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Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010; Minimum Data Set, Version 3.0 for Skilled Nursing Facilities and Medicaid Nursing Facilities; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 483

[CMS–1410–P]

RIN 0938–AP46

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010; Minimum Data Set, Version 3.0 for Skilled Nursing Facilities and Medicaid Nursing Facilities

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the payment rates used under the prospective payment system for skilled nursing facilities, for fiscal year 2010. In addition, it would recalibrate the case-mix indexes so that they more accurately reflect parity in expenditures related to the implementation of case-mix refinements in January 2006. It also discusses the results of our ongoing analysis of nursing home staff time measurement data collected in the Staff Time and Resource Intensity Verification project, and proposes a new RUG–IV case-mix classification model that will use the updated Minimum Data Set (MDS) 3.0 resident assessment for case-mix classification. In addition, this proposed rule includes a request for public comment on a possible requirement for the quarterly reporting of nursing home staffing data, and would revise the regulations to incorporate certain technical corrections. Finally, this proposed rule includes a request for public comments on applying the quality monitoring mechanism in place for all other SNF PPS facilities to rural swing-bed hospitals.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 30, 2009.

ADDRESSES: In commenting, please refer to file code CMS–1410–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions under the ''More Search Options'' tab.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1410–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1410–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. Centers for Medicare & Medicaid Services, Department of Health & Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. Centers for Medicare & Medicaid Services, Department of Health & Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Ellen Berry, (410) 786–4528 (for information related to clinical issues).

Trish Brooks, (410) 786–4561 (for information related to Resident Assessment Protocols (RAPs) under the Minimum Data Set (MDS)).

Jeanette Kranacs, (410) 786–9385 (for information related to the development of the payment rates and case-mix indexes).

Abby Ryan, (410) 786–4343 (for information related to the STRIVE project).

Jean Scott, (410) 786–6327 (for information related to the request for comment on the possible quarterly reporting of nursing home staffing data).

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

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

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Abbreviations

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

ADLs Activities of Daily Living
AIDS Acquired Immune Deficiency Syndrome
AOTA American Occupational Therapy Association
APTA American Physical Therapy Association
ARD Assessment Reference Date
ASHA American Speech-Language-Hearing Association
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
BIMS Brief Interview for Mental Status
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
CAH Critical Access Hospital
CAM Confusion Assessment Method
CARE Continuity Assessment Record and Evaluation
CAT Care Area Trigger
CBSA Core-Based Statistical Area
CFR Code of Federal Regulations
CMI Case-Mix Index
CMS Centers for Medicare & Medicaid Services
CMSO Center for Medicaid and State Operations
DRA Deficit Reduction Act of 2005, Pub. L. 109–171
DSM–IV Diagnostic and Statistical Manual of Mental Disorders, 4th Revision
FQHC Federally Qualified Health Center
FR **Federal Register**
FY Fiscal Year
GAO Government Accountability Office
HCPCS Healthcare Common Procedure Coding System
HHA Home Health Agencies
HIPPS Health Insurance Prospective Payment System
HIT Health Information Technology
HIV Human Immunodeficiency Virus Infection
IFC Interim Final Rule with Comment Period
IPPS Hospital Inpatient Prospective Payment System
IRF Inpatient Rehabilitation Facilities
LTCH Long-Term Care Hospital
MAC Medicare Administrative Contractor
MMACS Medicare/Medicaid Automated Certification System
MDS Minimum Data Set
MIPPA Medicare Improvements for Patients and Providers Act of 2008, Pub. L. 110–275
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. 110–173
MSA Metropolitan Statistical Area
MS–DRG Medicare Severity Diagnosis-Related Group
NCQA National Committee for Quality Assurance
NF Nursing Facility
NRST Non-Resident Specific Time
NTA Non-Therapy Ancillary
OIG Office of the Inspector General
OMB Office of Management and Budget
OMRA Other Medicare Required Assessment
OSCAR Online Survey Certification and Reporting System
PAC Post-Acute Care
PHQ–9 9-Item Patient Health Questionnaire
PPS Prospective Payment System
QM Quality Measure
RAI Resident Assessment Instrument
RAP Resident Assessment Protocol
RAVEN Resident Assessment Validation Entry
RFA Regulatory Flexibility Act, Pub. L. 96–354
RHC Rural Health Clinic
RIA Regulatory Impact Analysis
RST Resident Specific Time
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
SOM State Operations Manual
STM Staff Time Measurement
STRIVE Staff Time and Resource Intensity Verification
TEP Technical Expert Panel
UMRA Unfunded Mandates Reform Act, Pub. L. 104–4

I. Background

Annual updates to the prospective payment system (PPS) rates for skilled nursing facilities (SNFs) are required by section 1888(e) of the Social Security Act (the Act), as added by section 4432 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33, enacted on August 5, 1997), and amended by the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113, enacted on November 29, 1999), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554, enacted December 21, 2000), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173, enacted on December 8, 2003). Our most recent

annual update occurred in a final rule (73 FR 46416, August 8, 2008) that set forth updates to the SNF PPS payment rates for fiscal year (FY) 2009. We subsequently published a correction notice (73 FR 56998, October 1, 2008) with respect to those payment rate updates.

