Nonprofit SNFs	1.227	Average yield on Moody's AAA corporate bonds—vintage weighted (22 years).
Other Capital-Related Expenses	2.084	CPI–U for Rent of Primary Residence.
Total	100.000	

i. Effect of Revising and Rebasing the SNF Market Basket Index on the Labor-Related Share

We define the labor-related share (LRS) as those expenses that are labor-intensive and vary with, or are influenced by, the local labor market. Each year, we calculate a revised labor-related share based on the relative importance of labor-related cost categories in the input price index. In the FY 2014 SNF PPS proposed rule (78 FR 26462–63), we proposed to revise and update the labor-related share to reflect the relative importance of the following FY 2010-based SNF market basket cost weights that we believe are labor-intensive and vary with, or are influenced by, the local labor market: (1) Wages and salaries; (2) employee benefits; (3) contract labor; (4) the labor-related portion of nonmedical professional fees; (5) administrative and facilities support services; (6) all other: Labor-related services (previously referred to in the FY 2004-based SNF market basket as labor-intensive); and (7) a proportion of capital-related expenses. We proposed to continue to include a proportion of capital-related expenses because a portion of these expenses are deemed to be labor-intensive and vary with, or are influenced by, the local labor market. For example, a proportion of construction costs for a medical building would be attributable to local construction workers' compensation expenses.

Consistent with previous SNF market basket revisions and rebasings, the ''all other: labor-related services'' cost category is mostly comprised of building maintenance and security services (including, but not limited to, commercial and industrial machinery and equipment repair, nonresidential maintenance and repair, and investigation and security services). Because these services tend to be labor-intensive and are mostly performed at the SNF facility (and therefore, unlikely to be purchased in the national market), we believe that they meet our definition of labor-related services.

The inclusion of the administrative and facilities support services cost category into the labor-related share remains consistent with the current labor-related share, since this cost category was previously included in the FY 2004-based SNF market basket labor-intensive cost category. As stated in the FY 2014 SNF PPS proposed rule (78 FR 26462), we proposed to establish a separate administrative and facilities support services cost category so that we can use the ECI for Total Compensation for Office and Administrative Support Services to reflect the specific price changes associated with these services.

For the FY 2004-based SNF market basket, we assumed that all nonmedical professional services (including accounting and auditing services, engineering services, legal services, and management and consulting services) were purchased in the local labor market and, thus, all of their associated fees varied with the local labor market. As a result, we previously included 100 percent of these costs in the labor-related share. As we discussed in the FY 2014 SNF PPS proposed rule (78 FR 26462), in an effort to determine more accurately the share of nonmedical professional fees that should be included in the labor-related share, we surveyed SNFs regarding the proportion of those fees that are attributable to local firms and the proportion that are purchased from national firms. Based on these weighted results, we determined that SNFs purchase, on average, the following portions of contracted professional services inside their local labor market:

- 86 percent of accounting and auditing services.
- 89 percent of architectural, engineering services.
- 78 percent of legal services.
- 87 percent of management consulting services.

Together, these four categories represent 2.672 percentage points of the total costs for the proposed FY 2010-based SNF market basket. We applied the percentages from this special survey to their respective SNF market basket weights to separate them into labor-related and nonlabor-related costs. As a result, we are designating 2.285 of the 2.672 total to the labor-related share, with the remaining 0.387 categorized as nonlabor-related.

In addition to the professional services listed above, we also classified expenses under NAICS 55, Management of Companies and Enterprises, into the nonmedical professional fees cost category. The NAICS 55 data are mostly comprised of corporate, subsidiary, and regional managing offices, or otherwise referred to as home offices. Formerly, all of the expenses within this category were considered to vary with, or be influenced by, the local labor market, and thus, were included in the labor-related share. Because many SNFs are not located in the same geographic area as their home office, we analyzed data from a variety of sources to determine what proportion of these costs should be appropriately included in the labor-related share. As discussed in the FY 2014 SNF PPS proposed rule (78 FR 26462), we proposed a methodology to determine the proportion of NAICS 55 costs that should be allocated to the labor-related share based on the percent of SNF home office compensation attributable to those SNFs that had home offices located in their respective labor markets. Our proposed methodology was based on data from MCRs, as well as a CMS database of Home Office Medicare Records (HOMER). Using this proposed methodology, we determined that 32 percent of SNF home office compensation costs were for SNFs that

had home offices located in their respective local labor markets; therefore, we proposed to allocate 32 percent of NAICS 55 expenses to the labor-related share. We believe that this methodology provides a reasonable estimate of the NAICS 55 expenses that are appropriately allocated to the labor-related share, because we primarily rely on data on home office compensation costs as provided by SNFs on Medicare cost reports. By combining these data with the specific MSAs for the SNF and their associated home office, we believe we have a reasonable estimate of the proportion of SNF's home office costs that would be incurred in the local labor market.

In the proposed FY 2010-based SNF market basket, NAICS 55 expenses that were subject to allocation based on the home office allocation methodology represent 1.833 percent of the total costs. Based on the home office results, we are apportioning 0.587 percentage point of the 1.833 percentage points figure into the labor-related share and designating the remaining 1.247 percentage points as nonlabor-related.

The Benchmark I–O data contains other smaller cost categories that we allocate fully to either nonmedical professional fees: labor-related or nonmedical professional fees: nonlabor-related. Together, the sum of these smaller cost categories, the four nonmedical professional fees cost categories where survey results were available, and the NAICS 55 expenses represent all nonmedical professional fees, or 5.469 percent of total costs in the SNF market basket. Of the 5.469 percentage points, 3.427 percentage points represent professional fees: labor-related while 2.042 percentage points represent nonmedical professional fees: nonlabor-related.

For a complete discussion of our proposals related to the labor-related share and associated rationale, we refer readers to the FY 2014 SNF PPS proposed rule (78 FR 26462–63). A discussion of the comments we received related to these proposals, with our responses, appears below.

Comment: One commenter disagreed with our use of the professional fees survey to determine the labor-related portion of Nonmedical Professional Fees costs associated with accounting and auditing services; architectural, engineering services; legal services; and management and consulting services. They stated that the survey of 141 providers only represents 0.94 percent of the approximately 15,000 SNFs nationwide. Furthermore, they contended that even when the services are purchased from ''national firms,'' those services are priced by national firms according to local market costs.

Response: We believe a method that distributes these professional fees based on empirical research and data, and not on assumption, represents a technical improvement to the construction of the market basket and the estimate of the labor-related share. In an effort to draw a nationally representative sample of skilled nursing facilities, we used data on full-time equivalents (FTE's) to represent the sizes of each SNF and then selected institutions for participation in the survey, across various strata (to be representative across Census Region and Urban/Rural status), based on their relative FTE size. That is, the greater the number of one's FTEs, the greater the chance of being selected to participate in the sample from one's specific stratum.

The survey itself prompted sample institutions to select from multiple choice answers the proportions of their professional fees that are purchased from firms located outside of their respective local labor market. The multiple choice answers for each type of professional service included the following options: 0 percent of fees; 1–20 percent of fees; 21–40 percent of fees; 41–60 percent of fees; 61–80 percent of fees; 81–99 percent of fees; and 100 percent of fees. We chose this type of approach, as opposed to asking firms for more detailed approximations of their spending, in an attempt to reduce variability within the data.

Responses were gathered with each participating institution being assigned a sample weight equal to the inverse of their selection probability (with adjustments for non-response bias to ensure the representativeness of the data). This type of application represents a very common survey approach and is based on valid and widely-accepted statistical techniques. We believe that this methodology of weighting responses allows for an adequate sample size to draw inferences for this purpose.

We noted generally that, depending on the exact professional service, between 25 percent and 50 percent of the institutions indicated that they purchased at least some percentage of those services from firms beyond their local labor market. Given these findings, we developed a weighted average of the results to determine the final proportion to be excluded from the labor-related share for each of the four types of professional services surveyed.

The following represents a description of the steps we used in developing the weighted averages to designate these fees as labor-related or nonlabor-related:

First, for those institutions that spent between 1 percent and 20 percent of the professional services fees on firms located beyond their local labor markets, we multiplied their weighted count by the mid-point of that range (or 10 percent) as those estimates tended to have very low variability around their respective point estimates. As an example, for Accounting and Auditing services, if a weighted count of 500 SNFs responded that they paid ''1 to 20 percent'' of their professional fees for these services to firms located outside of their local labor market, we would multiply 500 times 10 percent. This would represent our first subtotal.

Second, for those firms that spent more than 20 percent of their fees on firms located outside of their local labor markets, the variance around the point estimates tended to be higher. As a result we multiplied the weighted number of firms by the low point within each multiple choice answer's range in order to develop our overall weighted estimates. Using a similar example as above, if a weighted count of 300 SNFs responded that they paid ''21 to 40 percent'' of their professional fees to firms located outside of their local labor market, we would multiply 300 times 21 percent. This would be repeated for the other categories, as well and represent our next set of subtotals.

For the last step in the calculations, we added the subtotals together and then divided by the total number of weighted SNFs in order to determine what proportion of their professional fees went to firms inside and outside of their local labor markets.

Additionally, we disagree with the commenter that services purchased from national firms are always priced at local labor market cost rates. We believe, for example, that an accounting firm that employs accountants located at their headquarters would have a standard pricing structure that is developed to ensure that their costs of operation are covered, regardless of the location of their clients. Finally, in the absence of a creditable data source from the commenter, we do not believe it would be appropriate to include costs associated with professional services purchased from nationally based firms located beyond the SNF's local labor market in the labor-related share.

After considering the comments we received, for the reasons discussed above and in the FY 2014 SNF PPS proposed rule, we are finalizing our proposal, as presented in the FY 2014 SNF PPS proposed rule (78 FR 26462 through 26463), to update and revise the

labor-related share effective October 1, 2013, to reflect the relative importance of the following FY 2010-based SNF market basket cost weights that we believe are labor-intensive and vary with, or are influenced by, the local labor market: (1) Wages and salaries; (2) employee benefits; (3) contract labor; (4) the labor-related portion of nonmedical professional fees; (5) administrative and facilities support services; (6) all other: labor-related services (previously referred to in the FY 2004-based SNF market basket as labor-intensive); and (7) a proportion of capital-related expenses. Furthermore, in the FY 2014 SNF PPS proposed rule (78 FR 26443), we also proposed if more recent data became available (for example, a more recent estimate of the FY 2010-based SNF market basket, MFP adjustment, and/or FY 2004-based SNF market basket used for the forecast error calculation), we would use such data, if appropriate, to determine the FY 2014 SNF market basket update, FY 2014 labor-related share relative importance, and MFP adjustment in the FY 2014 SNF PPS final rule. Accordingly, Table 2 below summarizes the revised and updated labor-related share for FY 2014, which is based on IGI's most recent forecast (second quarter 2013 forecast with historical data through first quarter 2013) of the rebased and revised FY 2010-based SNF market basket, compared to the labor-related share that was used for the FY 2013 SNF PPS update.

TABLE 2—FY 2013 AND FY 2014 SNF LABOR-RELATED SHARE

	Relative importance, labor-related, FY 2013 (FY 2004-based index) 12:2 forecast	Relative importance, labor-related, FY 2014 (FY 2010-based index) 13:2 forecast
Wages and salaries [1]	49.847	49.118
Employee benefits	11.532	11.423
Nonmedical Professional fees: labor-related	1.307	3.446
Administrative and facilities support services	N/A	0.499
All Other: Labor-related services [2]	3.364	2.287
Capital-related (.391)	2.333	2.772
Total	68.383	69.545

[1] The wages and salaries and employee benefits cost weight reflect contract labor costs.
[2] Previously referred to as labor-intensive services cost category in the FY 2004-based SNF market basket.

2. Market Basket Estimate for the FY 2014 SNF PPS Update

We also proposed to determine the FY 2014 SNF market basket percentage under section 1888(e)(5)(B)(i) of the Act based on the percentage increase in the revised and rebased FY 2010-based SNF market basket (78 FR 26441). As discussed above, we are finalizing our proposal to revise and rebase the SNF market basket to reflect a base year of FY 2010. Thus, we are finalizing our proposal to use the FY 2010-based SNF market basket to determine the SNF market basket percentage increase for FY 2014. Section IV.B.5 of this final rule includes further discussion of the SNF market basket percentage increase for FY 2014.

3. Forecast Error Adjustment

As discussed in the June 10, 2003 supplemental proposed rule (68 FR 34768) and finalized in the August 4, 2003, final rule (68 FR 46057 through 46059), the regulations at § 413.337(d)(2) provide for an adjustment to account for market basket forecast error. The initial adjustment for market basket forecast error 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, resulting in an increase of 3.26 percent to the FY 2004 update. 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 the difference between the forecasted and actual change in the market basket when the difference 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 for FY 2008 and subsequent fiscal years. As we stated in the FY 2004 SNF PPS final rule that first issued the market basket forecast error adjustment (68 FR 46058, August 4, 2003), the adjustment will ''. . . reflect both upward and downward adjustments, as appropriate.''

In the FY 2014 SNF PPS proposed rule (78 FR 26441 through 26442), we discussed the forecast error for FY 2012 (the most recently available FY for which there is final data), and proposed a new method for reporting the forecast error in situations where the forecast error calculation is equal to 0.5 percentage point when rounded to one significant digit (otherwise referred to as a tenth of a percentage point). For FY 2012, the estimated increase in the market basket index was 2.7 percentage points, while the actual increase was 2.2 percentage points, resulting in the actual increase being 0.5 percentage point lower than the estimated increase. As the forecast error calculation in this instance does not permit one to determine definitively if the forecast error adjustment threshold has been exceeded, we proposed to report the forecast error to two significant digits so that we may determine whether the forecast error correction threshold has been exceeded and whether the forecast error adjustment should be applied under § 413.337(d)(2). This policy would apply only in those instances where the forecast error, when rounded to one significant digit, is 0.5 percentage point. Furthermore, we stated that we would apply the proposed policy where the difference between the actual and projected market basket is either positive or negative 0.5 percentage point. We believe this approach is necessary and appropriate to ensure that the necessity for a forecast error adjustment is accurately determined in accordance with § 413.337(d)(2). Therefore, we proposed that, following the policy outlined above, we would determine the forecast error for FY 2012 to the second significant digit, or the hundredth of a percentage point. The forecasted FY 2012 SNF market basket

percentage change was 2.7 percent. When rounded to the second significant digit, it was 2.69 percent. This would be subtracted from the actual FY 2012 SNF market basket percentage change, rounded to the second significant digit, of 2.18 percent to yield a negative forecast error correction of 0.51 percentage point. As the forecast error correction, when rounded to two significant digits, exceeds 0.5 percentage point, a forecast error adjustment would be warranted under the policy outlined in the FY 2008 SNF PPS final rule (72 FR 43425) (see § 413.337(d)(2)).

We stated in the proposed rule that, consistent with prior applications of the forecast error adjustment since establishing the 0.5 percentage point threshold, and consistent with our applications of both the market basket adjustment and productivity adjustment described below, once we have determined that a forecast error adjustment is warranted, we will continue to apply the adjustment itself at one significant digit (otherwise referred to as a tenth of a percentage point). Therefore, the FY 2014 SNF market basket percentage change of 2.3 percent would be adjusted downward by the forecast error correction of 0.5 percentage point, resulting in a net SNF market basket increase factor of 1.8 percent.

We received a number of comments on the proposed change to how the forecast error is reported in these limited circumstances, as well as more general comments on the SNF forecast error adjustment. A discussion of these comments, with our responses, appears below.

Comment: The comments received on this topic supported the approach proposed in the FY 2014 SNF PPS proposed rule for reporting the forecast error in situations where the forecast error calculation is equal to 0.5 percentage point when rounded to one significant digit. Some commenters did, however, state that we should consider using a 0.45 percentage point threshold instead of the 0.5 percentage point threshold, where we would apply a forecast error adjustment when the forecast error exceeded 0.45 percentage point. According to the commenters, this would permit us to continue applying an adjustment at the one significant digit level without requiring different methods for reporting the forecast error in a given year. Finally, it was requested that we confirm that in cases where the threshold rounds to 0.50 percentage point, at the two significant digit level, that a forecast error adjustment would not be applied.

Response: We appreciate the support for our proposal from commenters. With respect to the commenters' suggestion that we adopt a 0.45 percentage point threshold rather than the current 0.5 percentage point threshold, we note that we did not propose to change the forecast error threshold in the FY 2014 SNF PPS proposed rule, and thus we are not adopting such a change at this time. We proposed only to change how the forecast error is *reported* to create greater transparency, in those limited cases where the forecast error rounds to 0.5 percentage point at the one significant digit level, as to whether and why the forecast error adjustment is or is not being applied in a given year. We continue to believe that a 0.5 percentage point threshold is appropriate and enables us to identify those instances where the difference between the actual and projected market basket becomes sufficiently significant to indicate that the historical price changes are not being adequately reflected.

In response to the comment concerning whether, under our proposed policy, the forecast error adjustment would be applied in cases where the forecast error rounds to 0.50 percentage point at the two significant digit level, we would not apply the forecast error adjustment in such a case as the forecast error would not exceed the 0.5 percentage point threshold.

Comment: Several commenters suggested that we apply a cumulative forecast error adjustment to account for all of the variations in the market basket forecasts since FY 2003. These commenters stated that while the industry has tolerated the adjustment process, the lack of any cumulative adjustment in recent years violates the precedent set by CMS in 2003 when the last cumulative adjustment was made and that the cumulative adjustment in 2003 demonstrated recognition by us of the cumulatively erosive effect of multi-year forecasting errors. The commenters recommended that we adopt a policy which recognizes the cumulative effect of multi-year market basket forecast errors and that an adjustment be made to account for the cumulative errors since FY 2003.

Response: In the FY 2004 SNF PPS final rule, we applied a one-time, cumulative forecast error adjustment resulting in an increase of 3.26 percent (68 FR 46036, 46058). Since that time, the forecast errors have been relatively small and clustered near zero. As stated in prior rulemaking on the SNF PPS—including, most recently, the FY 2012 SNF PPS final rule (76 FR 48527, August 8, 2011)—we believe the forecast error correction should be applied only when the degree of forecast error in any given year is such that the SNF base payment rate does not adequately reflect the historical price changes faced by SNFs. Accordingly, 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 year-to-year variances that are a routine and inherent aspect of this type of statistical measurement.

Accordingly, for the reasons discussed in this final rule and in the FY 2014 SNF PPS proposed rule (78 FR 26441 through 26442), we are finalizing our proposal to report the forecast error to the second significant digit in only those instances where the forecast error rounds to 0.5 percentage point at one significant digit. Effective October 1, 2013, we will report the forecast error to the second significant digit in those instances where the forecast error rounds to 0.5 percentage point at one significant digit, so that we may determine whether the forecast error adjustment threshold has been exceeded. As discussed above, once we have determined that a forecast error adjustment is warranted, we will continue to apply the adjustment itself at one significant digit (otherwise referred to as a tenth of a percentage point).

4. Multifactor Productivity Adjustment

Section 3401(b) of the Affordable Care Act (consisting of the Patient Protection and Affordable Care Act, Pub. L. 111–148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111–152, enacted on March 30, 2010) requires that, in FY 2012 (and in subsequent FYs), the market basket percentage under the SNF payment system as described in section 1888(e)(5)(B)(i) of the Act is to be reduced annually by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act, added by section 3401(a) of the Affordable Care Act, sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to ''the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost-reporting period, or other annual period)'' (the MFP adjustment). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business

multifactor productivity (MFP). Please see *http://www.bls.gov/mfp* to obtain the BLS historical published MFP data.

The projection of MFP is currently produced by IGI, an economic forecasting firm. To generate a forecast of MFP, IGI replicated the MFP measure calculated by the BLS, using a series of proxy variables derived from IGI's U.S. macroeconomic models. This process is described in greater detail in section III.F.3 of the FY 2012 SNF PPS final rule (76 FR 48527 through 48529).

a. Incorporating the Multifactor Productivity Adjustment Into the Market Basket Update

Section 1888(e)(5)(A) of the Act requires the Secretary to ''establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.'' Section 1888(e)(5)(B)(ii) of the Act, added by section 3401(b) of the Affordable Care Act, requires that for FY 2012 and each subsequent FY, after determining the market basket percentage described in section 1888(e)(5)(B)(i) of the Act, ''the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)'' (which we refer to as the multifactor productivity (MFP) adjustment). Section 1888(e)(5)(B)(ii) of the Act further states that the reduction of the market basket percentage by the MFP adjustment may result in the market basket percentage being less than zero for a FY, and may result in payment rates under section 1888(e) of the Act for a FY being less than such payment rates for the preceding FY. Thus, if the application of the MFP adjustment to the market basket percentage calculated under section 1888(e)(5)(B)(i) of the Act results in an MFP-adjusted market basket percentage that is less than zero, then the annual update to the unadjusted federal per diem rates under section 1888(e)(4)(E)(ii) of the Act would be negative, and such rates would decrease relative to the prior FY.

For the FY 2014 SNF PPS update, the MFP adjustment is calculated as the 10-year moving average of changes in MFP for the period ending September 30, 2014. In accordance with section 1888(e)(5)(B)(i) of the Act and § 413.337(d)(2) of the regulations, the SNF PPS market basket percentage for FY 2014 is based on IGI's second quarter 2013 forecast of the FY 2010-based SNF market basket update (which is 2.3 percent), as adjusted by the forecast error adjustment (which is 0.5 percent), and is estimated to be 1.8 percent. In accordance with section 1888(e)(5)(B)(ii) of the Act (as added by section 3401(b) of the Affordable Care Act) and § 413.337(d)(3), this market basket percentage is then reduced by the MFP adjustment (which is the 10-year moving average of changes in MFP for the period ending September 30, 2014) of 0.5 percent. In the FY 2014 SNF PPS proposed rule (78 FR 26443), we proposed that if more recent data became available, we would use that data, if appropriate, to determine the FY 2014 MFP adjustment. The MFP adjustment of 0.4 percent set forth in the proposed rule was based on IGI's first quarter 2013 forecast. The 0.5 percent MFP adjustment set forth in this final rule is based on updated IGI data (that is, IGI second quarter 2013 forecast). The resulting MFP-adjusted SNF market basket update is equal to 1.3 percent, or 1.8 percent less the 0.5 percentage point MFP adjustment.

5. Market Basket Update Factor for FY 2014

Sections 1888(e)(4)(E)(ii)(IV) and 1888(e)(5)(i) of the Act require that SNF PPS unadjusted federal per diem rates for the previous fiscal year be adjusted by the market basket index percentage change for the fiscal year involved, in order to compute the unadjusted federal per diem rates for the current year. Accordingly, we determined the total growth from the average market basket index for the period of October 1, 2012 through September 30, 2013 to the average market basket index for the period of October 1, 2013 through September 30, 2014. This process yields a market basket update factor of 2.3 percent. As further explained in section IV.B.3 of this final rule, as applicable, we adjust the market basket update factor to reflect the forecast error from the most recently available FY for which there is final data and apply this adjustment whenever the difference between the forecasted and actual percentage change in the market basket exceeds a 0.5 percentage point threshold. Since the forecasted FY 2012 SNF market basket percentage change exceeded the actual FY 2012 SNF market basket percentage change (FY 2012 is the most recently available FY for which there is final data) by more than 0.5 percentage point, the FY 2014 market basket update factor of 2.3 percent would be adjusted downward by the applicable difference, in this case 0.5 percentage points, which reduces the FY 2014 market basket update factor to 1.8 percent. In addition, for FY 2014, section 1888(e)(5)(B) of the Act requires us to reduce the market basket percentage by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2014) of 0.5 percent, as described in section IV.B.4. of this final rule. The resulting MFP-adjusted SNF market basket update would be equal to 1.3 percent, or 1.8 percent less 0.5 percentage point. We used the FY 2010-based SNF market basket percentage, adjusted as described above, to adjust each per diem component of the federal rates forward to reflect the change in the average prices for FY 2014 from average prices for FY 2013. We further adjust the rates by a wage index budget neutrality factor, described later in this section. Tables 3 and 4 reflect the updated components of the unadjusted federal rates for FY 2014, prior to adjustment for case-mix.

TABLE 3—FY 2014 UNADJUSTED FEDERAL RATE PER DIEM—URBAN

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$165.81	$124.90	$16.45	$84.62

TABLE 4—FY 2014 UNADJUSTED FEDERAL RATE PER DIEM—RURAL

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$158.41	$144.01	$17.57	$86.19

6. Case-Mix Adjustment

Under section 1888(e)(4)(G)(i) of the Act, the federal rate also incorporates an adjustment to account for case-mix, using a classification system that accounts for the relative resource utilization of different patient types. The statute specifies that the adjustment is to reflect both a resident classification system established by the Secretary to account for the relative resource use of different patient types, as well as resident assessment data and other data that the Secretary considers appropriate. In the May 12, 1998 interim final rule with comment period that initially implemented the SNF PPS (63 FR 26252), we developed the 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 (CMIs). The original RUG–III grouper logic was based on clinical data collected in 1990, 1995, and 1997. As discussed in the FY 2010 SNF PPS proposed rule (74 FR 22208), we subsequently conducted a multi-year data collection and analysis under the Staff Time and Resource Intensity Verification (STRIVE) project to update the case-mix classification system for FY 2011. The resulting Resource Utilization Groups, Version 4 (RUG–IV) case-mix classification system reflected the data collected in 2006 through 2007 during the STRIVE project, and the RUG–IV model was finalized in the FY 2010 SNF PPS final rule (74 FR 40288) to take effect in FY 2011 concurrently with an updated new resident assessment instrument, version 3.0 of the Minimum Data Set (MDS 3.0), which collects the clinical data used for case-mix classification under RUG–IV.

We note that case-mix classification is based, in part, on the beneficiary's need for skilled nursing care and therapy services. The case-mix classification system uses clinical data from the MDS to assign a case-mix group to each patient that is then used to calculate a per diem payment under the SNF PPS. Further, because the MDS is used as a basis for payment as well as a clinical assessment, we have provided extensive training on proper coding and the time frames for MDS completion in the RAI Manual. For an MDS to be considered valid for use in determining payment, the MDS assessment must be completed in compliance with the instructions in the RAI Manual in effect at the time the assessment is completed. For payment and quality monitoring purposes, the RAI Manual consists of both the Manual instructions and the interpretive guidance and policy clarifications posted on the appropriate MDS Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html*.

Under section 1888(e)(4)(H), each update of the payment rates must include the case-mix classification methodology applicable for the upcoming FY. The payment rates set forth in this final rule reflect the use of the RUG–IV case-mix classification system from October 1, 2013, through September 30, 2014. We list the case-mix adjusted RUG–IV payment rates, provided separately for urban and rural SNFs, in Tables 5 and 6 with corresponding case-mix values. These tables do not reflect the add-on for SNF residents with AIDS enacted by section 511 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Pub. L. 108–173) discussed below, which we apply only after making all other adjustments (including the wage index and case-mix adjustments).

TABLE 5—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—URBAN

RUG–IV Category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUX	2.67	1.87	$442.71	$233.56	.....	$84.62	$760.89
RUL	2.57	1.87	426.13	233.56	.....	84.62	744.31
RVX	2.61	1.28	432.76	159.87	.....	84.62	677.25
RVL	2.19	1.28	363.12	159.87	.....	84.62	607.61
RHX	2.55	0.85	422.82	106.17	.....	84.62	613.61
RHL	2.15	0.85	356.49	106.17	.....	84.62	547.28
RMX	2.47	0.55	409.55	68.70	.....	84.62	562.87
RML	2.19	0.55	363.12	68.70	.....	84.62	516.44
RLX	2.26	0.28	374.73	34.97	.....	84.62	494.32
RUC	1.56	1.87	258.66	233.56	.....	84.62	576.84
RUB	1.56	1.87	258.66	233.56	.....	84.62	576.84
RUA	0.99	1.87	164.15	233.56	.....	84.62	482.33
RVC	1.51	1.28	250.37	159.87	.....	84.62	494.86
RVB	1.11	1.28	184.05	159.87	.....	84.62	428.54
RVA	1.10	1.28	182.39	159.87	.....	84.62	426.88
RHC	1.45	0.85	240.42	106.17	.....	84.62	431.21
RHB	1.19	0.85	197.31	106.17	.....	84.62	388.10
RHA	0.91	0.85	150.89	106.17	.....	84.62	341.68
RMC	1.36	0.55	225.50	68.70	.....	84.62	378.82
RMB	1.22	0.55	202.29	68.70	.....	84.62	355.61
RMA	0.84	0.55	139.28	68.70	.....	84.62	292.60
RLB	1.50	0.28	248.72	34.97	.....	84.62	368.31
RLA	0.71	0.28	117.73	34.97	.....	84.62	237.32
ES3	3.58	.....	593.60	.....	16.45	84.62	694.67
ES2	2.67	.....	442.71	.....	16.45	84.62	543.78
ES1	2.32	.....	384.68	.....	16.45	84.62	485.75
HE2	2.22	.....	368.10	.....	16.45	84.62	469.17
HE1	1.74	.....	288.51	.....	16.45	84.62	389.58
HD2	2.04	.....	338.25	.....	16.45	84.62	439.32
HD1	1.60	.....	265.30	.....	16.45	84.62	366.37
HC2	1.89	.....	313.38	.....	16.45	84.62	414.45
HC1	1.48	.....	245.40	.....	16.45	84.62	346.47

TABLE 5—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—URBAN—Continued

RUG–IV Category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
HB2	1.86		308.41		16.45	84.62	409.48
HB1	1.46		242.08		16.45	84.62	343.15
LE2	1.96		324.99		16.45	84.62	426.06
LE1	1.54		255.35		16.45	84.62	356.42
LD2	1.86		308.41		16.45	84.62	409.48
LD1	1.46		242.08		16.45	84.62	343.15
LC2	1.56		258.66		16.45	84.62	359.73
LC1	1.22		202.29		16.45	84.62	303.36
LB2	1.45		240.42		16.45	84.62	341.49
LB1	1.14		189.02		16.45	84.62	290.09
CE2	1.68		278.56		16.45	84.62	379.63
CE1	1.50		248.72		16.45	84.62	349.79
CD2	1.56		258.66		16.45	84.62	359.73
CD1	1.38		228.82		16.45	84.62	329.89
CC2	1.29		213.89		16.45	84.62	314.96
CC1	1.15		190.68		16.45	84.62	291.75
CB2	1.15		190.68		16.45	84.62	291.75
CB1	1.02		169.13		16.45	84.62	270.20
CA2	0.88		145.91		16.45	84.62	246.98
CA1	0.78		129.33		16.45	84.62	230.40
BB2	0.97		160.84		16.45	84.62	261.91
BB1	0.90		149.23		16.45	84.62	250.30
BA2	0.70		116.07		16.45	84.62	217.14
BA1	0.64		106.12		16.45	84.62	207.19
PE2	1.50		248.72		16.45	84.62	349.79
PE1	1.40		232.13		16.45	84.62	333.20
PD2	1.38		228.82		16.45	84.62	329.89
PD1	1.28		212.24		16.45	84.62	313.31
PC2	1.10		182.39		16.45	84.62	283.46
PC1	1.02		169.13		16.45	84.62	270.20
PB2	0.84		139.28		16.45	84.62	240.35
PB1	0.78		129.33		16.45	84.62	230.40
PA2	0.59		97.83		16.45	84.62	198.90
PA1	0.54		89.54		16.45	84.62	190.61

TABLE 6—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—RURAL

RUG–IV Category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUX	2.67	1.87	$422.95	$269.30		$86.19	$778.44
RUL	2.57	1.87	407.11	269.30		86.19	762.60
RVX	2.61	1.28	413.45	184.33		86.19	683.97
RVL	2.19	1.28	346.92	184.33		86.19	617.44
RHX	2.55	0.85	403.95	122.41		86.19	612.55
RHL	2.15	0.85	340.58	122.41		86.19	549.18
RMX	2.47	0.55	391.27	79.21		86.19	556.67
RML	2.19	0.55	346.92	79.21		86.19	512.32
RLX	2.26	0.28	358.01	40.32		86.19	484.52
RUC	1.56	1.87	247.12	269.30		86.19	602.61
RUB	1.56	1.87	247.12	269.30		86.19	602.61
RUA	0.99	1.87	156.83	269.30		86.19	512.32
RVC	1.51	1.28	239.20	184.33		86.19	509.72
RVB	1.11	1.28	175.84	184.33		86.19	446.36
RVA	1.10	1.28	174.25	184.33		86.19	444.77
RHC	1.45	0.85	229.69	122.41		86.19	438.29
RHB	1.19	0.85	188.51	122.41		86.19	397.11
RHA	0.91	0.85	144.15	122.41		86.19	352.75
RMC	1.36	0.55	215.44	79.21		86.19	380.84
RMB	1.22	0.55	193.26	79.21		86.19	358.66
RMA	0.84	0.55	133.06	79.21		86.19	298.46
RLB	1.50	0.28	237.62	40.32		86.19	364.13
RLA	0.71	0.28	112.47	40.32		86.19	238.98
ES3	3.58		567.11		17.57	86.19	670.87
ES2	2.67		422.95		17.57	86.19	526.71
ES1	2.32		367.51		17.57	86.19	471.27
HE2	2.22		351.67		17.57	86.19	455.43
HE1	1.74		275.63		17.57	86.19	379.39
HD2	2.04		323.16		17.57	86.19	426.92
HD1	1.60		253.46		17.57	86.19	357.22

TABLE 6—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES—RURAL—Continued

RUG–IV Category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
HC2	1.89		299.39		17.57	86.19	403.15
HC1	1.48		234.45		17.57	86.19	338.21
HB2	1.86		294.64		17.57	86.19	398.40
HB1	1.46		231.28		17.57	86.19	335.04
LE2	1.96		310.48		17.57	86.19	414.24
LE1	1.54		243.95		17.57	86.19	347.71
LD2	1.86		294.64		17.57	86.19	398.40
LD1	1.46		231.28		17.57	86.19	335.04
LC2	1.56		247.12		17.57	86.19	350.88
LC1	1.22		193.26		17.57	86.19	297.02
LB2	1.45		229.69		17.57	86.19	333.45
LB1	1.14		180.59		17.57	86.19	284.35
CE2	1.68		266.13		17.57	86.19	369.89
CE1	1.50		237.62		17.57	86.19	341.38
CD2	1.56		247.12		17.57	86.19	350.88
CD1	1.38		218.61		17.57	86.19	322.37
CC2	1.29		204.35		17.57	86.19	308.11
CC1	1.15		182.17		17.57	86.19	285.93
CB2	1.15		182.17		17.57	86.19	285.93
CB1	1.02		161.58		17.57	86.19	265.34
CA2	0.88		139.40		17.57	86.19	243.16
CA1	0.78		123.56		17.57	86.19	227.32
BB2	0.97		153.66		17.57	86.19	257.42
BB1	0.90		142.57		17.57	86.19	246.33
BA2	0.70		110.89		17.57	86.19	214.65
BA1	0.64		101.38		17.57	86.19	205.14
PE2	1.50		237.62		17.57	86.19	341.38
PE1	1.40		221.77		17.57	86.19	325.53
PD2	1.38		218.61		17.57	86.19	322.37
PD1	1.28		202.76		17.57	86.19	306.52
PC2	1.10		174.25		17.57	86.19	278.01
PC1	1.02		161.58		17.57	86.19	265.34
PB2	0.84		133.06		17.57	86.19	236.82
PB1	0.78		123.56		17.57	86.19	227.32
PA2	0.59		93.46		17.57	86.19	197.22
PA1	0.54		85.54		17.57	86.19	189.30

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 SNF residents with Acquired Immune Deficiency Syndrome (AIDS) to reflect increased costs associated with these residents, effective for services furnished on or after October 1, 2004. This special add-on for SNF residents with AIDS is required to remain in effect until ''. . . the Secretary certifies that there is an appropriate adjustment in the case mix . . . to compensate for the increased costs associated with [such] residents . . . .'' The add-on for SNF residents with AIDS is also discussed in Program Transmittal #160 (Change Request #3291), issued on April 30, 2004, which is available online at *www.cms.gov/transmittals/downloads/r160cp.pdf*. In the FY 2010 SNF PPS final rule (74 FR 40288) (in which we finalized the RUG–IV case-mix classification system), we did not address the certification of a case mix adjustment alternative to the add-on for SNF residents with AIDS, thus allowing the add-on payment required by section 511 of the MMA to remain in effect. For the limited number of SNF residents that qualify for this add-on, there is a significant increase in payments. Using FY 2011 data, we identified fewer than 4,100 SNF residents with a diagnosis code of 042 (Human Immunodeficiency Virus (HIV) Infection) who qualify for this add-on. For FY 2014, an urban facility with a resident with AIDS in RUG–IV group ''HC2'' would have a case-mix adjusted payment of $414.45 (see Table 4) before the application of the add-on required by the MMA. After application of the add-on, an increase of 128 percent, this urban facility would receive a case-mix adjusted payment of approximately $944.95 for this resident.

Currently, we use the International Classification of Diseases, 9th revision, Clinical Modification (ICD–9–CM) code 042 to identify those residents for whom it is appropriate to apply the AIDS add-on established by section 511 of the MMA. In this context, we note that, in accordance with the requirements of the final rule published in the **Federal Register** on September 5, 2012 (77 FR 54664), we will be discontinuing our current use of the ICD–9–CM, effective with the compliance date for using the International Classification of Diseases, 10th revision, Clinical Modification (ICD–10–CM) of October 1, 2014. In the FY 2014 SNF PPS proposed rule (78 FR 26444), with regard to the above-referenced ICD–9–CM diagnosis code of 042, we proposed to transition to the equivalent ICD–10–CM diagnosis code of B20 upon the October 1, 2014 implementation date for conversion to ICD–10–CM in order to identify those residents for whom it is appropriate to apply the AIDS add-on. We invited public comment on this proposal. We received only one comment that included a reference to this proposal, and this comment simply acknowledged the proposal without offering any specific observations about it. Accordingly, in this final rule, we are finalizing this proposal without any modification. Therefore, effective with services furnished on or after October 1, 2014, for the reasons set forth above and in the FY 2014 SNF PPS proposed rule (78 FR 26444), the AIDS add-on established by section 511 of the MMA

will apply to beneficiaries with an ICD–10–CM diagnosis code of B20.

7. Wage Index Adjustment

Section 1888(e)(4)(G)(ii) of the Act requires that we adjust the portion of the federal rates attributable to wages and wage-related costs for the area in which the facility is located compared to the national average of such costs using a wage index that we find appropriate. Since the implementation of the SNF PPS, we have used hospital wage data in developing a wage index to be applied to SNFs. In the FY 2014 SNF PPS proposed rule (78 FR 26446 through 26447), 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 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 the SNF PPS.

In the FY 2014 SNF PPS proposed rule (78 FR 26447), we also proposed to continue using the same methodology discussed in the FY 2008 SNF PPS final rule (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 2014 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 proposed to use the average wage index from all contiguous CBSAs as a reasonable proxy. For FY 2014, there are no rural geographic areas that do not have hospitals, and thus this methodology will not be applied. Furthermore, we indicated that we would not apply this methodology to rural Puerto Rico, but instead would continue using the most recent wage index previously available for that area due to the distinct economic circumstances that exist there (for example, due to the close proximity to one another of almost all of Puerto Rico's various urban and non-urban areas, using the methodology discussed in the FY 2008 final rule would produce a wage index for rural Puerto Rico that is inappropriately higher than that in half of its urban areas). For urban areas without specific hospital wage index data, we proposed to 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. For FY 2014, the only urban area without wage index data available is CBSA 25980, Hinesville-Fort Stewart, GA.

In the SNF PPS final rule for FY 2006 (70 FR 45026, August 4, 2005), we adopted the changes discussed in the 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. We indicated in the FY 2008 SNF PPS final rule (72 FR 43423), that 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 are available online at *http://www.whitehouse.gov/omb/bulletins/index.html.*

On February 28, 2013, OMB issued OMB Bulletin No. 13–01, announcing revisions to the delineation of Metropolitan Statistical Areas, Micropolitian Statistical Areas, and Combined Statistical Areas, and guidance on uses of the delineation of these areas. A copy of this bulletin may be obtained at *http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf.* This bulletin states that it provides the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published in the June 28, 2010 **Federal Register** (75 FR 37246–37252) and Census Bureau data.

While the revisions OMB published on February 28, 2013 are not as sweeping as the changes made when we adopted the CBSA geographic designations for FY 2006, the February 28, 2013 bulletin does contain a number of significant changes. For example, there are new CBSAs, urban counties that become rural, rural counties that become urban, and existing CBSAs that are being split apart.

The changes made by the bulletin and their ramifications must be extensively reviewed and assessed by CMS before using them for the SNF PPS wage index. Because the bulletin was not issued until February 28, 2013, we were unable to undertake such a lengthy process before publication of the FY 2014 proposed rule. By the time the bulletin was issued, the FY 2014 SNF PPS proposed rule was in the advanced stages of development. We had already developed the FY 2014 proposed wage index based on the previous OMB definitions. As we stated in the FY 2014 SNF PPS proposed rule (78 FR 26448), to allow for sufficient time to assess the new changes and their ramifications, we intend to propose changes to the wage index based on the newest CBSA changes in the FY 2015 SNF PPS proposed rule, and thus we would continue to use the previous OMB definitions (that is, those used for the FY 2013 SNF PPS update notice) for the FY 2014 SNF PPS wage index.

A discussion of the comments that we received on the wage index adjustment to the federal rates, and our responses to those comments, appears below.

Comment: Commenters recommend that we reconsider developing a SNF-specific wage index suggesting that ''hospital cost data may not be the most reliable resource when determining geographical differences in salary structure for skilled nursing facilities.'' Additionally, one commenter recommends that this rule reflect any changes needed to ensure that adjustments more accurately reflect salary experiences of facilities. Commenters request that we provide an update in the final rule on its efforts and plans for wage index reform for the SNF PPS that aims to minimize fluctuations, match the costs of labor in the market, and provides for a single wage index policy.

Response: Tables A and B in the Addendum of this final rule reflect updated hospital wage data used to develop the SNF PPS wage index published in the FY 2014 SNF PPS proposed rule (78 FR 26471 through 26480). Consistent with our previous responses to these recurring comments (most recently published in the FY 2010 SNF PPS final rule (74 FR 40301)), developing a wage index that utilizes data specific to SNFs would require us to engage in a resource-intensive audit process. Also, we note that section 315 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554, enacted on December 21, 2000) 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. However, to date, this has proven to be unfeasible 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. As discussed above, we continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index (without the occupational mix adjustment) is appropriate and reasonable for the SNF PPS.