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

Section 4432 of the BBA amended section 1888 of the Act to provide for the implementation of a per diem PPS for SNFs, covering all costs (routine, ancillary, and capital-related) of covered SNF services furnished to beneficiaries under Part A of the Medicare program, effective for cost reporting periods beginning on or after July 1, 1998. In this proposed rule, we propose to update the per diem payment rates for SNFs for FY 2010. Major elements of the SNF PPS include:

• *Rates*. As discussed in section I.F.1. of this proposed rule, we established per diem Federal rates for urban and rural areas using allowable costs from FY 1995 cost reports. These rates also included a ''Part B add-on'' (an estimate of the cost of those services that, before July 1, 1998, were paid under Part B but furnished to Medicare beneficiaries in a SNF during a Part A covered stay). We adjust the rates annually using a SNF market basket index, and we adjust them by the hospital inpatient wage index to account for geographic variation in wages. We also apply a case-mix adjustment to account for the relative resource utilization of different patient types. This adjustment utilizes a refined, 53-group version of the Resource Utilization Groups, version III (RUG–III) case-mix classification system, based on information obtained from the required resident assessments using the Minimum Data Set (MDS) 2.0. Additionally, as noted in the final rule for FY 2006 (70 FR 45028, August 4, 2005), the payment rates at various times have also reflected specific legislative provisions, including section 101 of the BBRA, sections 311, 312, and 314 of the BIPA, and section 511 of the MMA.

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

• *Coverage*. The establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because the RUG–III classification is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have attempted, where possible, to coordinate claims review procedures with the existing resident assessment process and case-mix classification system. This approach includes an administrative presumption that utilizes a beneficiary's initial classification in one of the upper 35 RUGs of the refined 53-group system to assist in making certain SNF level of care determinations. In the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the RUG–III classification structure (see section II.E. of this proposed rule for a discussion of the relationship between the case-mix classification system and SNF level of care determinations, and section III.D for a discussion of this process in the context of the proposed conversion to version 4 of the RUGs (RUG–IV)).

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

• *Application of the SNF PPS to SNF services furnished by swing-bed hospitals*. Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed.

For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF services furnished under a swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, these services furnished by non-CAH rural hospitals are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002. A more detailed discussion of this provision appears in section VIII of this proposed rule.

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

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

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

Along with other revisions proposed later in this preamble, this proposed rule provides these required annual updates to the Federal rates.

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

There were several provisions in the BBRA that resulted in adjustments to the SNF PPS. We described these provisions in detail in the SNF PPS final rule for FY 2001 (65 FR 46770, July 31, 2000). In particular, section 101(a) of the BBRA provided for a temporary 20 percent increase in the per diem adjusted payment rates for 15 specified RUG–III groups. In accordance with section 101(c)(2) of the BBRA, this temporary payment adjustment expired on January 1, 2006, upon the implementation of case-mix refinements (see section I.F.1. of this proposed rule). We included further information on BBRA provisions that affected the SNF PPS in Program Memorandums A–99–53 and A–99–61 (December 1999).

Also, section 103 of the BBRA designated certain additional services for exclusion from the consolidated billing requirement, as discussed in section VII. of this proposed rule. Further, for swing-bed hospitals with more than 49 (but less than 100) beds, section 408 of the BBRA provided for the repeal of certain statutory restrictions on length of stay and

aggregate payment for patient days, effective with the end of the SNF PPS transition period described in section 1888(e)(2)(E) of the Act. In the final rule for FY 2002 (66 FR 39562, July 31, 2001), we made conforming changes to the regulations at § 413.114(d), effective for services furnished in cost reporting periods beginning on or after July 1, 2002, to reflect section 408 of the BBRA.