In addition, we note that we have engaged in research efforts relating to the development of an alternative hospital wage index for the IPPS, which examined the issues the commenters mentioned about ensuring that the wage index minimizes fluctuations, matches the costs of labor in the market, and provides for a single wage index policy. Section 3137(b) of the Affordable Care Act required the Secretary of Health and Human Services to submit to Congress a report that includes a plan to reform the hospital wage index under section 1886 of the Act. In developing the plan, the Secretary was directed to take into account the goals for reforming such system set forth in the June 2007 MedPAC report entitled ''Report to Congress: Promoting Greater Efficiency in Medicare'' (available at *http://www.medpac.gov/documents/jun07_entirereport.pdf.*), including establishing a new hospital compensation index system that:

- Uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved;
- Minimizes wage index adjustments between and within MSAs and Statewide rural areas;
- Includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;
- Takes into account the effect that implementation of the system would have on health care providers and on each region of the country.
- Addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and
- Provides for a transition.

As delegated by the Secretary, CMS contracted with Acumen, L.L.C. (Acumen) to review the June 2007 MedPAC report and recommend a methodology for an improved Medicare wage index system. After consultation with relevant parties during the development of the plan, the Secretary submitted the report to Congress, which is available via the Internet at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Reform.html.* We will continue to monitor closely research efforts surrounding the development of an alternative hospital wage index for the IPPS and the potential impact or influence of that research on the SNF PPS.

Once calculated, we apply the wage index adjustment to the labor-related portion of the federal rate, which is 69.545 percent of the total rate. This percentage reflects the labor-related relative importance for FY 2014, using the FY 2010-based SNF market basket. Each year, we calculate a revised labor-related share, based on the relative importance of labor-related cost categories (that is, those cost categories that are sensitive to local area wage costs) in the input price index. As discussed in section IV.B.2 of this final rule, for the FY 2014 SNF PPS update, we revised the labor-related share to reflect the relative importance of the revised FY 2010-based SNF market basket cost weights for the following cost categories: wages and salaries; employee benefits; contract labor; the labor-related portion of nonmedical professional fees; administrative and facilities support services; all other: labor-related services (previously referred to in the FY 2004-based SNF market basket as labor-intensive); and a proportion of capital-related expenses.

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, FY 2010, and FY 2014. 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 2014 than the base-year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2014 in four steps. First, we compute the FY 2014 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 2014 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2014 relative importance for each cost category by multiplying this ratio by the base year (FY 2010) weight. Finally, we add the FY 2014 relative importance for each of the labor-related cost categories to produce the FY 2014 labor-related relative importance. Tables 7 and 8 show the case-mix adjusted RUG–IV federal rates by labor-related and non-labor-related components. Table 2 in section IV.B.4 provides the FY 2014 labor-related share components based on the revised and rebased FY 2010-based SNF market basket.

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

RUG–IV category	Total rate	Labor portion	Non-labor portion
RUX	$760.89	$529.16	$231.73
RUL	744.31	517.63	226.68
RVX	677.25	470.99	206.26
RVL	607.61	422.56	185.05
RHX	613.61	426.74	186.87
RHL	547.28	380.61	166.67
RMX	562.87	391.45	171.42
RML	516.44	359.16	157.28
RLX	494.32	343.77	150.55
RUC	576.84	401.16	175.68
RUB	576.84	401.16	175.68
RUA	482.33	335.44	146.89
RVC	494.86	344.15	150.71
RVB	428.54	298.03	130.51
RVA	426.88	296.87	130.01

TABLE 7—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES FOR URBAN SNFS BY LABOR AND NON-LABOR COMPONENT—Continued

RUG–IV category	Total rate	Labor portion	Non-labor portion
RHC	431.21	299.88	131.33
RHB	388.10	269.90	118.20
RHA	341.68	237.62	104.06
RMC	378.82	263.45	115.37
RMB	355.61	247.31	108.30
RMA	292.60	203.49	89.11
RLB	368.31	256.14	112.17
RLA	237.32	165.04	72.28
ES3	694.67	483.11	211.56
ES2	543.78	378.17	165.61
ES1	485.75	337.81	147.94
HE2	469.17	326.28	142.89
HE1	389.58	270.93	118.65
HD2	439.32	305.53	133.79
HD1	366.37	254.79	111.58
HC2	414.45	288.23	126.22
HC1	346.47	240.95	105.52
HB2	409.48	284.77	124.71
HB1	343.15	238.64	104.51
LE2	426.06	296.30	129.76
LE1	356.42	247.87	108.55
LD2	409.48	284.77	124.71
LD1	343.15	238.64	104.51
LC2	359.73	250.17	109.56
LC1	303.36	210.97	92.39
LB2	341.49	237.49	104.00
LB1	290.09	201.74	88.35
CE2	379.63	264.01	115.62
CE1	349.79	243.26	106.53
CD2	359.73	250.17	109.56
CD1	329.89	229.42	100.47
CC2	314.96	219.04	95.92
CC1	291.75	202.90	88.85
CB2	291.75	202.90	88.85
CB1	270.20	187.91	82.29
CA2	246.98	171.76	75.22
CA1	230.40	160.23	70.17
BB2	261.91	182.15	79.76
BB1	250.30	174.07	76.23
BA2	217.14	151.01	66.13
BA1	207.19	144.09	63.10
PE2	349.79	243.26	106.53
PE1	333.20	231.72	101.48
PD2	329.89	229.42	100.47
PD1	313.31	217.89	95.42
PC2	283.46	197.13	86.33
PC1	270.20	187.91	82.29
PB2	240.35	167.15	73.20
PB1	230.40	160.23	70.17
PA2	198.90	138.33	60.57
PA1	190.61	132.56	58.05

TABLE 8—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES FOR RURAL SNFS BY LABOR AND NON-LABOR COMPONENT

RUG–IV category	Total rate	Labor portion	Non-labor portion
RUX	$778.44	$541.37	$237.07
RUL	762.60	530.35	232.25
RVX	683.97	475.67	208.30
RVL	617.44	429.40	188.04
RHX	612.55	426.00	186.55
RHL	549.18	381.93	167.25
RMX	556.67	387.14	169.53
RML	512.32	356.29	156.03
RLX	484.52	336.96	147.56
RUC	602.61	419.09	183.52
RUB	602.61	419.09	183.52
RUA	512.32	356.29	156.03

TABLE 8—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES FOR RURAL SNFS BY LABOR AND NON-LABOR COMPONENT—Continued

RUG–IV category	Total rate	Labor portion	Non-labor portion
RVC	509.72	354.48	155.24
RVB	446.36	310.42	135.94
RVA	444.77	309.32	135.45
RHC	438.29	304.81	133.48
RHB	397.11	276.17	120.94
RHA	352.75	245.32	107.43
RMC	380.84	264.86	115.98
RMB	358.66	249.43	109.23
RMA	298.46	207.56	90.90
RLB	364.13	253.23	110.90
RLA	238.98	166.20	72.78
ES3	670.87	466.56	204.31
ES2	526.71	366.30	160.41
ES1	471.27	327.74	143.53
HE2	455.43	316.73	138.70
HE1	379.39	263.85	115.54
HD2	426.92	296.90	130.02
HD1	357.22	248.43	108.79
HC2	403.15	280.37	122.78
HC1	338.21	235.21	103.00
HB2	398.40	277.07	121.33
HB1	335.04	233.00	102.04
LE2	414.24	288.08	126.16
LE1	347.71	241.81	105.90
LD2	398.40	277.07	121.33
LD1	335.04	233.00	102.04
LC2	350.88	244.02	106.86
LC1	297.02	206.56	90.46
LB2	333.45	231.90	101.55
LB1	284.35	197.75	86.60
CE2	369.89	257.24	112.65
CE1	341.38	237.41	103.97
CD2	350.88	244.02	106.86
CD1	322.37	224.19	98.18
CC2	308.11	214.28	93.83
CC1	285.93	198.85	87.08
CB2	285.93	198.85	87.08
CB1	265.34	184.53	80.81
CA2	243.16	169.11	74.05
CA1	227.32	158.09	69.23
BB2	257.42	179.02	78.40
BB1	246.33	171.31	75.02
BA2	214.65	149.28	65.37
BA1	205.14	142.66	62.48
PE2	341.38	237.41	103.97
PE1	325.53	226.39	99.14
PD2	322.37	224.19	98.18
PD1	306.52	213.17	93.35
PC2	278.01	193.34	84.67
PC1	265.34	184.53	80.81
PB2	236.82	164.70	72.12
PB1	227.32	158.09	69.23
PA2	197.22	137.16	60.06
PA1	189.30	131.65	57.65

Section 1888(e)(4)(G)(ii) of the Act also requires that we apply this wage index adjustment in a manner that does not result in aggregate payments under the SNF PPS that are greater or less than would otherwise be made in the absence of the wage adjustment. For FY 2014 (federal rates effective October 1, 2013), 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 2013 to the weighted average wage adjustment factor for FY 2014. For this calculation, we use the same 2012 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 budget neutrality factor for FY 2014 is 1.0006. The wage index applicable to FY 2014 is set forth in Tables A and B, which appear in the Addendum of this final rule, and is also available on the CMS Web site at *http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.*

After consideration of the comments we received, for the reasons discussed in this final rule and in the FY 2014 SNF PPS proposed rule, we are finalizing the wage index adjustment and related policies as proposed in the FY 2014 SNF PPS proposed rule (78 FR 24446 through 26449) without modification.

8. Adjusted Rate Computation Example

Using the hypothetical SNF XYZ described below, Table 9 shows the adjustments made to the federal per diem rates to compute the provider's actual per diem PPS payment under the described scenario. We derive the Labor and Non-labor columns from Table 7. As illustrated in Table 9, SNF XYZ's total PPS payment would equal $41,718.20.

TABLE 9—ADJUSTED RATE COMPUTATION EXAMPLE SNF XYZ: LOCATED IN CEDAR RAPIDS, IA (URBAN CBSA 16300), WAGE INDEX: 0.8964

RUG–IV group	Labor	Wage index	Adjusted labor	Non-labor	Adjusted rate	Percent adjustment	Medicare days	Payment
RVX	$470.99	0.8964	$422.20	$206.26	$628.46	$628.46	14	$8,798.44
ES2	378.17	0.8964	338.99	165.61	504.60	504.60	30	15,138.00
RHA	237.62	0.8964	213.00	104.06	317.06	317.06	16	5,072.96
CC2*	219.04	0.8964	196.35	95.92	292.27	666.38	10	6,663.80
BA2	151.01	0.8964	135.37	66.13	201.50	201.50	30	6,045.00
							100	41,718.20

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

C. Additional Aspects of the SNF PPS

1. SNF Level of Care—Administrative Presumption

The establishment of the SNF PPS did not change the fundamental requirements for SNF coverage under Medicare. However, because the case-mix classification reflects the beneficiary's need for skilled nursing care and therapy, we have attempted, where possible, to coordinate claims review procedures with the existing resident assessment process and case-mix classification system discussed in section IV.B of this final rule. This approach includes an administrative presumption that utilizes a beneficiary's initial classification in one of the upper 52 RUGs of the 66-group RUG–IV case-mix classification system to assist in making certain SNF level of care determinations.

In accordance with section 1888(e)(4)(H)(ii) of the Act and the regulations at § 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 for Medicare coverage, as provided in § 409.30. As set forth in the FY 2011 SNF PPS update notice (75 FR 42910), this designation reflects an administrative presumption under the 66-group RUG–IV system that beneficiaries who are correctly assigned to one of the upper 52 RUG–IV 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 the 5-day Medicare-required assessment.

A beneficiary assigned to any of the lower 14 RUG–IV groups is not automatically classified as either meeting or not meeting the SNF level of care 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 52 RUG–IV groups during the immediate post-hospital period require a covered level of care, which would be less likely for those beneficiaries assigned to one of the lower 14 RUG–IV groups.

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 case-mix classification structure. In this final rule, we continue to designate the upper 52 RUG–IV groups for purposes of this administrative presumption, consisting of all groups encompassed by the following RUG–IV categories:

- Rehabilitation plus Extensive Services;
- Ultra High Rehabilitation;
- Very High Rehabilitation;
- High Rehabilitation;
- Medium Rehabilitation;
- Low Rehabilitation;
- Extensive Services;
- Special Care High;
- Special Care Low; and,
- Clinically Complex.

However, we note that this administrative presumption policy does not supersede the SNF's responsibility to ensure that its decisions relating to level of care are appropriate and timely, including a review to confirm that the services prompting the beneficiary's assignment to one of the upper 52 RUG–IV groups (which, in turn, serves to trigger the administrative presumption) are themselves medically necessary. As we explained in the FY 2000 SNF PPS final rule (64 FR 41667), the administrative presumption:

> . . . is itself rebuttable in those individual cases in which the services actually received by the resident do not meet the basic statutory criterion of being reasonable and necessary to diagnose or treat a beneficiary's condition (according to section 1862(a)(1) of the Act). Accordingly, the presumption would not apply, for example, in those situations in which a resident's assignment to one of the upper . . . groups is itself based on the receipt of services that are subsequently determined to be not reasonable and necessary.

Moreover, we want to stress the importance of careful monitoring for changes in each patient's condition to determine the continuing need for Part A SNF benefits after the assessment reference date of the 5-day assessment.

2. Consolidated Billing

Sections 1842(b)(6)(E) and 1862(a)(18) of the Act (as added by section 4432(b) of the BBA) require 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, section 1862(a)(18) places the responsibility with the SNF for billing Medicare for physical therapy, occupational therapy, and speech-language pathology services that the resident receives during a noncovered stay. Section 1888(e)(2)(A) of the Act excludes a certain limited number of services from the consolidated billing provision (primarily those services furnished by physicians and certain other types of practitioners), which remain separately

billable under Part B when furnished to a SNF's Part A resident. 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).

We note that section 103 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA, Pub. L. 106–113, enacted on November 29, 1999) amended section 1888(e)(2)(A) of the Act by further excluding a number of individual ''high-cost, low probability'' services, identified by Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) that otherwise remained subject to this provision. We discuss this BBRA amendment in greater detail in the FY 2001 SNF PPS proposed and final rules (65 FR 19231 through 19232, April 10, 2000, and 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 *www.cms.gov/transmittals/downloads/ab001860.pdf*.

As explained in the FY 2001 SNF PPS proposed rule (65 FR 19232), 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) of the BBRA ''is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs . . . .'' By contrast, we noted that the Congress declined to designate for exclusion any of the remaining services within those four categories (thus, leaving all of those services subject to SNF consolidated billing), because they are relatively inexpensive and are furnished routinely in SNFs.

As we further explained in the FY 2001 SNF PPS final rule (65 FR 46790), and as our longstanding policy, any additional service codes that we might designate for exclusion under our discretionary authority must meet the same statutory criteria used in identifying the original codes excluded from consolidated billing under section 103(a) of the BBRA: The code must fall within one of the four service categories specified in the BBRA, and the code also must meet the same standards of high cost and low probability in the SNF setting, as discussed in the BBRA Conference report. 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 2014 SNF PPS proposed rule (78 FR 26449–26450), we specifically invited public comments identifying HCPCS 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. A discussion of the public comments received on this topic, along with our responses, appears below.

Comment: One commenter suggested that we should categorically exclude all chemotherapy and radiation therapy services from consolidated billing. Another commenter reiterated a recommendation that commenters had repeatedly urged us to adopt in previous years, to expand the existing exclusion for certain high-intensity outpatient hospital services (such as radiation therapy) to encompass services furnished in other, nonhospital settings.

Response: With respect to chemotherapy services, we have noted repeatedly in prior rulemaking on the SNF PPS—including, most recently, the FY 2012 SNF PPS final rule (76 FR 48532 through 48533, August 8, 2011)—that in creating a statutory carve-out for chemotherapy and certain other designated types of services, the BBRA

> . . . did not categorically exclude all such services from SNF consolidated billing. Instead, the legislation specifically identified individual excluded services within designated categories, by Healthcare Common Procedure Coding System (HCPCS) code. The BBRA's Conference Report explained that this legislation specifically targeted those 'high-cost, low probability' items and services that '. . . are not typically administered in a SNF, or are exceptionally expensive, or are given as infusions, thus requiring special staff expertise to administer' (H.R. Conf. Rep. No. 106–479 at 854). By contrast, other types of services within those categories that '. . . are relatively inexpensive and are administered routinely in SNFs' remain subject to SNF consolidated billing under this legislation.

Radiation therapy, by contrast, is not one of the service categories designated for exclusion under the BBRA legislation, but instead is encompassed within the administrative exclusion for certain types of exceptionally intensive outpatient services under the regulations at § 411.15(p)(3)(iii). As such, *all* types of radiation therapy services are, in fact, already excluded from consolidated billing, but *only* when furnished in the hospital or CAH setting. In response to the recurring calls for expanding this exclusion to encompass services furnished in freestanding (nonhospital/CAH) settings, we have repeatedly noted—most recently, in the FY 2012 SNF PPS final rule (76 FR 48532, August 8, 2011)—that the existing law does not provide us with the authority to ''. . . establish a categorical exclusion for these services that would apply irrespective of the setting in which they are furnished.'' In addition, as we initially noted in the FY 2009 SNF PPS final rule (73 FR 46436, August 8, 2008) and then reiterated in a number of subsequent final rules, the repeated calls to expand the administrative exclusion for high-intensity outpatient services in this manner would appear to reflect

> . . . 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 . . . and as also explained in Medicare Learning Network (MLN) Matters article SE0432 . . . the rationale for establishing this exclusion was to address those types of services that are so far beyond the normal scope of SNF care that they *require the intensity of the hospital setting* in order to be furnished safely and effectively.

Moreover, we note that when the Congress enacted the consolidated billing exclusion for certain RHC and FQHC services in section 410 of the MMA, the accompanying legislative history's description of present law acknowledged that the existing exclusions for exceptionally intensive outpatient services are specifically limited to '. . . certain outpatient services *from a Medicare-participating hospital or critical access hospital* . . .' (emphasis added). (See the House Ways

and Means Committee Report (H. Rep. No. 108–178, Part 2 at 209), and the Conference Report (H. Conf. Rep. No. 108–391 at 641)). Therefore, these services are excluded from SNF consolidated billing *only* when furnished in the outpatient hospital or CAH setting, and not when furnished in other, freestanding (non-hospital or non-CAH) settings.

Comment: One commenter cited the longstanding chemotherapy exclusion for Rituximab (Rituxan, HCPCS code J9310), which it characterized as a ''*non-cancer* chemotherapy . . . drug used to treat rheumatoid arthritis'' (emphasis added), and presented this as a precedent for expanding this exclusion to encompass a number of other drugs that are not used in the treatment of cancer. The commenter asserted that in the absence of such an exclusion, suppliers of these drugs who do not have ''an executed contract in place with the SNF prior to administration'' would be ''forced to absorb the significant cost of the drug or biologic.''

Response: We note that the description of Rituximab as a ''non-cancer'' chemotherapy drug is not entirely accurate, and requires a more detailed discussion. As explained on MedlinePlus, the Web site of the National Institutes of Health's U.S. National Library of Medicine (*http://www.nlm.nih.gov/medlineplus/druginfo/meds/a607038.html*),

> Rituximab is used alone or with other medications to treat certain types of non-Hodgkin's lymphoma (NHL; a type of cancer that begins in a type of white blood cells that normally fights infection). Rituximab is also used with another medication to treat the symptoms of rheumatoid arthritis (RA; a condition in which the body attacks its own joints, causing pain, swelling, and loss of function) in people who have already been treated with a certain type of medication called a tumor necrosis factor (TNF) inhibitor.

Thus, while it is true that this drug is approved for use in treating certain non-cancer conditions such as rheumatoid arthritis, it is actually approved for use in treating cancer as well, and it is this latter application that represents the basis for its exclusion from consolidated billing as a chemotherapy drug. In this context, we note that when an otherwise excluded chemotherapy drug is prescribed for a use that does not involve treating cancer, the drug would not qualify as an excluded ''chemotherapy'' drug in that instance. This is consistent with the discussion of the chemotherapy exclusion in the FY 2010 SNF PPS final rule (74 FR 40354), which notes that this exclusion does not encompass drugs that ''are not anti-cancer drugs,'' as well as in the FY 2012 SNF PPS final rule (76 FR 48531), which similarly notes that this exclusion does not extend to drugs that ''are actually used to treat diseases *other than* cancer'' (emphasis added). Moreover, the commenter appears to be concerned that the absence of an executed contract would serve to absolve the SNF of its liability to pay the supplier for a bundled service. We note that this is not the case. In MLN Matters article #MM3592 (available online at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3592.pdf*), while emphasizing the importance of written agreements between SNFs and their suppliers, we clearly specify that an arrangement between a SNF and its supplier ''is validated not by the presence of specific supporting written documentation but rather by their actual compliance with the requirements governing such 'arrangements','' and that ''the absence of an agreement with its supplier (written or not) does not relieve the SNF of its responsibility to pay suppliers for services 'bundled' in the SNF PPS payment from Medicare.''

Comment: Some commenters advocated the exclusion of other types of services that do not fall within the categories identified in the BBRA. We received a comment requesting that DIFICID® (fidaxomicin) be excluded from consolidated billing. DIFICID® is an orally administered tablet that is used specifically for treating severe cases of diarrhea associated with certain potentially life-threatening infections of the gastrointestinal tract. The commenter noted this drug's potential to reduce the recurrence of such infections (along with associated hospitalizations and physician office visits), and to improve patient quality of life. The commenter cited as precedents the existing authority for excluding certain ''high-cost, low probability'' services under the BBRA, as well as the separate payment made for certain drugs under the heading of screening and preventive services, as discussed in MLN Matters Special Edition article #SE0436 (available online at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0436.pdf*). The commenter then urged the creation of a similar exclusion for DIFICID® on public policy grounds, expressing concern that the continued inclusion of DIFICID® within the SNF PPS bundle might prompt SNFs to opt for alternate treatments that are less expensive, but also less efficacious.

Response: As we have consistently stated (most recently, in the FY 2012 SNF PPS final rule (76 FR 48530, August 8, 2011)), the BBRA authorizes us to identify additional services for exclusion *only within* those particular service categories—chemotherapy items; chemotherapy administration services; radioisotope services; and, customized prosthetic devices—that it has designated for this purpose, and does not give us the authority simply to carve out additional categories of services beyond those specified in the law on ''public policy grounds.'' Accordingly, as DIFICID® does not fall within one of the specific service categories designated for this purpose in the statute itself, we are unable to exclude it from consolidated billing under this authority. Further, we note that while the cited MLN Matters article does indeed discuss certain drugs that are separately covered under Medicare Part B or Part D when furnished to Part A SNF residents, those particular drugs are vaccines that are *preventive* rather than therapeutic in nature and, as such, are by definition outside the scope of the Part A SNF benefit (see Pub. L. 100–04, ch.6, § 20.4); by contrast, therapeutic drugs such as DIFICID® would fall within the scope of SNF coverage under Part A. Regarding the commenter's concern that the continued inclusion of DIFICID® within the SNF PPS bundle could affect the extent to which SNFs may be inclined to consider its use, we note that while bundling provides incentives for SNFs to be efficient in the provision of care, SNFs are still required to provide ''the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being'' of each resident in accordance with the resident's assessment and plan of care (§ 483.25).

Comment: One commenter reiterated a number of recommendations that commenters had urged us to adopt in previous years. These included expanding the existing chemotherapy exclusion to encompass related drugs that are commonly administered in conjunction with chemotherapy to ameliorate the side effects of the chemotherapy drugs, and excluding additional categories of services beyond those specified in the BBRA, such as positron emission tomography (PET) scans.

Response: Regarding the exclusion of chemotherapy-related drugs, we have noted repeatedly in this and previous final rules—most recently, the FY 2012 SNF PPS final rule (76 FR 48532, August 8, 2011)—that the BBRA authorizes us to identify additional

service codes for exclusion only within those particular service categories (chemotherapy items; chemotherapy administration services; radioisotope services; and, customized prosthetic devices) that it has designated for this purpose, and does not give us the authority to exclude other services which, though they may be related, fall outside of the specified service categories themselves. Thus, while anti-emetics (anti-nausea drugs), for example, are commonly administered in conjunction with chemotherapy, they are not inherently chemotherapeutic in nature (that is, they do not actively destroy cancer cells) and, consequently, do not fall within the excluded chemotherapy category designated in the BBRA. Regarding the exclusion of PET scans, we noted in the FY 2012 SNF PPS final rule that ''. . . we decline to add to the exclusion list those services submitted by commenters that have already been considered and not excluded in previous years based on their being outside the particular service categories that the statute authorizes for exclusion'' (76 FR 48531, August 8, 2011). Such services would include PET scans, as discussed previously in the FY 2006 SNF PPS final rule (70 FR 45049, August 4, 2005).

Comment: One commenter recommended that the surgical debridement procedures represented by HCPCS codes 11040 through 11044 be excluded from consolidated billing.

Response: We note that debridement codes 11040 (skin, partial thickness) and 11041 (skin, full thickness) were discontinued as of December 2010. The remaining debridement codes that the commenter cited—11042 (skin, and subcutaneous tissue), 11043 (skin, subcutaneous tissue, and muscle), and 11044 (skin, subcutaneous tissue, muscle, and bone)—are listed correctly in Carrier/A/B MAC File 1 as physician services that are excluded from consolidated billing. However, these same three codes (along with the two discontinued ones) currently appear erroneously in Major Category I.F of the FI/A/B MAC Annual Update as included (that is, bundled) ambulatory surgery codes. Accordingly, we will make the appropriate corrections to the FI/A/B MAC Annual Update to ensure that it no longer lists these codes incorrectly as ambulatory surgery inclusions.

Comment: One commenter suggested that, rather than relying solely on feedback through the public comment process on possible exclusions from consolidated billing, CMS should convene an official expert group to review the codes and make formal recommendations.

Response: In the FY 2010 SNF PPS final rule (74 FR 40354, August 11, 2009), we noted that the Congress gave specific direction regarding the review of consolidated billing codes that it envisioned: In the BBRA Conference Report (H.R. Rep. No. 106–479 at 854 (1999) (Conf. Rep.)), it specified that the GAO was to conduct a special, one-time comprehensive review of the existing code set, and it then conferred on the Secretary the authority ''. . . to review periodically and modify, as needed, the list of excluded services.'' However, as we explained in the FY 2002 SNF PPS final rule (66 FR 39588, July 31, 2001), this ongoing review function must be considered within the context of the overall process in which it takes place:

> . . . we do not view making additions to the list of excluded services as a part of a process of continual expansion to encompass an ever-broadening array of excluded services. Further, . . . the fundamental purpose of the consolidated billing provision . . . is to make the SNF responsible for billing Medicare for essentially *all* of its residents' services, other than those identified in a small number of narrow and specifically delimited statutory exclusions (emphasis added).

Thus, the purpose of this ongoing review is not to devise new and increasingly expansive rationales for the unbundling of services, but rather, simply to ensure that services which meet the *already-established* criteria for exclusion are not overlooked. We believe that our longstanding practice of periodically inviting input through the public comment process (which is already open to any interested parties who may wish to provide the benefit of their expertise in this area) is both appropriate and sufficient to achieve this objective.

3. Payment for SNF-Level Swing-Bed Services

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

Accordingly, all non-CAH swing-bed rural hospitals are being paid under the SNF PPS. Therefore, all rates and wage indexes outlined in earlier sections of this final rule for the SNF PPS 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 FY 2002 final rule (66 FR 39562) and in the FY 2010 final rule (74 FR 40288). As finalized in the FY 2010 SNF PPS final rule (74 FR 40356–57), effective October 1, 2010, non-CAH swing-bed rural hospitals are required to complete an MDS 3.0 swing-bed assessment, which is limited to the required demographic, payment, and quality items. The latest changes in the MDS for swing-bed rural hospitals appear on the SNF PPS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.* We received no comments on this aspect of the proposed rule.

D. Other Issues

1. Monitoring Impact of FY 2012 Policy Changes

In the FY 2014 SNF PPS proposed rule (78 FR 26463 through 26465), we discussed our monitoring efforts associated with impacts of certain policy changes finalized in the FY 2012 SNF PPS final rule (76 FR 48486). Specifically, we have been monitoring the impact of the following changes:

- Recalibration of the FY 2011 SNF parity adjustment to align overall payments under RUG–IV with those under RUG–III.
- Allocation of group therapy time to pay more appropriately for group therapy services based on resource utilization and cost.
- Implementation of changes to the MDS 3.0 patient assessment instrument, most notably the introduction of the Change-of-Therapy (COT) Other Medicare Required Assessment (OMRA).

We have posted quarterly memos to the SNF PPS Web site which highlight some of the trends we have observed over a given time period. These memos may be accessed through the SNF PPS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF_Monitoring.zip.* In the FY 2014 SNF PPS proposed rule (78 FR 26465), we stated that based on the data reviewed thus far, we have found no evidence of possible negative impacts on SNF providers cited

in the comments in the FY 2012 SNF PPS final rule (see 76 FR 48497–98, 48537), particularly references to a ''double hit'' from the combined impact of the recalibration of the FY 2011 SNF parity adjustment and the FY 2012 policy changes. Therefore, we stated that while we will continue our SNF monitoring efforts, we will post information to the aforementioned Web site only as appropriate.

A discussion of the comments we received on these efforts, with our responses, appears below.

Comment: One commenter stated that they appreciate the transparency demonstrated by releasing the quarterly findings memos and urged us to continue this practice into the future.

Response: We appreciate the support for our efforts to provide this data on the FY 2012 policy changes. As stated in the FY 2014 SNF PPS proposed rule (78 FR 26465), this level of analysis was being conducted to determine if any evidence existed of possible negative impacts on SNF providers cited in the comments in the FY 2012 SNF PPS final rule (76 FR 48497–48498, 48537), particularly references to a ''double hit'' from the combined impact of the recalibration of the FY 2011 SNF parity adjustment and the FY 2012 policy changes (for example, allocation of group therapy and introduction of the COT OMRA). Based on the data we have examined so far, there is no evidence of such negative impacts—overall case mix has not been affected significantly and providers appear to have adjusted their internal processes and care planning activities well to accommodate the FY 2012 policy changes. Given these findings, we do not regard the continued publishing of quarterly memos, in the absence of some marked finding, as still being necessary at this point. Therefore, as stated in the FY 2014 SNF PPS proposed rule (78 FR 26465), we will continue our SNF monitoring efforts but will henceforth only post information regarding our monitoring activities discussed above to the SNF PPS Web site as appropriate.

Comment: One commenter asked that we reevaluate the potential negative impacts of implementing the COT OMRA; specifically, that the COT OMRA is unnecessarily burdensome and inflexible. This commenter requested that we consider ways to make the COT OMRA more flexible for providers.

Response: As noted in the FY 2012 SNF PPS final rule (76 FR 48518), the COT OMRA was implemented because the then-existing range of PPS assessments did not give providers adequate opportunity to report changes in the resident's therapy services that occur outside the observation window which, as always, should be based on medical evidence. Since implementing the COT OMRA, we have continued to monitor its utilization and determine if any negative impacts have resulted for facilities and/or SNF residents. Our monitoring efforts have revealed, as demonstrated in Table 21 of the FY 2014 SNF PPS proposed rule (78 FR 26465), that the COT OMRA comprises just 11 percent of all assessments completed for SNF residents. As such, based on the limited number of COT OMRAs being completed, we do not believe that the COT OMRA represents a significant burden for providers.

With respect to the flexibility of the assessment, the limited number of COT OMRAs might also be the result of the flexibility in completing the COT OMRA afforded in the MDS RAI Manual (for example, the flexibility discussed in Chapter 2 of the MDS RAI Manual, whereby the COT observation period for a resident is reset if a scheduled or unscheduled assessment is completed on or prior to day 7 of the COT observation period). Additionally, as the COT OMRA may be used to report either an increase or decrease in therapy services relative to the resident's previous therapy RUG classification, the COT OMRA has helped ensure greater accuracy of SNF payments and ensure that providers are appropriately reimbursed for the level of care delivered to their residents. Therefore, while we will continue to monitor for potential negative impacts associated with the FY 2012 policy changes, as noted above, we have not yet found any evidence of such an adverse impact.

2. Ensuring Accuracy in Grouping to Rehabilitation RUG–IV Categories

In the FY 2014 SNF PPS proposed rule (78 FR 26465–26466), we clarified that our classification criteria for the Rehabilitation RUG categories require that the resident receive the requisite number of distinct calendar days of therapy to be classified into the Rehabilitation RUG category, and focused particularly on issues related to classification into the Medium and Low Rehabilitation categories. We explained that in requiring distinct calendar days of therapy, our classification criteria are consistent with the SNF level of care requirement under § 409.31(b)(1), which provides that skilled services must be needed and received on a daily basis, and § 409.34(a)(2),which specifies that the ''daily basis'' criterion can be met by skilled rehabilitation services that are needed and provided at least 5 days per week. However, we explained in the FY 2014 SNF PPS proposed rule (78 FR 26465–66) that the MDS item set currently does not contain an item that permits SNFs to report the total number of distinct calendar days of therapy provided by all rehabilitation disciplines. Instead, the MDS item set requires the SNF to record, separately by each therapy discipline, the number of days therapy was received during the 7-day look-back period, without distinguishing between distinct calendar days. As we explained in the FY 2014 SNF PPS proposed rule, currently, the RUG grouper adds these days together which results in some residents being classified into the Medium and Low Rehabilitation RUG categories when they do not actually meet our classification criteria. Thus, we proposed to add an item to the MDS 3.0 item set (item O0420) which would permit SNF providers to code the total number of distinct calendar days that the resident received therapy services across all rehabilitation disciplines during the assessment look-back period to ensure that residents are classified into the correct Rehabilitation RUG in accordance with our existing classification criteria. We stated that effective October 1, 2013, facilities would be required to record under this item the number of distinct calendar days of therapy provided by all the rehabilitation disciplines over the 7-day look-back period for the current assessment, which would be used to classify the resident into the correct Rehabilitation RUG category. A discussion of the comments we received on this proposal, and our responses, appear below.

Comment: Many commenters supported the proposal to add a new item to the MDS 3.0 to capture distinct therapy days and agreed that patients should be appropriately categorized into the applicable RUG category to ensure accurate payment. Several commenters appeared to be under the impression that this proposal will change the policy on how many days of therapy are required in order to group to specific rehabilitation RUG categories. Furthermore, some commenters stated that we did not provide any clinical basis for this addition to the MDS 3.0, and that therapist judgment should be the deciding factor for scheduling therapy services to best meet the residents' needs.

Response: We appreciate that many commenters supported the proposal to add item O0420 to the MDS 3.0 to capture distinct therapy days and to pay more accurately for therapy services. We emphasize that we did not propose to add item O0420 as a result of a change

in policy; instead, we proposed to add this item to enable us to implement our existing policy more accurately. As explained in the FY 2014 SNF PPS proposed rule (78 FR 26465 through 26466), throughout all iterations of the SNF PPS from 1998 until the present time, in order to qualify for the Medium Rehabilitation (Medium Rehab) RUG category, a resident must receive at least 150 minutes of therapy per week (a seven-day time period) and 5 days of any combination of the three rehabilitation disciplines (physical therapy, occupational therapy, or speech-language pathology). The policy has always been that the term ''days'' in this context denotes distinct calendar days of therapy. Similarly, for the Low, High, Very High, and Ultra High Rehabilitation RUG categories, the policy has always been that distinct calendar days of therapy are required to classify into these RUG categories (for example, for the Low Rehabilitation category, 3 distinct calendar days of therapy are required). Thus, in the proposed rule, we clarified that our classification criteria for the Rehabilitation RUG categories require that the resident receive the requisite number of distinct calendar days of therapy to be classified into the Rehabilitation RUG category. However, there has not been a way until now to record on the MDS 3.0 the number of distinct calendar days of therapy provided across all rehabilitation disciplines in order to ensure accurate calculation of these days in the RUG grouper software. It is true that our proposed change to the MDS 3.0 item set will require an additional item for reporting of therapy services; however, this change solely addresses the manner of reporting (and not the manner of providing) these services. We agree that licensed therapists are to use their clinical judgment to treat the patients in the most appropriate manner, and to maintain professional standards while providing all necessary services. Providers are not required to change clinical practice patterns based on this additional reporting requirement; rather, they could continue to provide therapy as they always have and would use the new item to report more accurately the days on which they provided therapy services, in order to ensure that the patient is assigned to the correct RUG.

In addition, we note that under section 1814(a)(2)(B) of the Act, one of the basic elements of the SNF level of care (which constitutes a precondition for SNF coverage under Part A) is that a beneficiary must *need* and *receive* skilled care on a daily basis. Under an exception in the regulations at § 409.34(a)(2), when skilled rehabilitation services are not available 7 days a week, they can still be considered furnished on a ''daily basis'' when *needed* and *provided* at least 5 days a week. However, it is important to note that merely *scheduling* therapy services on 5 distinct calendar days during the week would be insufficient to satisfy this requirement unless the beneficiary also has an actual *clinical need* for the services to be scheduled in this manner. As noted in § 30.6 of the Medicare Benefit Policy Manual, Chapter 8:

> It is not sufficient for the scheduling of therapy sessions to be arranged so that some therapy is furnished each day, unless the patient's medical needs indicate that daily therapy is required. For example, if physical therapy is furnished on 3 days each week and occupational therapy is furnished on 2 other days each week, the ''daily basis'' requirement would be satisfied only if there is a valid medical reason why both cannot be furnished on the same day. The basic issue here is not whether the services are needed, but when they are needed. Unless there is a legitimate medical need for scheduling a therapy session each day, the ''daily basis'' requirement for SNF coverage would not be met.

Accordingly, we do not expect that the addition of this MDS item, which is intended to facilitate more accurate reporting, will result in any changes in clinical practice patterns, as SNFs should already be appropriately providing skilled rehabilitation services on a daily basis *only* in those instances where the beneficiary has an actual need for therapy to be furnished on at least 5 distinct calendar days during the week.

Comment: Some commenters stated that the proposal to add item O0420 to the MDS 3.0 would have a significant impact on the ability of residents to qualify for a rehabilitation RUG for the 5-day PPS assessment because the Assessment Reference Date (ARD) for the 5-day PPS assessment must be set for no later than Day 8 of the stay. They expressed concern that residents who miss therapy for clinical or scheduling reasons are not being appropriately classified into rehabilitation RUG categories. Additionally, these commenters explained that it is difficult to provide therapy to a resident for 5 distinct days over a 7-day period and this challenge correlates to residents being placed in non-rehabilitation RUGs. They suggested that CMS does not adequately reimburse for rehabilitation services that are delivered beyond the minimum number of minutes required for a specific RUG category and that this amounts to unpaid therapy services provided to residents.

Additionally, these commenters stated that this proposal will result in greater burden for providers; for example, requiring scheduling changes for therapists, requiring therapists to work on weekends, evenings, and holidays, and requiring part-time therapists to work on full-time schedules. They explained that the need for two different therapy disciplines does not change, irrespective of whether these therapies are received on distinct days or on the same days. Some commenters requested that we implement an ''exceptions'' policy to account for missed or rescheduled therapy sessions beyond provider control which result in different therapies being provided on the same day.

Finally, several commenters expressed concern related to a possible conflict between the proposal to add item O0420 to the MDS item set to capture more appropriately the distinct days of therapy provided and instructions from CMS in recent guidance which clarified the term ''daily skilled services defined'' (CMS Transmittal 161, October 26, 2012) which states, ''A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the ''daily basis'' requirement when they need and receive those services on at least 5 days a week. (If therapy services are provided less than 5 days a week, the ''daily'' requirement would not be met.) This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.'' For the above reasons, several commenters suggested we postpone the proposed addition to the MDS 3.0 of item O0420 requiring that facilities report the number of distinct calendar days of therapy and carefully review the impact of the change as discussed in these comments.

Response: We do not agree with the commenters' assertion that the proposal to add item O0420 to the MDS 3.0 item set will make it more difficult to classify residents into rehabilitation RUGs during the 5-day PPS assessment period because the ARD must be set for no later than Day 8 of the stay. As we discussed in the FY 2014 SNF PPS proposed rule (78 FR 26465–66) and in this final rule, the addition of this item was not proposed as a result of a change in policy. Our policy has always been that distinct calendar days of therapy are

required to classify into a Rehabilitation RUG. The new MDS item was proposed to provide for more accurate reporting and calculation of these therapy days, and to ensure that patients are appropriately classified into Rehabilitation RUG categories in accordance with our existing classification policy. Furthermore, given that residents currently classify on the 5-day PPS assessment for Rehabilitation RUGs which require 5 calendar days of therapy (Medium, High, Very High, or Ultra High), it appears that providers are clearly able to provide the necessary therapy time within the first days of the SNF stay regardless of this new item. More generally, if facilities are having difficulty meeting the daily skilled needs of the residents in their care, then this might indicate a need for the facility to revisit its admissions policies and determine if the facility is accepting such patients only when it can appropriately meet their care needs.

Furthermore, with regard to the comments that it is difficult to provide therapy to a resident for 5 distinct days over a 7-day period, we would note that, based on the monitoring reports we have published to the SNF PPS Web site (*http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Spotlight.html*), in FY 2012, 84.3 percent of the days billed to Medicare Part A were billed at one of the upper three rehabilitation RUG categories (Ultra-High, Very-High, and High) which require that 1 discipline provide at least 5 days of therapy. This is a longstanding requirement that appeared in the applicable instructions at least as far back as 2006, as noted on page 3–216 of the MDS RAI Manual, Version 2.0:

> If orders are received for more than one therapy discipline, enter the number of days at least one therapy service is performed. For example, if PT is provided on MWF, and OT is provided on MWF, the MDS should be coded as 3 days, not 6 days.

Accordingly, since multiple therapy disciplines furnished on the same calendar day would still comprise only a single calendar day's worth of therapy, this means that those residents being classified into one of these RUG categories must have received at least one therapy discipline on 5 distinct calendar days during the look-back period for the assessment. Therefore, given that 84.3 percent of patient days are billed at one of these upper three rehabilitation RUG categories, the vast majority of SNF residents should be currently receiving at least 5 distinct calendar days of therapy per week. If this is the standard of practice that exists within the SNF industry currently, as evidenced by the current billing and care delivery patterns, we do not agree with the comment that it is difficult for SNFs to provide therapy to their residents for 5 distinct days over a 7-day period. Again, the new MDS item is not being added as a result of any change in policy, but simply to provide for more accurate reporting of therapy days so we can ensure that patients are appropriately classified into Rehabilitation RUGs in accordance with our current classification criteria.