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

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

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

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

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

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

For the limited number of SNF residents that qualify for the AIDS add-on, implementation of this provision results in a significant increase in payment. For example, using FY 2007 data, we identified slightly more than 2,700 SNF residents with a diagnosis code of 042 (Human Immunodeficiency Virus (HIV) Infection). For FY 2010, an urban facility with a resident with AIDS in RUG group ''SSA'' would have a case-mix adjusted payment of $252.71 (see Table 4) before the application of the MMA adjustment. After an increase of 128 percent, this urban facility would receive a case-mix adjusted payment of approximately $576.18. A further discussion of the AIDS add-on in the context of research conducted during the recent STRIVE study appears in section III.E.6. of this proposed rule.

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

F. Skilled Nursing Facility Prospective Payment—General Overview

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

1. Payment Provisions—Federal Rate

The PPS uses per diem Federal payment rates based on mean SNF costs in a base year (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 an estimate of the amounts that would be payable under Part B for covered SNF services furnished to individuals during the course of a covered Part A stay in a SNF.

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

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

Further, in accordance with section 1888(e)(4)(E)(ii)(IV) of the Act, the Federal rates in this proposed rule reflect an update to the rates that we published in the final rule for FY 2009 (73 FR 46416, August 8, 2008) and the associated correction notice (73 FR 56998, October 1, 2008), equal to the full change in the SNF market basket index. A more detailed discussion of the SNF market basket index and related issues appears in section I.F.2. and section VI. of this proposed rule.

2. FY 2010 Rate Updates Using the Skilled Nursing Facility Market Basket Index

Section 1888(e)(5) of the Act requires us to establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. We use the SNF market basket index to update the Federal rates on an annual basis. In the SNF PPS final rule for FY 2008 (72 FR 43425 through 43430, August 3, 2007), we revised and rebased the market basket, which included updating the base year from FY 1997 to FY 2004. The proposed FY 2010 market basket increase is 2.1 percent, which is based on IHS Global Insight, Inc. first quarter 2009 forecast with historical data through fourth quarter 2008.

In addition, as explained in the final rule for FY 2004 (66 FR 46058, August 4, 2003) and in section VI.B. of this proposed rule, the annual update of the payment rates includes, as appropriate, an adjustment to account for market basket forecast error. As described in the final rule for FY 2008, the threshold percentage that serves to trigger an adjustment to account for market basket forecast error is 0.5 percentage point effective for FY 2008 and subsequent years. This adjustment takes into account the forecast error from the most recently available FY for which there is final data, and applies whenever the difference between the forecasted and actual change in the market basket exceeds a 0.5 percentage point threshold. For FY 2008 (the most recently available FY for which there is final data), the estimated increase in the market basket index was 3.3 percentage points, while the actual increase was 3.6 percentage points, resulting in a difference of 0.3 percentage point. Accordingly, as the difference between the estimated and actual amount of change does not exceed the 0.5 percentage point threshold, the payment rates for FY 2010 do not include a forecast error adjustment. Table 1 shows the forecasted and actual market basket amounts for FY 2008.

TABLE 1—DIFFERENCE BETWEEN THE FORECASTED AND ACTUAL MARKET BASKET INCREASES FOR FY 2008

Index	Forecasted FY 2008 increase *	Actual FY 2008 increase **	FY 2008 difference ***
SNF	3.3	3.6	0.3

* Published in **Federal Register**; based on second quarter 2007 IHS Global Insight Inc. forecast (2004-based index).
** Based on the first quarter 2009 IHS Global Insight forecast (2004-based index).
*** The FY 2008 forecast error correction for the PPS Operating portion will be applied to the FY 2010 PPS update recommendations. Any forecast error less than 0.5 percentage points will not be reflected in the update recommendation.

II. FY 2010 Annual Update of Payment Rates Under the Prospective Payment System for Skilled Nursing Facilities

A. Federal Prospective Payment System

This proposed rule sets forth a schedule of Federal prospective payment rates applicable to Medicare Part A SNF services beginning October 1, 2009. The schedule incorporates per diem Federal rates that provide Part A payment for almost all costs of services furnished to a beneficiary in a SNF during a Medicare-covered stay.

1. Costs and Services Covered by the Federal Rates

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

2. Methodology Used for the Calculation of the Federal Rates

The proposed FY 2010 rates would reflect an update using the full amount of the latest market basket index. The proposed FY 2010 market basket increase factor is 2.1 percent. A complete description of the multi-step process used to calculate Federal rates initially appeared in the May 12, 1998 interim final rule (63 FR 26252), as further revised in subsequent rules. We note that in accordance with section 101(c)(2) of the BBRA, the previous temporary increases in the per diem adjusted payment rates for certain designated RUGs, as specified in section 101(a) of the BBRA and section 314 of the BIPA, are no longer in effect due to the implementation of case-mix refinements as of January 1, 2006. However, the temporary increase of 128 percent in the per diem adjusted payment rates for SNF residents with AIDS, enacted by section 511 of the MMA, remains in effect.