In addition, commenters suggested that CMS does not adequately reimburse for rehabilitation services that are delivered beyond the minimum number of minutes required for a specific RUG category. We recognize that residents who do not meet the minimum qualifying minutes/days of therapy services may not be placed into Rehabilitation RUGs. However, we do not consider this a flaw of the SNF PPS RUG–IV system, as some commenters have suggested. The RUG–IV system was designed so that RUG payment levels are based on an average amount of minutes of therapy provided, not the minimum threshold of minutes for each RUG category. The original RUG–III grouper logic was based on clinical data collected in 1990, 1995, and 1997. As discussed in the SNF PPS proposed rule for FY 2010 (74 FR 22208, May 12, 2009), we subsequently conducted a multi-year data collection and analysis under the Staff Time and Resource Intensity Verification (STRIVE) project to update the case-mix classification system for FY 2011. The resulting RUG–IV case-mix classification system reflected the data collected in 2006 and 2007 during the STRIVE project, and was finalized in the FY 2010 SNF PPS final rule (74 FR 40288, August 11, 2009) for implementation in FY 2011. In the FY 2010 SNF PPS proposed rule (74 FR 22208, 22223–25) and final rule (74 FR 40288, 40319–21, we explained the process of calculating therapy time to determine RUG payment levels. As part of this explanation, we discussed how we adjusted the therapy time for the calculations: ''We give the maximum credit possible for any day that therapy time was recorded for 15 or more minutes to avoid underestimating the actual amounts of therapy furnished to patients'' (74 FR 22225). Therapy reimbursement for each RUG is based on the average utilization between the thresholds, so those at the minimum thresholds are, in fact, being adequately paid relative to the average resource amount used to determine the reimbursement level. Moreover, the majority of MDS assessments submitted to CMS show that the number of therapy minutes provided to beneficiaries cluster at the minimum threshold amount necessary to qualify for a given RUG group. This would suggest that, for the majority of billed therapy days, the resource intensity used to determine the reimbursement for that RUG group is greater than the resource intensity of the therapy provided to the resident. Therefore, we do not agree that the system allows for a significant amount of unpaid therapy provided to SNF residents.

In addition, we do not agree with the assertion that adding item O0420 to the MDS 3.0 item set will result in greater burden to the providers. As discussed previously, this item is not being added as a result of a change in policy. Facilities should not change practice patterns merely because of the additional item for reporting therapy. Until now, facilities have been calculating the days of therapy that each discipline provided to a specific resident. The new item will require the providers to use the exact same clinical information found on daily notes or therapy logs to count the days that therapy was provided to a patient; however, instead of counting each discipline's days separately they will now have to count each distinct calendar day that any therapy was provided. We agree that the need for different therapy disciplines does not change regardless of whether these therapies are provided on the same or distinct calendar days. However, as explained previously, the ''daily basis'' requirement for Part A SNF coverage can be met only when therapy is not merely scheduled but is actually *needed* and provided on each of 5 distinct calendar days during the week. In addition, the design of the SNF PPS RUG–IV system requires very specific calculation of therapy minutes and days in order to place patients most appropriately into the correct case-mix classification. Therefore, we do not believe it would be appropriate to establish an ''exceptions'' policy to allow for counting of different therapies on the same day when residents experience missed or rescheduled therapy sessions beyond provider control.

Finally, with respect to the comments raising the issue of a potential conflict between the proposed MDS item and the daily basis discussion in Transmittal 161, we would note that the particular language being cited was not, in fact, introduced by this transmittal. Rather, it has long appeared in the manual instructions and was also discussed as

far back as the FY 2000 SNF PPS final rule (64 FR 41670, July 30, 1999):

* * * Some comments reflected certain longstanding misconceptions regarding the SNF level of care definition, in terms of a beneficiary's need for and receipt of skilled services on a daily basis which, as a practical matter, can be furnished only in an SNF on an inpatient basis. One recurring misconception with regard to the ''daily basis'' requirement (which some of the commenters expressed as well) is that Medicare coverage guidelines provide for specific breaks in skilled therapy services for the observance of a prescribed list of national holidays. Another longstanding misconception shared by some commenters is that the cessation of therapy for so much as a single day due, for example, to the beneficiary's temporary illness or fatigue, would mandate an automatic discontinuance of coverage * * * As explained below, these interpretations of Medicare SNF coverage requirements are incorrect.

[T]he requirement for daily skilled services should not be applied so strictly that it would not be met merely because there is a brief, isolated absence from the facility in a situation where discharge from the facility would not be practical * * * [W]ith regard to the ''daily basis'' requirement, the Medicare program does not specify in regulations or guidelines an official list of holidays or other specific occasions that a facility may observe as breaks in rehabilitation services, but recognizes that the resident's own condition dictates the amount of service that is appropriate. Accordingly, the facility itself must judge whether a brief, temporary pause in the delivery of therapy services would adversely affect the resident's condition (emphasis added).

Similarly, section 409.34(b) states that a ''. . . break of one or two days in the furnishing of rehabilitation services will not preclude coverage if discharge would not be practical for the one or two days during which, for instance, the physician has suspended the therapy sessions because the patient exhibited extreme fatigue.'' We note that the references in the manual (see Pub. L. 100–02, ch. 8, § 30.6) and the regulations in this context to an isolated break in therapy denote a situation in which such a lapse represents a rare exception rather than a regular or frequent occurrence. Accordingly, the policy reflected in the above-cited manual, rule preamble, and regulation is intended to indicate that such a lapse would not necessarily result in discontinuing coverage that is already ongoing.

While coverage may continue where there is a brief, isolated break in therapy as discussed above, the patient's RUG classification and the level of payment are still based on the number of days and minutes of therapy provided to the patient as reported on the MDS 3.0, and the new MDS item will ensure that these days are calculated correctly. Thus, we do not believe that the addition of the new MDS item presents a conflict with existing coverage policy as set forth in the manual, as they address separate issues. The manual and regulatory provisions cited above provide that in certain exceptional circumstances coverage of a SNF stay will not necessarily be discontinued because of a brief, isolated break in therapy; and the new MDS item provides the information necessary (total number of days that therapy was provided during the look-back period) to enable us to determine the appropriate RUG classification and payment for that SNF stay. We believe that this MDS item, by permitting more accurate reporting of therapy days, enables us to ensure that residents are appropriately classified into Rehabilitation RUG categories in accordance with our existing classification criteria. In addition, we note that if a resident's stay is also based on receipt of non-rehabilitation related skilled services (for example, ventilator care) in combination with rehabilitation services (which we believe to characterize the majority of SNF stays), then such non-rehabilitation care would also constitute care provided toward meeting the daily basis requirement. Therefore, the new MDS item would not appear to present a conflict with the daily basis requirement discussed in Transmittal 161, but instead permits providers to report the precise number of distinct calendar days their residents receive therapy during the assessment observation period. Furthermore, because this new MDS item allows for more accurate reporting and thus more accurate RUG classification and payment, we do not see any reason to postpone the addition of the item to MDS 3.0 item set.

Comment: Some commenters expressed concern over the practical implementation of adding item O0420 to the MDS 3.0 item set. They stated that October 1, 2013 is too soon for software vendors to incorporate the new reporting requirement into SNF and therapy software systems and to program, test, and implement the changes. Additionally, although the commenters appreciated that CMS released draft programming specifications, they criticized the accompanying warning which stated that this version of the specifications should be considered provisional and subject to change until the final specifications are published. They stated that the timeframe between CMS issuing the final rule and the effective date of October 1, 2013 does not give the software vendors and facilities that are already overburdened with the implementation of electronic health records sufficient time to make these changes.

Response: We appreciate the concern that commenters expressed about implementing the additional reporting requirement for the MDS 3.0. We recognize the need for software vendors to program, test, and implement the changes that will need to be made. However, we remind commenters that CMS offers j-RAVEN, which is a free software option that allows facilities to collect and maintain facility, patient, and assessment information for subsequent submission to the appropriate data repository. This software will be available and ready for the implementation of the new MDS 3.0 reporting requirement and facilities that contract with alternative software vendors may choose to utilize the CMS-provided software until the vendor-created software is ready for implementation. With regard to the draft specifications, CMS released these specifications at the same time as we released the proposed rule. Software vendors had the ability to begin planning for any potential programming requirements with the release of draft specifications. We believe that software vendors should be structuring projects in a manner that is responsive to potentially changing requirements.

Accordingly, for the reasons specified in this final rule and in the FY 2014 SNF PPS proposed rule (78 FR 26465–26466), we are finalizing our proposal to add an item to the MDS item set (Item O0420) effective October 1, 2013, which will capture the number of distinct calendar days that the resident received therapy services during the assessment look-back period across all rehabilitation disciplines. As proposed, effective October 1, 2013, facilities will be required to record under this item the number of distinct calendar days of therapy provided by all rehabilitation disciplines over the 7-day look-back period for the current assessment, which will be used to classify the resident into the correct Rehabilitation RUG category.

3. SNF Therapy Research Project

In the FY 2014 SNF PPS proposed rule (78 FR 26466), we discussed our current research efforts associated with SNF payments for therapy services. As stated in the FY 2014 SNF PPS proposed rule (78 FR 26466), we contracted with Acumen, LLC and the Brookings Institution to identify

potential alternatives to the existing methodology used to pay for therapy services received under the SNF PPS. A discussion of the comments on this topic, with our responses, appears below.

Comment: All of the comments we received on this work supported CMS's broad objective to develop a new methodology for paying for therapy services received in the SNF. These commenters urged CMS to expedite the research necessary to develop a new therapy payment model, with one commenter stating that CMS should be prepared to implement a new system by FY 2015. A few commenters stated that CMS should seek input from stakeholders on how best to revise the current therapy payment model.

Response: We appreciate the broad support for this research initiative and understand well the importance and urgency of completing this work in both a timely and efficient manner. We also recognize the importance of seeking input from stakeholders on how best to revise the current therapy payment model, which is why we had created the therapy research email box at *SNFTherapyPayments@cms.hhs.gov.* Stakeholders can send input on a revised therapy payment model at any time.

In terms of the timeframe for completing this work and implementing a new payment model, we believe it would be premature to speculate on when a new model will be ready to be implemented. As many of the comments on this issue indicate, it is very important to ensure that any change to the current therapy payment model addresses any concerns with the existing model and provides sufficient time for providers to understand and prepare for implementation of such a model.

V. Provisions of the Final Rule; Regulations Text

In this final rule, in addition to accomplishing the required annual update of the SNF PPS payment rates and finalizing the other policies discussed above, we are also finalizing certain revisions to the regulations text. One of these revisions relates to the regulations dealing with SNF level of care certifications and recertifications. In the calendar year (CY) 2011 Medicare Physician Fee Schedule (MPFS) final rule with comment period (75 FR 73387, 73602, 73626–73627), we revised the regulations at § 424.20(e)(2) to implement section 3108 of the Affordable Care Act, which amended section 1814(a)(2) of the Act by adding physician assistants to the provision authorizing nurse practitioners and clinical nurse specialists to sign SNF level of care certifications and recertifications. However, as we stated in the FY 2014 SNF PPS proposed rule, we inadvertently neglected to make a conforming change in the regulations text at § 424.11(e)(4). Therefore, we proposed to make a minor technical correction in the regulations text at § 424.11(e)(4) regarding the types of practitioners (in addition to physicians) who can sign the required SNF level of care certification and recertifications. The correction consisted of a conforming change to reflect that physician assistants ''as defined in section 1861(aa)(5) of the Act'' are now authorized to perform this function, in accordance with section 1814(a)(2) of the Act (as amended by section 3108 of the Affordable Care Act) and the implementing regulations at § 424.20(e)(2). We received no comments on this proposal and, therefore, are finalizing this provision essentially as proposed. However, we are revising the statutory citation of the physician assistant definition to read ''section 1861(aa)(5)(A) of the Act'' in order to provide greater clarity and specificity as to the precise location of this definition in the statute. In addition, we inadvertently neglected to make a similar conforming technical change in the second paragraph of § 424.10(a), which describes the general purpose of this subpart of the regulations, and describes the types of practitioners (in addition to physicians) permitted under section 1814(a)(2) of the Act to certify and recertify the need for post-hospital extended care services. Thus, in this final rule, we also are making a similar minor technical correction to the regulations text at § 424.10(a) so that it accurately reflects that physician assistants are now permitted under section 1814(a)(2) of the Act to certify and recertify the need for post-hospital extended care services and so that it conforms with the regulations text at § 424.20(e)(2) and § 424.11(e)(4) (as revised in this rule).

Additionally, in the FY 2014 SNF PPS proposed rule (78 FR 26438), we proposed to make the wage index tables available exclusively through the Internet on CMS's SNF PPS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.* In order to accommodate this approach, we also proposed to revise the phrase ''wage index'' that currently appears in the second sentence of § 413.345 to read ''factors to be applied in making the area wage adjustment,'' consistent with the wording of the corresponding statutory authority at section 1888(e)(4)(H)(iii) of the Act. We received no comments on this proposal, and therefore, are finalizing this provision as proposed.

VI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to OMB for review and approval. In order to evaluate fairly whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

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

In the May 6, 2013 proposed rule (78 FR 26437) we solicited public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements (ICRs). We did not receive any comments.

ICRs Regarding Nursing Home and Swing Bed PPS Item Sets

Under sections 4204(b) and 4214(d) of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987, Pub. L. 100–203 enacted on December 22, 1987), the submission and retention of resident assessment data for purposes of carrying out OBRA 1987 are not subject to the PRA. While certain data items that are collected under the SNF resident assessment instrument (or MDS 3.0) fall under the OBRA 1987 exemption, MDS 3.0's PPS-related item sets are outside the scope of OBRA 1987 and require PRA consideration.

As discussed in section IV.D.2 of this rule, we are finalizing our proposal to add Item O0420 to the MDS 3.0 form to capture the number of distinct calendar days a SNF resident has received therapy across all rehabilitation disciplines in a seven-day look-back period. The item would not be added as a result of any change in statute or policy; rather, it would be added to ensure that our existing Rehabilitation RUG classification policies are properly implemented as intended. We do not believe this action will cause any

measureable adjustments to our burden estimates.

While we are not revising the form's burden estimates, we are revising OCN 0938–1140 (CMS–10387) by adding item O0420 to the Nursing Home and Swing Bed PPS Item Sets.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of the proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, [CMS–1446–F] by fax: (202) 395–6974 or by email: *OIRA_submission@omb.eop.gov.*

VII. Economic Analyses

A. Regulatory Impact Analysis

1. Introduction

We have examined the impacts of this final rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA, March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct 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). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated an economically significant rule, under section 3(f)(1) of Executive Order 12866, and thus a major rule under the Congressional Review Act. Also, the rule has been reviewed by OMB.

2. Statement of Need

This final rule updates the SNF prospective payment rates for FY 2014 as required under section 1888(e)(4)(E) of the Act. It also responds to section 1888(e)(4)(H) of the Act, which requires the Secretary to ''provide for publication in the **Federal Register**'' before the August 1 that precedes the start of each fiscal year, of the unadjusted federal per diem rates, the case-mix classification system, and the factors to be applied in making the area wage adjustment. As these statutory provisions prescribe a detailed methodology for calculating and disseminating payment rates under the SNF PPS, we do not have the discretion to adopt an alternative approach.

3. Overall Impacts

This final rule sets forth the updates of the SNF PPS rates contained in the update notice for FY 2013 (77 FR 46214). Based on the above, we estimate that the aggregate impact would be an increase of $470 million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as adjusted by the forecast error correction and MFP adjustment. The impact analysis of this final rule represents the projected effects of the changes in the SNF PPS from FY 2013 to FY 2014. Although the best data available are utilized, there is no attempt to predict behavioral responses to these changes, or to make adjustments for future changes in such variables as days or case-mix.

Certain events may occur to limit the scope or accuracy of our impact analysis, as this analysis is future-oriented and, thus, very susceptible to forecasting errors due to certain events that may occur within the assessed impact time period. Some examples of possible events may include legislated general Medicare program funding changes by the Congress, or changes specifically related to SNFs. In addition, changes to the Medicare program may continue to be made as a result of previously-enacted legislation, or new statutory provisions. Although these changes may not be specific to the SNF PPS, the nature of the Medicare program is such that the changes may interact and, thus, 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 sections 1888(e)(4)(E) and 1888(e)(5) of the Act, we update the FY 2013 payment rates by a factor equal to the market basket index percentage change adjusted by the forecast error for FY 2012, the latest FY for which final data are available, and the MFP adjustment to determine the payment rates for FY 2014. As discussed previously, for FY 2012 and each subsequent FY, as required by section 1888(e)(5)(B) of the Act as amended by section 3401(b) of the Affordable Care Act, the market basket percentage is reduced by the MFP adjustment. 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 the MMA provision. Our latest estimates indicate that there are fewer than 4,100 beneficiaries who qualify for the add-on payment for SNF residents with AIDS. The impact to Medicare is included in the ''total'' column of Table 10. In updating the SNF PPS rates for FY 2014, 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).

The annual update set forth in this final rule applies to SNF payments in FY 2014. 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 or rule in the **Federal Register** for each subsequent FY that will provide for an update to the SNF payment rates and include an associated impact analysis.

4. Detailed Economic Analysis

The FY 2014 SNF PPS impacts appear in Table 10. Using the most recently available data, in this case FY 2012, we apply the current FY 2013 wage index and labor-related share value to the number of payment days to simulate FY 2013 payments. Then, using the same FY 2012 data, we apply the FY 2014 wage index and labor-related share value to simulate FY 2014 payments. We tabulate the resulting payments according to the classifications in Table 10, for example, facility type, geographic region, facility ownership, and compare the difference between current and FY 2014 payments to determine the overall impact. 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, census region, and ownership.

The first row of figures 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 nineteen rows show the effects on facilities by urban versus rural status by census region. The last three rows

show the effects on facilities by ownership (that is, government, profit, and non-profit status).

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 2014 SNF PPS payments. The FY 2014 update of 1.3 percent (consisting of the market basket increase of 2.3 percentage points, reduced by the 0.5 percentage point forecast error correction and further reduced by the 0.5 percentage point MFP adjustment) 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 1.3 percent, assuming facilities do not change their care delivery and billing practices in response.

As illustrated in Table 10, the combined effects of all of the changes vary by specific types of providers and by location. Though all facilities would experience payment increases, the projected impact on providers for FY 2014 varies due to the impact of the wage index update. For example, due to changes from updating the wage index, providers in the rural Pacific region would experience a 2.8 percent increase in FY 2014 total payments and providers in the urban East South Central region would experience a 0.8 percent increase in FY 2014 total payments.

TABLE 10—RUG–IV PROJECTED IMPACT TO THE SNF PPS FOR FY 2014

	Number of facilities FY 2014	Update wage data (percent)	Total FY 2014 change (percent)
Group:			
Total	15,380	0.0	1.3
Urban	10,582	0.1	1.4
Rural	4,798	−0.3	1.0
Hospital based urban	758	0.2	1.5
Freestanding urban	9,824	0.1	1.4
Hospital based rural	402	−0.3	1.0
Freestanding rural	4,396	−0.3	1.0
Urban by region:			
New England	804	0.3	1.6
Middle Atlantic	1,452	0.8	2.1
South Atlantic	1,741	−0.6	0.7
East North Central	2,049	−0.2	1.1
East South Central	526	−0.5	0.8
West North Central	868	−0.7	0.6
West South Central	1,241	−0.4	0.9
Mountain	490	−0.1	1.2
Pacific	1,405	1.1	2.5
Outlying	6	0.1	1.4
Rural by region:			
New England	153	0.2	1.5
Middle Atlantic	262	0.2	1.5
South Atlantic	608	−0.6	0.7
East North Central	928	−0.6	0.7
East South Central	551	−0.6	0.7
West North Central	1,114	0.5	1.8
West South Central	813	−0.9	0.4
Mountain	246	0.2	1.5
Pacific	123	1.4	2.8
Ownership:			
Government	832	0.2	1.5
Profit	10,724	0.0	1.3
Non-profit	3,824	0.0	1.3

Note: The Total column includes the 2.3 percent market basket increase, reduced by the 0.5 percentage point forecast error correction and further reduced by the 0.5 percentage point MFP adjustment. Additionally, we found no SNFs in rural outlying areas.

5. Alternatives Considered

As described above, we estimate that the aggregate impact for FY 2014 would be an increase of $470 million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as adjusted by the forecast error correction and the MFP adjustment.

Section 1888(e) of the Act establishes the SNF PPS for 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. This section of the statute specifies that the base year cost data to be used for computing the SNF PPS payment rates are 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, 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 provide for publication of the payment rates for each new FY in 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.

We received a number of comments on the potential impact of finalizing the proposals in the FY 2014 SNF PPS proposed rule. A discussion of those comments, and our responses, appear below.

Comment: In their March 2013 report (available at: *http://www.medpac.gov/documents/Mar13_entirereport.pdf*), and in their comment on this proposed rule, MedPAC recommended that CMS eliminate the market basket update for SNFs and rebase payments for the SNF PPS, beginning with a 4 percent reduction in FY 2014. Several commenters raised concerns with MedPAC's recommendations, specifically that the cost and margin data used by MedPAC to justify their recommendations did not adequately represent the costs of providing SNF care. A few commenters also noted that any cuts in Medicare rates can have a cascading effect in combination with increased fiscal pressures deriving from reduced Medicaid funding.

Response: With regard to MedPAC's proposals to eliminate the market basket update for SNFs and to implement a 4 percent reduction to the SNF PPS rates, we would note that CMS does not have the statutory authority to act on either one of these proposals at the current time.