We used the SNF market basket to adjust each per diem component of the Federal rates forward to reflect cost increases occurring between the midpoint of the Federal FY beginning October 1, 2008, and ending September 30, 2009, and the midpoint of the Federal FY beginning October 1, 2009, and ending September 30, 2010, to which the payment rates apply. In accordance with section 1888(e)(4)(E)(ii)(IV) of the Act, we would update the payment rates for FY 2010 by a factor equal to the full market basket index percentage increase. We further adjust the rates by a wage index budget neutrality factor, described later in this section. Tables 2 and 3 reflect the updated components of the unadjusted Federal rates for FY 2010.

TABLE 2—FY 2010 UNADJUSTED FEDERAL RATE PER DIEM URBAN

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$155.08	$116.82	$15.38	$79.15

TABLE 3—FY 2010 UNADJUSTED FEDERAL RATE PER DIEM RURAL

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$148.16	$134.70	$16.43	$80.61

B. Case-Mix Adjustments

1. Background

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

Although the establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage, there is a correlation between level of care and provider payment. One of the elements affecting the SNF PPS per diem rates is the RUG–III case-mix adjustment classification system based on beneficiary assessments using the MDS 2.0. RUG–III classification is based, in part, on the beneficiary's need for skilled nursing care and therapy. As discussed previously in section I.F.1 of this proposed rule, the SNF PPS final rule for FY 2006 (70 FR 45026, August 4, 2005) refined the case-mix classification system effective January 1, 2006, by adding nine new Rehabilitation Plus Extensive Services RUGs at the top of the original, 44-group system, for a total of 53 groups. This nine-group addition was designed to better account for the higher costs of beneficiaries requiring both rehabilitation and certain high intensity medical services. When we developed the refined RUG–53 system, we constructed new case-mix indexes, using the Staff Time Measurement (STM) study data that was collected during the 1990s and originally used in creating the SNF PPS case-mix classification system and case-mix indexes. In addition, the RUG–III system was standardized with the intent of ensuring parity in payments under the 44-group and 53-group models. In section II.B.2 of this proposed rule, we discuss further adjustments to those new case-mix indexes.

The RUG–III case-mix classification system uses clinical data from the MDS 2.0, and wage-adjusted staff time measurement data, to assign a case-mix group to each patient record that is then used to calculate a per diem payment under the SNF PPS. The existing RUG–III grouper logic was based on clinical data collected in 1990, 1995, and 1997. As discussed in section III.A.1, we have recently completed a multi-year data collection and analysis under the Staff Time and Resource Intensity Verification (STRIVE) project to update the RUG–III case-mix classification system for FY 2011. As discussed later in this preamble, we are proposing to introduce a revised case-mix classification system, the RUG–IV, based on the data collected in 2006–2007 during the STRIVE project. At the same time, we plan to introduce an updated new resident assessment instrument, the MDS 3.0, to collect the clinical data that will be used for case-mix classification under RUG–IV. We believe that the coordinated introduction of the RUG–IV and MDS 3.0 reflects current medical practice and resource use in SNFs across the country, and will enhance the accuracy of the SNF PPS. Further, we are proposing to defer implementation of the RUG–IV and MDS 3.0 until October 1, 2010, to allow all stakeholders adequate time for the systems updates and staff training needed to assure a smooth transition. We discuss the RUG–IV methodology

and the MDS 3.0 in greater detail in sections III.B. and IV.A., respectively.

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

2. Development of the Case-Mix Indexes

In the SNF PPS final rule for FY 2006 (70 FR 45032, August 4, 2005), we introduced two incremental refinements to the case-mix classification system:

- The addition of nine new case-mix groups at the top of the original 44-group hierarchy, designed to account for the care needs of beneficiaries requiring both extensive medical and rehabilitation services; and
- An adjustment to reflect the variability in the use of non-therapy ancillaries (NTAs).

We made these refinements by using the resource minute data from the original 44-group RUG–III model to create a new set of relative weights, or case-mix indexes (CMIs), for the 53 group RUG–III model. We then compared the CMIs for the two models in a way that was intended to ensure that estimated total payments under the 53-group model would be equal to those payments that would have been made under the 44-group model.