In addition, as we have stated in previous years—most recently, in the FY 2012 SNF PPS final rule (76 FR 48496, August 8, 2011)—we believe that it is not the appropriate role of the Medicare SNF benefit to cross-subsidize nursing home payments made under the Medicaid program. As noted by several commenters, the primary purpose of the SNF PPS is to provide accurate payment for Medicare Part A services provided in a SNF setting. Further, we note that MedPAC has also indicated that it is inappropriate for the Medicare payments to SNFs to serve as a remedy for any Medicaid shortfalls. Specifically, on page 177 of its March 2013 Report to Congress on Medicare Payment Policy (which is available online at *http://www.medpac.gov/documents/Mar13_EntireReport.pdf*), MedPAC stated:

> The Commission believes such cross-subsidization is not advisable for several reasons. First, the strategy of using Medicare rates to supplement low payments from other payers results in poorly targeted subsidies. Facilities with high shares of Medicare payments—presumably the facilities that need revenues the least—would receive the most in subsidies from higher Medicare payments, while facilities with low Medicare shares—presumably the facilities with the greatest need—would receive the smallest subsidies * * * In addition, Medicare's subsidy does not discriminate among states with relatively high and low payments * * * Finally, Medicare's current overpayments represent a subsidy of trust fund dollars (and its taxpayer support) to the low payments made by states and private payers.

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.

Comment: A few commenters requested that CMS consider a larger update to account for the forthcoming costs associated with the implementation of the Affordable Care Act employer responsibility requirements, which, at a general level, would require that employers with 50 or more full-time-equivalent employees provide health care coverage to their full-time employees (those working on average 30 or more hours per week) or face a penalty.

Response: As discussed in section IV.B of this proposed rule, CMS is required by statute to follow a specific methodology for updating the payment rates each year. We are not permitted to increase the update to account for these types of additional costs under existing authority.

6. Accounting Statement

As required by OMB Circular A–4 (available online at *www.whitehouse.gov/sites/default/files/omb/assets/regulatory_matters_pdf/a-4.pdf*), in Table 11, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. Table 11 provides our best estimate of the possible changes in Medicare payments under the SNF PPS as a result of the policies in this final rule, based on the data for 15,380 SNFs in our database. All expenditures are classified as transfers to Medicare SNF providers.

TABLE 11—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2013 SNF PPS FISCAL YEAR TO THE 2014 SNF PPS FISCAL YEAR

Category	Transfers
Annualized monetized transfers.	$470 million*
From Whom To Whom.	Federal Government to SNF Medicare Providers

*The net increase of $470 million in transfer payments is a result of the SNF market basket update to the payment rates, as adjusted by the forecast error correction and the MFP adjustment.

7. Conclusion

This final rule sets forth updates of the SNF PPS rates contained in the update notice for FY 2013 (77 FR 46214). Based on the above, we estimate the overall estimated payments for SNFs in FY 2014 are projected to increase by $470 million, or 1.3 percent, compared with those in FY 2013. We estimate that in FY 2014, SNFs in urban and rural areas would experience, on average, a 1.4 and 1.0 percent increase, respectively, in estimated payments compared with FY 2013. Providers in the rural Pacific region would experience the largest estimated increase in payments of approximately 2.8 percent. Providers in the rural West South Central region would experience the smallest increase in payments of 0.4 percent.

B. Regulatory Flexibility Act Analysis

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, non-profit organizations, and small governmental jurisdictions. Most SNFs and most other providers and suppliers are small entities, either by their non-profit status or by having revenues of $25.5 million or less in any 1 year. For purposes of the RFA, approximately 91 percent of SNFs are considered small businesses according to the Small Business Administration's latest size standards (NAICS 623110), with total revenues of $25.5 million or less in any 1 year. (For details, see the Small Business Administration's Web site at *http://www.sba.gov/category/navigation-structure/contracting/contracting-officials/eligibility-size-standards*). Individuals and States are not included in the definition of a small entity. In addition, approximately 25 percent of SNFs classified as small entities are non-profit organizations. Finally, the estimated number of small

business entities does not distinguish provider establishments that are within a single firm and, therefore, the number of SNFs classified as small entities may be higher than the estimate above.

This final rule sets forth updates of the SNF PPS rates contained in the update notice for FY 2013 (77 FR 46214). Based on the above, we estimate that the aggregate impact would be an increase of $470 million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as adjusted by the forecast error correction and the MFP adjustment. While it is projected in Table 10 that all groups of providers would experience a net increase in payments, we note that some individual providers within the same group but different regions may experience different impacts on payments than others due to the distributional impact of the FY 2014 wage indexes and the degree of Medicare utilization.

Guidance issued by the Department of Health and Human Services on the proper assessment of the impact on small entities in rulemakings, utilizes a cost or revenue impact of 3 to 5 percent as a significance threshold under the RFA. According to MedPAC, Medicare covers approximately 12 percent of total patient days in freestanding facilities and 23 percent of facility revenue. However, they note that the distribution of days and payments is highly variable. That is, the majority of SNFs have significantly lower Medicare utilization (Report to the Congress: Medicare Payment Policy, March 2013, available at *http://www.medpac.gov/documents/Mar13_EntireReport.pdf*). As a result, for most facilities, when all payers are included in the revenue stream, the overall impact on total revenues should be substantially less than those impacts presented in Table 10. As indicated in Table 10, the effect on facilities is projected to be an aggregate positive impact of 1.3 percent. As the overall impact on the industry as a whole, and thus on small entities specifically, is less than the 3 to 5 percent threshold discussed above, the Secretary has determined that this final rule would not have a significant impact on a substantial number of small entities.

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 would affect small rural hospitals that (a) furnish SNF services under a swing-bed agreement or (b) have a hospital-based SNF. We anticipate that the impact on small rural hospitals would be similar to the impact on SNF providers overall. Moreover, as noted in the FY 2012 final rule (76 FR 48539), the category of small rural hospitals would be included within the analysis of the impact of this final rule on small entities in general. As indicated in Table 10, the effect on facilities is projected to be an aggregate positive impact of 1.3 percent. As the overall impact on the industry as a whole is less than the 3 to 5 percent threshold discussed above, the Secretary has determined that this final rule would not have a significant impact on a substantial number of small rural hospitals.

C. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 (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 2013, that threshold is approximately $141 million. This final rule would not impose spending costs on State, local, or tribal governments in the aggregate, or by the private sector, of $141 million.

D. Federalism Analysis

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that impose substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. This final rule would have no substantial direct effect on State and local governments, preempt State law, or otherwise have federalism implications.

List of Subjects

42 CFR Part 413

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

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, 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 set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL 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); sec. 124 of Pub. L. 106–133 (113 Stat. 1501A–332) and sec. 3201 of Pub. L. 112–96 (126 Stat. 156).

■ 2. Section 413.345 is revised to read as follows:

§ 413.345 Publication of Federal prospective payment rates.

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

PART 424—CONDITIONS FOR MEDICARE PAYMENT

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

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

■ 4. In § 424.10, paragraph (a) is amended by removing the phrase ''nurse practitioners or clinical nurse specialists'' and adding in its place ''nurse practitioners, clinical nurse specialists, or physician assistants''.

■ 5. Section 424.11 is amended by revising paragraph (e)(4) to read as follows:

§ 424.11 General procedures.

* * * * *

(e) * * *

(4) A nurse practitioner or clinical nurse specialist as defined in paragraph (e)(5) or (e)(6) of this section, or a physician assistant as defined in section

1861(aa)(5)(A) of the Act, in the circumstances specified in § 424.20(e).

* * * * *

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

Dated: July 19, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: July 29, 2013.

Kathleen Sebelius,

Secretary.

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

Addendum—FY 2014 CBSA Wage Index Tables

In this addendum, we provide the wage index tables referred to in the preamble to this final rule. Tables A and B display the CBSA-based wage index values for urban and rural providers. As noted previously in this final rule, we are adopting an approach already being followed by other Medicare payment systems, whereby for SNF PPS rules and notices published on or after October 1, 2013, these wage index tables will henceforth be made available exclusively through the Internet on the CMS Web site rather than being published in the **Federal Register** as part of the annual SNF PPS rulemaking.

TABLE A—FY 2014 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS

CBSA Code	Urban area (constituent counties)	Wage index
10180	Abilene, TX	0.8225
	Callahan County, TX.	
	Jones County, TX.	
	Taylor County, TX.	
10380	Aguadilla-Isabela-San Sebastián, PR.	0.3647
	Aguada Municipio, PR.	
	Aguadilla Municipio, PR.	
	Añasco Municipio, PR.	
	Isabela Municipio, PR.	
	Lares Municipio, PR.	
	Moca Municipio, PR.	
	Rincón Municipio, PR.	
	San Sebastián Municipio, PR.	
10420	Akron, OH	0.8521
	Portage County, OH.	
	Summit County, OH.	
10500	Albany, GA	0.8713
	Baker County, GA.	
	Dougherty County, GA.	
	Lee County, GA.	
	Terrell County, GA.	
	Worth County, GA.	
10580	Albany-Schenectady-Troy, NY.	0.8600
	Albany County, NY.	
	Rensselaer County, NY.	
	Saratoga County, NY.	
	Schenectady County, NY.	
	Schoharie County, NY.	
10740	Albuquerque, NM	0.9663
	Bernalillo County, NM.	
	Sandoval County, NM.	
	Torrance County, NM.	
	Valencia County, NM.	
10780	Alexandria, LA	0.7788
	Grant Parish, LA.	
	Rapides Parish, LA.	
10900	Allentown-Bethlehem-Easton, PA–NJ.	0.9215
	Warren County, NJ.	
	Carbon County, PA.	
	Lehigh County, PA.	
	Northampton County, PA.	
11020	Altoona, PA	0.9101
	Blair County, PA.	
11100	Amarillo, TX	0.8302
	Armstrong County, TX.	
	Carson County, TX.	
	Potter County, TX.	
	Randall County, TX.	
11180	Ames, IA	0.9425
	Story County, IA.	
11260	Anchorage, AK	1.2221
	Anchorage Municipality, AK.	
	Matanuska-Susitna Borough, AK.	
11300	Anderson, IN	0.9654
	Madison County, IN.	
11340	Anderson, SC	0.8766
	Anderson County, SC.	
11460	Arbor, MI	1.0086
	Washtenaw County, MI.	
11500	Anniston-Oxford, AL	0.7402
	Calhoun County, AL.	
11540	Appleton, WI	0.9445
	Calumet County, WI.	
	Outagamie County, WI.	
11700	Asheville, NC	0.8511
	Buncombe County, NC.	
	Haywood County, NC.	
	Henderson County, NC.	
	Madison County, NC.	
12020	Athens-Clarke County, GA.	0.9244
	Clarke County, GA.	
	Madison County, GA.	
	Oconee County, GA.	
	Oglethorpe County, GA.	
12060	Atlanta-Sandy Springs-Marietta, GA.	0.9452
	Barrow County, GA.	
	Bartow County, GA.	
	Butts County, GA.	
	Carroll County, GA.	
	Cherokee County, GA.	
	Clayton County, GA.	
	Cobb County, GA.	
	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.	1.2258
	Atlantic County, NJ.	
12220	Auburn-Opelika, AL	0.7771
	Lee County, AL.	
12260	Augusta-Richmond County, GA–SC.	0.9150
	Burke County, GA.	
	Columbia County, GA.	
	McDuffie County, GA.	
	Richmond County, GA.	
	Aiken County, SC.	
	Edgefield County, SC.	
12420	Austin-Round Rock, TX	0.9576
	Bastrop County, TX.	
	Caldwell County, TX.	
	Hays County, TX.	
	Travis County, TX.	
	Williamson County, TX.	
12540	Bakersfield, CA	1.1579
	Kern County, CA.	
12580	Baltimore-Towson, MD	0.9873
	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	0.9710
	Penobscot County, ME.	
12700	Barnstable Town, MA ...	1.3007
	Barnstable County, MA.	
12940	Baton Rouge, LA	0.8078
	Ascension Parish, LA.	
	East Baton Rouge Parish, LA.	
	East Feliciana Parish, LA.	
	Iberville Parish, LA.	
	Livingston Parish, LA.	
	Pointe Coupee Parish, LA.	
	St. Helena Parish, LA.	
	West Baton Rouge Parish, LA.	
	West Feliciana Parish, LA.	
12980	Battle Creek, MI	0.9915
	Calhoun County, MI.	
13020	Bay City, MI	0.9486
	Bay County, MI.	

TABLE A—FY 2014 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA Code	Urban area (constituent counties)	Wage index
13140	Beaumont-Port Arthur, TX.	0.8598
	Hardin County, TX.	
	Jefferson County, TX.	
	Orange County, TX.	
13380	Bellingham, WA	1.1890
	Whatcom County, WA.	
13460	Bend, OR	1.1807
	Deschutes County, OR.	
13644	Bethesda-Frederick-Gaithersburg, MD.	1.0319
	Frederick County, MD.	
	Montgomery County, MD.	
13740	Billings, MT	0.8691
	Carbon County, MT.	
	Yellowstone County, MT.	
13780	Binghamton, NY	0.8602
	Broome County, NY.	
	Tioga County, NY.	
13820	Birmingham-Hoover, AL	0.8367
	Bibb County, AL.	
	Blount County, AL.	
	Chilton County, AL.	
	Jefferson County, AL.	
	St. Clair County, AL.	
	Shelby County, AL.	
	Walker County, AL.	
13900	Bismarck, ND	0.7282
	Burleigh County, ND.	
	Morton County, ND.	
13980	Blacksburg-Christiansburg-Radford, VA.	0.8319
	Giles County, VA.	
	Montgomery County, VA.	
	Pulaski County, VA.	
	Radford City, VA.	
14020	Bloomington, IN	0.9304
	Greene County, IN.	
	Monroe County, IN.	
	Owen County, IN.	
14060	Bloomington-Normal, IL	0.9310
	McLean County, IL.	
14260	Boise City-Nampa, ID ...	0.9259
	Ada County, ID.	
	Boise County, ID.	
	Canyon County, ID.	
	Gem County, ID.	
	Owyhee County, ID.	
14484	Boston-Quincy, MA	1.2453
	Norfolk County, MA.	
	Plymouth County, MA.	
	Suffolk County, MA.	
14500	Boulder, CO	0.9850
	Boulder County, CO.	
14540	Bowling Green, KY	0.8573
	Edmonson County, KY.	
	Warren County, KY.	
14740	Bremerton-Silverdale, WA.	1.0268
	Kitsap County, WA.	
14860	Bridgeport-Stamford-Norwalk, CT.	1.3252
	Fairfield County, CT.	
15180	Brownsville-Harlingen, TX.	0.8179
	Cameron County, TX.	
15260	Brunswick, GA	0.8457
	Brantley County, GA.	
	Glynn County, GA.	
	McIntosh County, GA.	
15380	Buffalo-Niagara Falls, NY.	1.0045
	Erie County, NY.	
	Niagara County, NY.	
15500	Burlington, NC	0.8529
	Alamance County, NC.	
15540	Burlington-South Burlington, VT.	1.0130
	Chittenden County, VT.	
	Franklin County, VT.	
	Grand Isle County, VT.	
15764	Cambridge-Newton-Framingham, MA.	1.1146
	Middlesex County, MA.	
15804	Camden, NJ	1.0254
	Burlington County, NJ.	
	Camden County, NJ.	
	Gloucester County, NJ.	
15940	Canton-Massillon, OH ..	0.8730
	Carroll County, OH.	
	Stark County, OH.	
15980	Cape Coral-Fort Myers, FL.	0.8683
	Lee County, FL.	
16020	Cape Girardeau-Jackson, MO–IL.	0.9174
	Alexander County, IL.	
	Bollinger County, MO.	
	Cape Girardeau County, MO.	
16180	Carson City, NV	1.0721
	Carson City, NV.	
16220	Casper, WY	1.0111
	Natrona County, WY.	
16300	Cedar Rapids, IA	0.8964
	Benton County, IA.	
	Jones County, IA.	
	Linn County, IA.	
16580	Champaign-Urbana, IL	0.9416
	Champaign County, IL.	
	Ford County, IL.	
	Piatt County, IL.	
16620	Charleston, WV	0.8119
	Boone County, WV.	
	Clay County, WV.	
	Kanawha County, WV.	
	Lincoln County, WV.	
	Putnam County, WV.	
16700	Charleston-North Charleston-Summerville, SC.	0.8972
	Berkeley County, SC.	
	Charleston County, SC.	
	Dorchester County, SC.	
16740	Charlotte-Gastonia-Concord, NC–SC.	0.9447
	Anson County, NC.	
	Cabarrus County, NC.	
	Gaston County, NC.	
	Mecklenburg County, NC.	
	Union County, NC.	
	York County, SC.	
16820	Charlottesville, VA	0.9209
	Albemarle County, VA.	
	Fluvanna County, VA.	
	Greene County, VA.	
	Nelson County, VA.	
	Charlottesville City, VA.	
16860	Chattanooga, TN–GA ...	0.8783
	Catoosa County, GA.	
	Dade County, GA.	
	Walker County, GA.	
	Hamilton County, TN.	
	Marion County, TN.	
	Sequatchie County, TN.	
16940	Cheyenne, WY	0.9494
	Laramie County, WY.	
16974	Chicago-Naperville-Joliet, IL.	1.0418
	Cook County, IL.	
	DeKalb County, IL.	
	DuPage County, IL.	
	Grundy County, IL.	
	Kane County, IL.	
	Kendall County, IL.	
	McHenry County, IL.	
	Will County, IL.	
17020	Chico, CA	1.1616
	Butte County, CA.	
17140	Cincinnati-Middletown, OH–KY–IN.	0.9470
	Dearborn County, IN.	
	Franklin County, IN.	
	Ohio County, IN.	
	Boone County, KY.	
	Bracken County, KY.	
	Campbell County, KY.	
	Gallatin County, KY.	
	Grant County, KY.	
	Kenton County, KY.	
	Pendleton County, KY.	
	Brown County, OH.	
	Butler County, OH.	
	Clermont County, OH.	
	Hamilton County, OH.	
	Warren County, OH.	
17300	Clarksville, TN–KY	0.7802
	Christian County, KY.	
	Trigg County, KY.	
	Montgomery County, TN.	
	Stewart County, TN.	
17420	Cleveland, TN	0.7496
	Bradley County, TN.	
	Polk County, TN.	
17460	Cleveland-Elyria-Mentor, OH.	0.9303
	Cuyahoga County, OH.	
	Geauga County, OH.	
	Lake County, OH.	
	Lorain County, OH.	
	Medina County, OH.	
17660	Coeur d'Alene, ID	0.9064
	Kootenai County, ID.	
17780	College Station-Bryan, TX.	0.9497
	Brazos County, TX.	
	Burleson County, TX.	
	Robertson County, TX.	
17820	Colorado Springs, CO ..	0.9282
	El Paso County, CO.	
	Teller County, CO.	

TABLE A—FY 2014 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA Code	Urban area (constituent counties)	Wage index
17860	Columbia, MO	0.8196
	Boone County, MO.	
	Howard County, MO.	
17900	Columbia, SC	0.8601
	Calhoun County, SC.	
	Fairfield County, SC.	
	Kershaw County, SC.	
	Lexington County, SC.	
	Richland County, SC.	
	Saluda County, SC.	
17980	Columbus, GA–AL	0.8170
	Russell County, AL.	
	Chattahoochee County, GA.	
	Harris County, GA.	
	Marion County, GA.	
	Muscogee County, GA.	
18020	Columbus, IN	0.9818
	Bartholomew County, IN.	
18140	Columbus, OH	0.9803
	Delaware County, OH.	
	Fairfield County, OH.	
	Franklin County, OH.	
	Licking County, OH.	
	Madison County, OH.	
	Morrow County, OH.	
	Pickaway County, OH.	
	Union County, OH.	
18580	Corpus Christi, TX	0.8433
	Aransas County, TX.	
	Nueces County, TX.	
	San Patricio County, TX.	
18700	Corvallis, OR	1.0596
	Benton County, OR.	
18880	Crestview-Fort Walton Beach-Destin, FL.	0.8911
	Okaloosa County, FL.	
19060	Cumberland, MD–WV ..	0.8054
	Allegany County, MD.	
	Mineral County, WV.	
19124	Dallas-Plano-Irving, TX	0.9831
	Collin County, TX.	
	Dallas County, TX.	
	Delta County, TX.	
	Denton County, TX.	
	Ellis County, TX.	
	Hunt County, TX.	
	Kaufman County, TX.	
	Rockwall County, TX.	
19140	Dalton, GA	0.8625
	Murray County, GA.	
	Whitfield County, GA.	
19180	Danville, IL	0.9460
	Vermilion County, IL.	
19260	Danville, VA	0.7888
	Pittsylvania County, VA.	
	Danville City, VA.	
19340	Davenport-Moline-Rock Island, IA–IL.	0.9306
	Henry County, IL.	
	Mercer County, IL.	
	Rock Island County, IL.	
	Scott County, IA.	
19380	Dayton, OH	0.9034
	Greene County, OH.	
	Miami County, OH.	
	Montgomery County, OH.	
	Preble County, OH.	
19460	Decatur, AL	0.7165
	Lawrence County, AL.	
	Morgan County, AL.	
19500	Decatur, IL	0.8151
	Macon County, IL.	
19660	Deltona-Daytona Beach-Ormond Beach, FL.	0.8560
	Volusia County, FL.	
19740	Denver-Aurora-Broomfield, CO.	1.0395
	Adams County, CO.	
	Arapahoe County, CO.	
	Broomfield County, CO.	
	Clear Creek County, CO.	
	Denver County, CO.	
	Douglas County, CO.	
	Elbert County, CO.	
	Gilpin County, CO.	
	Jefferson County, CO.	
	Park County, CO.	
19780	Des Moines-West Des Moines, IA.	0.9393
	Dallas County, IA.	
	Guthrie County, IA.	
	Madison County, IA.	
	Polk County, IA.	
	Warren County, IA.	
19804	Detroit-Livonia-Dearborn, MI.	0.9237
	Wayne County, MI.	
20020	Dothan, AL	0.7108
	Geneva County, AL.	
	Henry County, AL.	
	Houston County, AL.	
20100	Dover, DE	0.9939
	Kent County, DE.	
20220	Dubuque, IA	0.8790
	Dubuque County, IA.	
20260	Duluth, MN–WI	1.0123
	Carlton County, MN.	
	St. Louis County, MN.	
	Douglas County, WI.	
20500	Durham-Chapel Hill, NC	0.9669
	Chatham County, NC.	
	Durham County, NC.	
	Orange County, NC.	
	Person County, NC.	
20740	Eau Claire, WI	1.0103
	Chippewa County, WI.	
	Eau Claire County, WI.	
20764	Edison-New Brunswick, NJ.	1.0985
	Middlesex County, NJ.	
	Monmouth County, NJ.	
	Ocean County, NJ.	
	Somerset County, NJ.	
20940	El Centro, CA	0.8848
	Imperial County, CA.	
21060	Elizabethtown, KY	0.7894
	Hardin County, KY.	
	Larue County, KY.	
21140	Elkhart-Goshen, IN	0.9337
	Elkhart County, IN.	
21300	Elmira, NY	0.8725
	Chemung County, NY.	
21340	El Paso, TX	0.8404
	El Paso County, TX.	
21500	Erie, PA	0.7940
	Erie County, PA.	
21660	Eugene-Springfield, OR	1.1723
	Lane County, OR.	
21780	Evansville, IN–KY	0.8381
	Gibson County, IN.	
	Posey County, IN.	
	Vanderburgh County, IN.	
	Warrick County, IN.	
	Henderson County, KY.	
	Webster County, KY.	
21820	Fairbanks, AK	1.0997
	Fairbanks North Star Borough, AK.	
21940	Fajardo, PR	0.3728
	Ceiba Municipio, PR.	
	Fajardo Municipio, PR.	
	Luquillo Municipio, PR.	
22020	Fargo, ND–MN	0.7802
	Cass County, ND.	
	Clay County, MN.	
22140	Farmington, NM	0.9735
	San Juan County, NM.	
22180	Fayetteville, NC	0.8601
	Cumberland County, NC.	
	Hoke County, NC.	
22220	Fayetteville-Springdale-Rogers, AR–MO.	0.8955
	Benton County, AR.	
	Madison County, AR.	
	Washington County, AR.	
	McDonald County, MO.	
22380	Flagstaff, AZ	1.2786
	Coconino County, AZ.	
22420	Flint, MI	1.1238
	Genesee County, MI.	
22500	Florence, SC	0.7999
	Darlington County, SC.	
	Florence County, SC.	
22520	Florence-Muscle Shoals, AL.	0.7684
	Colbert County, AL.	
	Lauderdale County, AL.	
22540	Fond du Lac, WI	0.9477
	Fond du Lac County, WI.	
22660	Fort Collins-Loveland, CO.	0.9704
	Larimer County, CO.	
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL.	1.0378
	Broward County, FL.	
22900	Fort Smith, AR–OK	0.7561
	Crawford County, AR.	
	Franklin County, AR.	
	Sebastian County, AR.	
	Le Flore County, OK.	
	Sequoyah County, OK.	
23060	Fort Wayne, IN	0.9010
	Allen County, IN.	
	Wells County, IN.	
	Whitley County, IN.	
23104	Fort Worth-Arlington, TX.	0.9535
	Johnson County, TX.	
	Parker County, TX.	

TABLE A—FY 2014 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA Code	Urban area (constituent counties)	Wage index
	Tarrant County, TX.	
	Wise County, TX.	
23420	Fresno, CA	1.1768
	Fresno County, CA.	
23460	Gadsden, AL	0.7983
	Etowah County, AL.	
23540	Gainesville, FL	0.9710
	Alachua County, FL.	
	Gilchrist County, FL.	
23580	Gainesville, GA	0.9253
	Hall County, GA.	
23844	Gary, IN	0.9418
	Jasper County, IN.	
	Lake County, IN.	
	Newton County, IN.	
	Porter County, IN.	
24020	Glens Falls, NY	0.8367
	Warren County, NY.	
	Washington County, NY.	
24140	Goldsboro, NC	0.8550
	Wayne County, NC.	
24220	Grand Forks, ND–MN ..	0.7290
	Polk County, MN.	
	Grand Forks County, ND.	
24300	Grand Junction, CO	0.9270
	Mesa County, CO.	
24340	Grand Rapids-Wyoming, MI.	0.9091
	Barry County, MI.	
	Ionia County, MI.	
	Kent County, MI.	
	Newaygo County, MI.	
24500	Great Falls, MT	0.9235
	Cascade County, MT.	
24540	Greeley, CO	0.9653
	Weld County, CO.	
24580	Green Bay, WI	0.9587
	Brown County, WI.	
	Kewaunee County, WI.	
	Oconto County, WI.	
24660	Greensboro-High Point, NC.	0.8320
	Guilford County, NC.	
	Randolph County, NC.	
	Rockingham County, NC.	
24780	Greenville, NC	0.9343
	Greene County, NC.	
	Pitt County, NC.	
24860	Greenville-Mauldin-Easley, SC.	0.9604
	Greenville County, SC.	
	Laurens County, SC.	
	Pickens County, SC.	
25020	Guayama, PR	0.3707
	Arroyo Municipio, PR.	
	Guayama Municipio, PR.	
	Patillas Municipio, PR.	
25060	Gulfport-Biloxi, MS	0.8575
	Hancock County, MS.	
	Harrison County, MS.	
	Stone County, MS.	
25180	Hagerstown-Martinsburg, MD–WV.	0.9234
	Washington County, MD.	
	Berkeley County, WV.	
	Morgan County, WV.	
25260	Hanford-Corcoran, CA ..	1.1124
	Kings County, CA.	
25420	Harrisburg-Carlisle, PA	0.9533
	Cumberland County, PA.	
	Dauphin County, PA.	
	Perry County, PA.	
25500	Harrisonburg, VA	0.9090
	Rockingham County, VA.	
	Harrisonburg City, VA.	
25540	Hartford-West Hartford-East Hartford, CT.	1.1050
	Hartford County, CT.	
	Middlesex County, CT.	
	Tolland County, CT.	
25620	Hattiesburg, MS	0.7938
	Forrest County, MS.	
	Lamar County, MS.	
	Perry County, MS.	
25860	Hickory-Lenoir-Morganton, NC.	0.8492
	Alexander County, NC.	
	Burke County, NC.	
	Caldwell County, NC.	
	Catawba County, NC.	
25980	Hinesville-Fort Stewart, GA [1].	0.8700
	Liberty County, GA.	
	Long County, GA.	
26100	Holland-Grand Haven, MI.	0.8016
	Ottawa County, MI.	
26180	Honolulu, HI	1.2321
	Honolulu County, HI.	
26300	Hot Springs, AR	0.8474
	Garland County, AR.	
26380	Houma-Bayou Cane-Thibodaux, LA.	0.7525
	Lafourche Parish, LA.	
	Terrebonne Parish, LA.	
26420	Houston-Sugar Land-Baytown, TX.	0.9915
	Austin County, TX.	
	Brazoria County, TX.	
	Chambers County, TX.	
	Fort Bend County, TX.	
	Galveston County, TX.	
	Harris County, TX.	
	Liberty County, TX.	
	Montgomery County, TX.	
	San Jacinto County, TX.	
	Waller County, TX.	
26580	Huntington-Ashland, WV–KY–OH.	0.8944
	Boyd County, KY.	
	Greenup County, KY.	
	Lawrence County, OH.	
	Cabell County, WV.	
	Wayne County, WV.	
26620	Huntsville, AL	0.8455
	Limestone County, AL.	
	Madison County, AL.	
26820	Idaho Falls, ID	0.9312
	Bonneville County, ID.	
	Jefferson County, ID.	
26900	Indianapolis-Carmel, IN	1.0108
	Boone County, IN.	
	Brown County, IN.	
	Hamilton County, IN.	
	Hancock County, IN.	
	Hendricks County, IN.	
	Johnson County, IN.	
	Marion County, IN.	
	Morgan County, IN.	
	Putnam County, IN.	
	Shelby County, IN.	
26980	Iowa City, IA	0.9854
	Johnson County, IA.	
	Washington County, IA.	
27060	Ithaca, NY	0.9326
	Tompkins County, NY.	
27100	Jackson, MI	0.8944
	Jackson County, MI.	
27140	Jackson, MS	0.8162
	Copiah County, MS.	
	Hinds County, MS.	
	Madison County, MS.	
	Rankin County, MS.	
	Simpson County, MS.	
27180	Jackson, TN	0.7729
	Chester County, TN.	
	Madison County, TN.	
27260	Jacksonville, FL	0.8956
	Baker County, FL.	
	Clay County, FL.	
	Duval County, FL.	
	Nassau County, FL.	
	St. Johns County, FL.	
27340	Jacksonville, NC	0.7861
	Onslow County, NC.	
27500	Janesville, WI	0.9071
	Rock County, WI.	
27620	Jefferson City, MO	0.8465
	Callaway County, MO.	
	Cole County, MO.	
	Moniteau County, MO.	
	Osage County, MO.	
27740	Johnson City, TN	0.7226
	Carter County, TN.	
	Unicoi County, TN.	
	Washington County, TN.	
27780	Johnstown, PA	0.8450
	Cambria County, PA.	
27860	Jonesboro, AR	0.7983
	Craighead County, AR.	
	Poinsett County, AR.	
27900	Joplin, MO	0.7983
	Jasper County, MO.	
	Newton County, MO.	
28020	Kalamazoo-Portage, MI	0.9959
	Kalamazoo County, MI.	
	Van Buren County, MI.	
28100	Kankakee-Bradley, IL ...	0.9657
	Kankakee County, IL.	
28140	Kansas City, MO–KS ...	0.9447
	Franklin County, KS.	
	Johnson County, KS.	
	Leavenworth County, KS.	
	Linn County, KS.	
	Miami County, KS.	
	Wyandotte County, KS.	
	Bates County, MO.	
	Caldwell County, MO.	
	Cass County, MO.	
	Clay County, MO.	
	Clinton County, MO.	

TABLE A—FY 2014 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA Code	Urban area (constituent counties)	Wage index
	Jackson County, MO.	
	Lafayette County, MO.	
	Platte County, MO.	
	Ray County, MO.	
28420	Kennewick-Pasco-Richland, WA.	0.9459
	Benton County, WA.	
	Franklin County, WA.	
28660	Killeen-Temple-Fort Hood, TX.	0.8925
	Bell County, TX.	
	Coryell County, TX.	
	Lampasas County, TX.	
28700	Kingsport-Bristol-Bristol, TN–VA.	0.7192
	Hawkins County, TN.	
	Sullivan County, TN.	
	Bristol City, VA.	
	Scott County, VA.	
	Washington County, VA.	
28740	Kingston, NY	0.9066
	Ulster County, NY.	
28940	Knoxville, TN	0.7432
	Anderson County, TN.	
	Blount County, TN.	
	Knox County, TN.	
	Loudon County, TN.	
	Union County, TN.	
29020	Kokomo, IN	0.9061
	Howard County, IN.	
	Tipton County, IN.	
29100	La Crosse, WI–MN	1.0205
	Houston County, MN.	
	La Crosse County, WI.	
29140	Lafayette, IN	0.9954
	Benton County, IN.	
	Carroll County, IN.	
	Tippecanoe County, IN.	
29180	Lafayette, LA	0.8231
	Lafayette Parish, LA.	
	St. Martin Parish, LA.	
29340	Lake Charles, LA	0.7765
	Calcasieu Parish, LA.	
	Cameron Parish, LA.	
29404	Lake County-Kenosha County, IL–WI.	1.0658
	Lake County, IL.	
	Kenosha County, WI.	
29420	Lake Havasu City-Kingman, AZ.	0.9912
	Mohave County, AZ.	
29460	Lakeland-Winter Haven, FL.	0.8283
	Polk County, FL.	
29540	Lancaster, PA	0.9695
	Lancaster County, PA.	
29620	Lansing-East Lansing, MI.	1.0618
	Clinton County, MI.	
	Eaton County, MI.	
	Ingham County, MI.	
29700	Laredo, TX	0.7586
	Webb County, TX.	
29740	Las Cruces, NM	0.9265
	Dona Ana County, NM.	
29820	Las Vegas-Paradise, NV.	1.1627
	Clark County, NV.	
29940	Lawrence, KS	0.8664
	Douglas County, KS	
30020	Lawton, OK	0.7893
	Comanche County, OK.	
30140	Lebanon, PA	0.8157
	Lebanon County, PA.	
30300	Lewiston, ID–WA	0.9215
	Nez Perce County, ID.	
	Asotin County, WA.	
30340	Lewiston-Auburn, ME	0.9048
	Androscoggin County, ME.	
30460	Lexington-Fayette, KY	0.8902
	Bourbon County, KY.	
	Clark County, KY.	
	Fayette County, KY.	
	Jessamine County, KY.	
	Scott County, KY.	
	Woodford County, KY.	
30620	Lima, OH	0.9158
	Allen County, OH.	
30700	Lincoln, NE	0.9465
	Lancaster County, NE.	
	Seward County, NE.	
30780	Little Rock-North Little Rock-Conway, AR.	0.8629
	Faulkner County, AR.	
	Grant County, AR.	
	Lonoke County, AR.	
	Perry County, AR.	
	Pulaski County, AR.	
	Saline County, AR.	
30860	Logan, UT–ID	0.8754
	Franklin County, ID.	
	Cache County, UT.	
30980	Longview, TX	0.8933
	Gregg County, TX.	
	Rusk County, TX.	
	Upshur County, TX.	
31020	Longview, WA	1.0460
	Cowlitz County, WA.	
31084	Los Angeles-Long Beach-Glendale, CA.	1.2417
	Los Angeles County, CA.	
31140	Louisville-Jefferson County, KY–IN.	0.8852
	Clark County, IN.	
	Floyd County, IN.	
	Harrison County, IN.	
	Washington County, IN.	
	Bullitt County, KY.	
	Henry County, KY.	
	Meade County, KY.	
	Nelson County, KY.	
	Oldham County, KY.	
	Shelby County, KY.	
	Spencer County, KY.	
	Trimble County, KY.	
31180	Lubbock, TX	0.8956
	Crosby County, TX.	
	Lubbock County, TX.	
31340	Lynchburg, VA	0.8771
	Amherst County, VA.	
	Appomattox County, VA.	
	Bedford County, VA.	
	Campbell County, VA.	
	Bedford City, VA.	
	Lynchburg City, VA.	
31420	Macon, GA	0.9014
	Bibb County, GA.	
	Crawford County, GA.	
	Jones County, GA.	
	Monroe County, GA.	
	Twiggs County, GA.	
31460	Madera-Chowchilla, CA	0.8317
	Madera County, CA.	
31540	Madison, WI	1.1414
	Columbia County, WI.	
	Dane County, WI.	
	Iowa County, WI.	
31700	Manchester-Nashua, NH.	1.0057
	Hillsborough County, NH.	
31740	Manhattan, KS	0.7843
	Geary County, KS.	
	Pottawatomie County, KS.	
	Riley County, KS.	
31860	Mankato-North Mankato, MN.	0.9277
	Blue Earth County, MN.	
	Nicollet County, MN.	
31900	Mansfield, OH	0.8509
	Richland County, OH.	
32420	Mayagüez, PR	0.3762
	Hormigueros Municipio, PR.	
	Mayagüez Municipio, PR.	
32580	McAllen-Edinburg-Mission, TX.	0.8393
	Hidalgo County, TX.	
32780	Medford, OR	1.0690
	Jackson County, OR.	
32820	Memphis, TN–MS–AR	0.9038
	Crittenden County, AR.	
	DeSoto County, MS.	
	Marshall County, MS.	
	Tate County, MS.	
	Tunica County, MS.	
	Fayette County, TN.	
	Shelby County, TN.	
	Tipton County, TN.	
32900	Merced, CA	1.2734
	Merced County, CA.	
33124	Miami-Miami Beach-Kendall, FL.	0.9870
	Miami-Dade County, FL.	
33140	Michigan City-La Porte, IN.	0.9216
	LaPorte County, IN.	
33260	Midland, TX	1.0049
	Midland County, TX.	
33340	Milwaukee-Waukesha-West Allis, WI.	0.9856
	Milwaukee County, WI.	
	Ozaukee County, WI.	
	Washington County, WI.	
	Waukesha County, WI.	
33460	Minneapolis-St. Paul-Bloomington, MN–WI.	1.1213
	Anoka County, MN.	
	Carver County, MN.	
	Chisago County, MN.	
	Dakota County, MN.	
	Hennepin County, MN.	
	Isanti County, MN.	

TABLE A—FY 2014 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA Code	Urban area (constituent counties)	Wage index
	Ramsey County, MN.	
	Scott County, MN.	
	Sherburne County, MN.	
	Washington County, MN.	
	Wright County, MN.	
	Pierce County, WI.	
	St. Croix County, WI.	
33540	Missoula, MT	0.9142
	Missoula County, MT.	
33660	Mobile, AL	0.7507
	Mobile County, AL.	
33700	Modesto, CA	1.3629
	Stanislaus County, CA.	
33740	Monroe, LA	0.7530
	Ouachita Parish, LA.	
	Union Parish, LA.	
33780	Monroe, MI	0.8718
	Monroe County, MI.	
33860	Montgomery, AL	0.7475
	Autauga County, AL.	
	Elmore County, AL.	
	Lowndes County, AL.	
	Montgomery County, AL.	
34060	Morgantown, WV	0.8339
	Monongalia County, WV.	
	Preston County, WV.	
34100	Morristown, TN	0.6861
	Grainger County, TN.	
	Hamblen County, TN.	
	Jefferson County, TN.	
34580	Mount Vernon-Anacortes, WA.	1.0652
	Skagit County, WA.	
34620	Muncie, IN.	
	Delaware County, IN	0.8743
34740	Muskegon-Norton Shores, MI.	1.1076
	Muskegon County, MI.	
34820	Myrtle Beach-North Myrtle Beach-Conway, SC.	0.8700
	Horry County, SC.	
34900	Napa, CA	1.5375
	Napa County, CA.	
34940	Naples-Marco Island, FL.	0.9108
	Collier County, FL.	
34980	Nashville-Davidson—Murfreesboro-Franklin, TN.	0.9141
	Cannon County, TN.	
	Cheatham County, TN.	
	Davidson County, TN.	
	Dickson County, TN.	
	Hickman County, TN.	
	Macon County, TN.	
	Robertson County, TN.	
	Rutherford County, TN.	
	Smith County, TN.	
	Sumner County, TN.	
	Trousdale County, TN.	
	Williamson County, TN.	
	Wilson County, TN.	
35004	Nassau-Suffolk, NY	1.2755
	Nassau County, NY.	
	Suffolk County, NY.	
35084	Newark-Union, NJ–PA	1.1268
	Essex County, NJ.	
	Hunterdon County, NJ.	
	Morris County, NJ.	
	Sussex County, NJ.	
	Union County, NJ.	
	Pike County, PA.	
35300	New Haven-Milford, CT	1.1883
	New Haven County, CT.	
35380	New Orleans-Metairie-Kenner, LA.	0.8752
	Jefferson Parish, LA.	
	Orleans Parish, LA.	
	Plaquemines Parish, LA.	
	St. Bernard Parish, LA.	
	St. Charles Parish, LA.	
	St. John the Baptist Parish, LA.	
	St. Tammany Parish, LA.	
35644	New York-White Plains-Wayne, NY–NJ.	1.3089
	Bergen County, NJ.	
	Hudson County, NJ.	
	Passaic County, NJ.	
	Bronx County, NY.	
	Kings County, NY.	
	New York County, NY.	
	Putnam County, NY.	
	Queens County, NY.	
	Richmond County, NY.	
	Rockland County, NY.	
	Westchester County, NY.	
35660	Niles-Benton Harbor, MI	0.8444
	Berrien County, MI.	
35840	North Port-Bradenton-Sarasota-Venice, FL.	0.9428
	Manatee County, FL.	
	Sarasota County, FL.	
35980	Norwich-New London, CT.	1.1821
	New London County, CT.	
36084	Oakland-Fremont-Hayward, CA.	1.7048
	Alameda County, CA.	
	Contra Costa County, CA.	
36100	Ocala, FL	0.8425
	Marion County, FL.	
36140	Ocean City, NJ	1.0584
	Cape May County, NJ.	
36220	Odessa, TX	0.9661
	Ector County, TX.	
36260	Ogden-Clearfield, UT ...	0.9170
	Davis County, UT.	
	Morgan County, UT.	
	Weber County, UT.	
36420	Oklahoma City, OK	0.8879
	Canadian County, OK.	
	Cleveland County, OK.	
	Grady County, OK.	
	Lincoln County, OK.	
	Logan County, OK.	
	McClain County, OK.	
	Oklahoma County, OK.	
36500	Olympia, WA	1.1601
	Thurston County, WA.	
36540	Omaha-Council Bluffs, NE–IA.	0.9756
	Harrison County, IA.	
	Mills County, IA.	
	Pottawattamie County, IA.	
	Cass County, NE.	
	Douglas County, NE.	
	Sarpy County, NE.	
	Saunders County, NE.	
	Washington County, NE.	
36740	Orlando-Kissimmee, FL	0.9063
	Lake County, FL.	
	Orange County, FL.	
	Osceola County, FL.	
	Seminole County, FL.	
36780	Oshkosh-Neenah, WI ...	0.9398
	Winnebago County, WI.	
36980	Owensboro, KY	0.7790
	Daviess County, KY.	
	Hancock County, KY.	
	McLean County, KY.	
37100	Oxnard-Thousand Oaks-Ventura, CA.	1.3113
	Ventura County, CA.	
37340	Palm Bay-Melbourne-Titusville, FL.	0.8790
	Brevard County, FL.	
37380	Palm Coast, FL	0.8174
	Flagler County, FL.	
37460	Panama City-Lynn Haven-Panama City Beach, FL.	0.7876
	Bay County, FL.	
37620	Parkersburg-Marietta-Vienna, WV–OH.	0.7569
	Washington County, OH.	
	Pleasants County, WV.	
	Wirt County, WV.	
	Wood County, WV.	
37700	Pascagoula, MS	0.7542
	George County, MS.	
	Jackson County, MS.	
37764	Peabody, MA	1.0553
	Essex County, MA.	
37860	Pensacola-Ferry Pass-Brent, FL.	0.7767
	Escambia County, FL.	
	Santa Rosa County, FL.	
37900	Peoria, IL	0.8434
	Marshall County, IL.	
	Peoria County, IL.	
	Stark County, IL.	
	Tazewell County, IL.	
	Woodford County, IL.	
37964	Philadelphia, PA	1.0849
	Bucks County, PA.	
	Chester County, PA.	
	Delaware County, PA.	
	Montgomery County, PA.	
	Philadelphia County, PA.	
38060	Phoenix-Mesa-Scottsdale, AZ.	1.0465
	Maricopa County, AZ.	
	Pinal County, AZ.	
38220	Pine Bluff, AR	0.8069
	Cleveland County, AR.	
	Jefferson County, AR.	
	Lincoln County, AR.	
38300	Pittsburgh, PA	0.8669

TABLE A—FY 2014 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA Code	Urban area (constituent counties)	Wage index
	Allegheny County, PA.	
	Armstrong County, PA.	
	Beaver County, PA.	
	Butler County, PA.	
	Fayette County, PA.	
	Washington County, PA.	
	Westmoreland County, PA.	
38340	Pittsfield, MA	1.0920
	Berkshire County, MA.	
38540	Pocatello, ID	0.9754
	Bannock County, ID.	
	Power County, ID.	
38660	Ponce, PR	0.4594
	Juana Díaz Municipio, PR.	
	Ponce Municipio, PR.	
	Villalba Municipio, PR.	
38860	Portland-South Portland-Biddeford, ME.	0.9981
	Cumberland County, ME.	
	Sagadahoc County, ME.	
	York County, ME.	
38900	Portland-Vancouver-Beaverton, OR–WA.	1.1766
	Clackamas County, OR.	
	Columbia County, OR.	
	Multnomah County, OR.	
	Washington County, OR.	
	Yamhill County, OR.	
	Clark County, WA.	
	Skamania County, WA.	
38940	Port St. Lucie, FL	0.9352
	Martin County, FL.	
	St. Lucie County, FL.	
39100	Poughkeepsie-Newburgh-Middletown, NY.	1.1544
	Dutchess County, NY.	
	Orange County, NY.	
39140	Prescott, AZ	1.0161
	Yavapai County, AZ.	
39300	Providence-New Bedford-Fall River, RI–MA.	1.0539
	Bristol County, MA.	
	Bristol County, RI.	
	Kent County, RI.	
	Newport County, RI.	
	Providence County, RI.	
	Washington County, RI.	
39340	Provo-Orem, UT	0.9461
	Juab County, UT.	
	Utah County, UT.	
39380	Pueblo, CO	0.8215
	Pueblo County, CO.	
39460	Punta Gorda, FL	0.8734
	Charlotte County, FL.	
39540	Racine, WI	0.8903
	Racine County, WI.	
39580	Raleigh-Cary, NC	0.9304
	Franklin County, NC.	
	Johnston County, NC.	
	Wake County, NC.	
39660	Rapid City, SD	0.9568
	Meade County, SD.	
	Pennington County, SD.	
39740	Reading, PA	0.9220
	Berks County, PA.	
39820	Redding, CA	1.4990
	Shasta County, CA.	
39900	Reno-Sparks, NV	1.0326
	Storey County, NV.	
	Washoe County, NV.	
40060	Richmond, VA	0.9723
	Amelia County, VA.	
	Caroline County, VA.	
	Charles City County, VA.	
	Chesterfield County, VA.	
	Cumberland County, VA.	
	Dinwiddie County, VA.	
	Goochland County, VA.	
	Hanover County, VA.	
	Henrico County, VA.	
	King and Queen County, VA.	
	King William County, VA.	
	Louisa County, VA.	
	New Kent County, VA.	
	Powhatan County, VA.	
	Prince George County, VA.	
	Sussex County, VA.	
	Colonial Heights City, VA.	
	Hopewell City, VA.	
	Petersburg City, VA.	
	Richmond City, VA.	
40140	Riverside-San Bernardino-Ontario, CA.	1.1497
	Riverside County, CA.	
	San Bernardino County, CA.	
40220	Roanoke, VA	0.9195
	Botetourt County, VA.	
	Craig County, VA.	
	Franklin County, VA.	
	Roanoke County, VA.	
	Roanoke City, VA.	
	Salem City, VA.	
40340	Rochester, MN	1.1662
	Dodge County, MN.	
	Olmsted County, MN.	
	Wabasha County, MN.	
40380	Rochester, NY	0.8749
	Livingston County, NY.	
	Monroe County, NY.	
	Ontario County, NY.	
	Orleans County, NY.	
	Wayne County, NY.	
40420	Rockford, IL	0.9751
	Boone County, IL.	
	Winnebago County, IL.	
40484	Rockingham County-Strafford County, NH.	1.0172
	Rockingham County, NH.	
	Strafford County, NH.	
40580	Rocky Mount, NC	0.8750
	Edgecombe County, NC.	
	Nash County, NC.	
40660	Rome, GA	0.8924
	Floyd County, GA.	
40900	Sacramento-Arden-Arcade-Roseville, CA.	1.5498
	El Dorado County, CA.	
	Placer County, CA.	
	Sacramento County, CA.	
	Yolo County, CA.	
40980	Saginaw-Saginaw Township North, MI.	0.8849
	Saginaw County, MI.	
41060	St. Cloud, MN	1.0658
	Benton County, MN.	
	Stearns County, MN.	
41100	St. George, UT	0.9345
	Washington County, UT.	
41140	St. Joseph, MO–KS	0.9834
	Doniphan County, KS.	
	Andrew County, MO.	
	Buchanan County, MO.	
	DeKalb County, MO.	
41180	St. Louis, MO–IL	0.9336
	Bond County, IL.	
	Calhoun County, IL.	
	Clinton County, IL.	
	Jersey County, IL.	
	Macoupin County, IL.	
	Madison County, IL.	
	Monroe County, IL.	
	St. Clair County, IL.	
	Crawford County, MO.	
	Franklin County, MO.	
	Jefferson County, MO.	
	Lincoln County, MO.	
	St. Charles County, MO.	
	St. Louis County, MO.	
	Warren County, MO.	
	Washington County, MO.	
	St. Louis City, MO.	
41420	Salem, OR	1.1148
	Marion County, OR.	
	Polk County, OR.	
41500	Salinas, CA	1.5820
	Monterey County, CA.	
41540	Salisbury, MD	0.8948
	Somerset County, MD.	
	Wicomico County, MD.	
41620	Salt Lake City, UT	0.9350
	Salt Lake County, UT.	
	Summit County, UT.	
	Tooele County, UT.	
41660	San Angelo, TX	0.8169
	Irion County, TX.	
	Tom Green County, TX.	
41700	San Antonio, TX	0.8911
	Atascosa County, TX.	
	Bandera County, TX.	
	Bexar County, TX.	
	Comal County, TX.	
	Guadalupe County, TX.	
	Kendall County, TX.	
	Medina County, TX.	
	Wilson County, TX.	
41740	San Diego-Carlsbad-San Marcos, CA.	1.2213
	San Diego County, CA.	
41780	Sandusky, OH	0.7788
	Erie County, OH.	

TABLE A—FY 2014 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA Code	Urban area (constituent counties)	Wage index
41884	San Francisco-San Mateo-Redwood City, CA.	1.6743
	Marin County, CA.	
	San Francisco County, CA.	
	San Mateo County, CA.	
41900	San Germán-Cabo Rojo, PR.	0.4550
	Cabo Rojo Municipio, PR.	
	Lajas Municipio, PR.	
	Sabana Grande Municipio, PR.	
	San Germán Municipio, PR.	
41940	San Jose-Sunnyvale-Santa Clara, CA.	1.7086
	San Benito County, CA.	
	Santa Clara County, CA.	
41980	San Juan-Caguas-Guaynabo, PR.	0.4356
	Aguas Buenas Municipio, PR.	
	Aibonito Municipio, PR.	
	Arecibo Municipio, PR.	
	Barceloneta Municipio, PR.	
	Barranquitas Municipio, PR.	
	Bayamón Municipio, PR.	
	Caguas Municipio, PR.	
	Camuy Municipio, PR.	
	Canóvanas Municipio, PR.	
	Carolina Municipio, PR.	
	Cataño Municipio, PR.	
	Cayey Municipio, PR.	
	Ciales Municipio, PR.	
	Cidra Municipio, PR.	
	Comerío Municipio, PR.	
	Corozal Municipio, PR.	
	Dorado Municipio, PR.	
	Florida Municipio, PR.	
	Guaynabo Municipio, PR.	
	Gurabo Municipio, PR.	
	Hatillo Municipio, PR.	
	Humacao Municipio, PR.	
	Juncos Municipio, PR.	
	Las Piedras Municipio, PR.	
	Loíza Municipio, PR.	
	Manatí Municipio, PR.	
	Maunabo Municipio, PR.	
	Morovis Municipio, PR.	
	Naguabo Municipio, PR.	
	Naranjito Municipio, PR.	
	Orocovis Municipio, PR.	
	Quebradillas Municipio, PR.	
	Río Grande Municipio, PR.	
	San Juan Municipio, PR.	
	San Lorenzo Municipio, PR.	
	Toa Alta Municipio, PR.	
	Toa Baja Municipio, PR.	
	Trujillo Alto Municipio, PR.	
	Vega Alta Municipio, PR.	
	Vega Baja Municipio, PR.	
	Yabucoa Municipio, PR.	
42020	San Luis Obispo-Paso Robles, CA.	1.3036
	San Luis Obispo County, CA.	
42044	Santa Ana-Anaheim-Irvine, CA.	1.2111
	Orange County, CA.	
42060	Santa Barbara-Santa Maria-Goleta, CA.	1.2825
	Santa Barbara County, CA.	
42100	Santa Cruz-Watsonville, CA.	1.7937
	Santa Cruz County, CA.	
42140	Santa Fe, NM	1.0136
	Santa Fe County, NM.	
42220	Santa Rosa-Petaluma, CA.	1.6679
	Sonoma County, CA.	
42340	Savannah, GA	0.8757
	Bryan County, GA.	
	Chatham County, GA.	
	Effingham County, GA.	
42540	Scranton-Wilkes-Barre, PA.	0.8331
	Lackawanna County, PA.	
	Luzerne County, PA.	
	Wyoming County, PA.	
42644	Seattle-Bellevue-Everett, WA.	1.1733
	King County, WA.	
	Snohomish County, WA.	
42680	Sebastian-Vero Beach, FL.	0.8760
	Indian River County, FL.	
43100	Sheboygan, WI	0.9203
	Sheboygan County, WI.	
43300	Sherman-Denison, TX ..	0.8723
	Grayson County, TX	0.8723
43340	Shreveport-Bossier City, LA.	0.8262
	Bossier Parish, LA.	
	Caddo Parish, LA.	
	De Soto Parish, LA.	
43580	Sioux City, IA–NE–SD ..	0.9163
	Woodbury County, IA.	
	Dakota County, NE.	
	Dixon County, NE.	
	Union County, SD.	
43620	Sioux Falls, SD	0.8275
	Lincoln County, SD.	
	McCook County, SD.	
	Minnehaha County, SD.	
	Turner County, SD.	
43780	South Bend-Mishawaka, IN–MI.	0.9425
	St. Joseph County, IN.	
	Cass County, MI.	
43900	Spartanburg, SC	0.8782
	Spartanburg County, SC.	
44060	Spokane, WA	1.1174
	Spokane County, WA.	
44100	Springfield, IL	0.9165
	Menard County, IL.	
	Sangamon County, IL.	
44140	Springfield, MA	1.0378
	Franklin County, MA.	
	Hampden County, MA.	
	Hampshire County, MA.	
44180	Springfield, MO	0.8440
	Christian County, MO.	
	Dallas County, MO.	
	Greene County, MO.	
	Polk County, MO.	
	Webster County, MO.	
44220	Springfield, OH	0.8447
	Clark County, OH	
44300	State College, PA	0.9575
	Centre County, PA.	
44600	Steubenville-Weirton, OH–WV.	0.7598
	Jefferson County, OH.	
	Brooke County, WV.	
	Hancock County, WV.	
44700	Stockton, CA	1.3734
	San Joaquin County, CA.	
44940	Sumter, SC	0.7594
	Sumter County, SC.	
45060	Syracuse, NY	0.9897
	Madison County, NY.	
	Onondaga County, NY.	
	Oswego County, NY.	
45104	Tacoma, WA	1.1574
	Pierce County, WA.	
45220	Tallahassee, FL	0.8391
	Gadsden County, FL.	
	Jefferson County, FL.	
	Leon County, FL.	
	Wakulla County, FL.	
45300	Tampa-St. Petersburg-Clearwater, FL.	0.9075
	Hernando County, FL.	
	Hillsborough County, FL.	
	Pasco County, FL.	
	Pinellas County, FL.	
45460	Terre Haute, IN	0.9706
	Clay County, IN.	
	Sullivan County, IN.	
	Vermillion County, IN.	
	Vigo County, IN.	
45500	Texarkana, TX-Texarkana, AR.	0.7428
	Miller County, AR.	
	Bowie County, TX.	
45780	Toledo, OH	0.9013
	Fulton County, OH.	
	Lucas County, OH.	
	Ottawa County, OH.	
	Wood County, OH.	
45820	Topeka, KS	0.8974
	Jackson County, KS.	
	Jefferson County, KS.	
	Osage County, KS.	
	Shawnee County, KS.	
	Wabaunsee County, KS.	
45940	Trenton-Ewing, NJ	1.0648
	Mercer County, NJ.	
46060	Tucson, AZ	0.8953

TABLE A—FY 2014 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS—Continued

CBSA Code	Urban area (constituent counties)	Wage index
	Pima County, AZ.	
46140	Tulsa, OK	0.8145
	Creek County, OK.	
	Okmulgee County, OK.	
	Osage County, OK.	
	Pawnee County, OK.	
	Rogers County, OK.	
	Tulsa County, OK.	
	Wagoner County, OK.	
46220	Tuscaloosa, AL	0.8500
	Greene County, AL.	
	Hale County, AL.	
	Tuscaloosa County, AL.	
46340	Tyler, TX	0.8526
	Smith County, TX.	
46540	Utica-Rome, NY	0.8769
	Herkimer County, NY.	
	Oneida County, NY.	
46660	Valdosta, GA	0.7527
	Brooks County, GA.	
	Echols County, GA.	
	Lanier County, GA.	
	Lowndes County, GA.	
46700	Vallejo-Fairfield, CA	1.6286
	Solano County, CA.	
47020	Victoria, TX	0.8949
	Calhoun County, TX.	
	Goliad County, TX.	
	Victoria County, TX.	
47220	Vineland-Millville-Bridgeton, NJ.	1.0759
	Cumberland County, NJ.	
47260	Virginia Beach-Norfolk-Newport News, VA–NC.	0.9121
	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 ...	0.9947
	Tulare County, CA.	
47380	Waco, TX	0.8213
	McLennan County, TX.	
47580	Warner Robins, GA	0.7732
	Houston County, GA.	
47644	Warren-Troy-Farmington Hills, MI.	0.9432
	Lapeer County, MI.	
	Livingston County, MI.	
	Macomb County, MI.	
	Oakland County, MI.	
	St. Clair County, MI.	
47894	Washington-Arlington-Alexandria, DC–VA–MD–WV.	1.0533
	District of Columbia, DC.	
	Calvert County, MD.	
	Charles County, MD.	
	Prince George's County, MD.	
	Arlington County, VA.	
	Clarke County, VA.	
	Fairfax County, VA.	
	Fauquier County, VA.	
	Loudoun County, VA.	
	Prince William County, VA.	
	Spotsylvania County, VA.	
	Stafford County, VA.	
	Warren County, VA.	
	Alexandria City, VA.	
	Fairfax City, VA.	
	Falls Church City, VA.	
	Fredericksburg City, VA.	
	Manassas City, VA.	
	Manassas Park City, VA.	
	Jefferson County, WV.	
47940	Waterloo-Cedar Falls, IA.	0.8331
	Black Hawk County, IA.	
	Bremer County, IA.	
	Grundy County, IA.	
48140	Wausau, WI	0.8802
	Marathon County, WI.	
48300	Wenatchee-East Wenatchee, WA.	1.0109
	Chelan County, WA.	
	Douglas County, WA.	
48424	West Palm Beach-Boca Raton-Boynton Beach, FL.	0.9597
	Palm Beach County, FL.	
48540	Wheeling, WV–OH	0.6673
	Belmont County, OH.	
	Marshall County, WV.	
	Ohio County, WV.	
48620	Wichita, KS	0.8674
	Butler County, KS.	
	Harvey County, KS.	
	Sedgwick County, KS.	
	Sumner County, KS.	
48660	Wichita Falls, TX	0.9537
	Archer County, TX.	
	Clay County, TX.	
	Wichita County, TX.	
48700	Williamsport, PA	0.8268
	Lycoming County, PA.	
48864	Wilmington, DE–MD–NJ	1.0593
	New Castle County, DE.	
	Cecil County, MD.	
	Salem County, NJ.	
48900	Wilmington, NC.	
	Brunswick County, NC	0.8862
	New Hanover County, NC.	
	Pender County, NC.	
49020	Winchester, VA–WV	0.9034
	Frederick County, VA.	
	Winchester City, VA.	
	Hampshire County, WV.	
49180	Winston-Salem, NC	0.8560
	Davie County, NC.	
	Forsyth County, NC.	
	Stokes County, NC.	
	Yadkin County, NC.	
49340	Worcester, MA	1.1584
	Worcester County, MA.	
49420	Yakima, WA	1.0355
	Yakima County, WA.	
49500	Yauco, PR	0.3782
	Guánica Municipio, PR.	
	Guayanilla Municipio, PR.	
	Peñuelas Municipio, PR.	
	Yauco Municipio, PR.	
49620	York-Hanover, PA	0.9540
	York County, PA.	
49660	Youngstown-Warren-Boardman, OH–PA.	0.8262
	Mahoning County, OH.	
	Trumbull County, OH.	
	Mercer County, PA.	
49700	Yuba City, CA	1.1759
	Sutter County, CA.	
	Yuba County, CA.	
49740	Yuma, AZ	0.9674
	Yuma County, AZ.	

[1] At this time, there are no hospitals located in this urban area on which to base a wage index.

State code	Nonurban area	Wage index
1	Alabama	0.7147
2	Alaska	1.3662
3	Arizona	0.9166
4	Arkansas	0.7343
5	California	1.2788
6	Colorado	0.9802
7	Connecticut	1.1311
8	Delaware	1.0092
10	Florida	0.7985
11	Georgia	0.7459
12	Hawaii	1.0739
13	Idaho	0.7605
14	Illinois	0.8434
15	Indiana	0.8513
16	Iowa	0.8434
17	Kansas	0.7929
18	Kentucky	0.7784
19	Louisiana	0.7585
20	Maine	0.8238
21	Maryland	0.8696
22	Massachusetts	1.3614
23	Michigan	0.8270
24	Minnesota	0.9133
25	Mississippi	0.7568
26	Missouri	0.7775
27	Montana	0.9098
28	Nebraska	0.8855
29	Nevada	0.9781
30	New Hampshire	1.0339
31	New Jersey[1]	—
32	New Mexico	0.8922
33	New York	0.8220
34	North Carolina	0.8100
35	North Dakota	0.6785
36	Ohio	0.8377
37	Oklahoma	0.7704
38	Oregon	0.9435

State code	Nonurban area	Wage index
39	Pennsylvania	0.8430
40	Puerto Rico[1]	0.4047
41	Rhode Island[1]	—
42	South Carolina	0.8329
43	South Dakota	0.8164
44	Tennessee	0.7444
45	Texas	0.7874
46	Utah	0.8732
47	Vermont	0.9740
48	Virgin Islands	0.7060
49	Virginia	0.7758
50	Washington	1.0529
51	West Virginia	0.7407
52	Wisconsin	0.8904
53	Wyoming	0.9243
65	Guam	0.9611

[1] All counties within the State are classified as urban, with the exception of Puerto Rico. Puerto Rico has areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for FY 2014. The Puerto Rico wage index is the same as FY 2013.

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