In conducting this analysis, we used FY 2001 claims data (the most current claims data available at the time) to compare the distribution of payment days by RUG category in the 44-group model with the anticipated payments by RUG category in the refined 53-group model. Using the FY 2001 claims data, our initial projections of future utilization patterns under the refined case-mix system indicated that the new 53-group model would produce lower overall payments than under the original 44-group model. As the purpose of the refinements was to allocate payments more accurately rather than reduce overall expenditures, we adjusted the new case-mix indexes (CMIs) upward in order to ensure that our implementation of the case-mix refinements would achieve ''parity'' between the old and new models (that is, would not cause any change in overall payment levels). However, as noted in the SNF PPS proposed rule for FY 2009 (73 FR 25923, May 7, 2008), our continued monitoring of claims data subsequently showed that actual utilization patterns under the refined case-mix system differed significantly from the previous projections. As a consequence, rather than simply achieving parity, the 2006 adjustment inadvertently triggered a significant increase in overall payment levels, representing substantial overpayments to SNFs.

Accordingly, the FY 2009 proposed rule included a proposal to recalibrate the parity adjustment in order to restore the intended budget neutrality to the 2006 case-mix refinements. While many of the commenters on this proposal characterized it as an unwarranted reduction in the level of SNF payments, the actual purpose of the recalibration proposal was not to reduce overall SNF payments below their appropriate level, but rather, to restore those payments to their appropriate level by correcting the inadvertent increase in overall payments that had resulted from the original parity adjustment. Moreover, our intent was to establish a more accurate baseline for SNF expenditures under the SNF PPS even as we were evaluating broader health care initiatives that could affect payment to SNFs. Thus, the recalibration was proposed as a prospective adjustment, and did not require recovery of any SNF PPS expenditures that had already been made. Commenters also expressed concern about the potential impact of the proposed recalibration on beneficiaries, providers, and the overall economy. As explained in the FY 2009 final rule (73 FR 46422, August 8, 2008), even though our analysis did not substantiate the commenters' concerns, we concluded that it nevertheless would be prudent to take additional time to evaluate the proposal, in order to allow for further consideration of any consequences that might result from it. For that reason, we did not proceed with the proposed recalibration at that time, but instead continued to evaluate this issue with the full expectation of implementing such an adjustment in the future.

In the course of this further evaluation, we conducted a thorough review of the recalibration methodology that we had proposed, and determined that it is, in fact, correct and appropriate to achieve the intended result of establishing parity in overall payments between the 44-group and 53-group models. In addition, as we stated in the FY 2009 final rule (73 FR 46424, August 8, 2008), we further considered the effects of the proposed recalibration on beneficiaries, SNF clinical staff, and quality of care. As discussed above, while the purpose of the original parity adjustment was to maintain the same overall payments under the 44-group and 53-group models, the effect of the adjustment was an inadvertent increase in overall payments under the 53-group model, resulting in overpayments to SNFs. By recalibrating the CMIs under the 53-group model, we expect to restore SNF payments to their appropriate level by correcting this inadvertent increase in overall payments. Because the recalibration would simply remove an unintended overpayment rather than decrease an otherwise appropriate payment amount, we do not believe that the recalibration should negatively affect beneficiaries, clinical staff, or quality of care, or create an undue hardship on providers. The purpose of the FY 2006 refinements was to reallocate payments so that they more accurately reflect resources used, not to increase or decrease overall expenditures. Thus, we believe that it is appropriate to proceed with the recalibration in order to ensure that we correctly accomplish the purpose of the FY 2006 case-mix refinements (that is, reallocating payments, rather than increasing or decreasing overall payments) and restore payments to their appropriate level. In addition, we believe that it is imperative that we proceed with this recalibration for FY 2010 so that the proper baseline can be established before we move to the RUG-IV model, as discussed previously in the SNF PPS proposed rule for FY 2009 (73 FR 25938, May 7, 2008).

Accordingly, we are now proposing to proceed with the recalibration using the methodology described in the FY 2009 proposed and final rules (73 FR 25923, 73 FR 46421–24). As we explained in the FY 2009 proposed rule, we would use actual 2006 claims data to recalibrate both of the adjustments to the CMIs: The parity adjustment designed to make the change from the 44-group model to the 53-group model in a budget neutral manner, and the factor used to recognize the variability in NTA utilization. A detailed description of the method proposed to recalibrate the two adjustments appears in the FY 2009 SNF PPS proposed and final rules (73 FR 25923, 73 FR 46421–24). Under this proposed recalibration, the parity and NTA adjustments to the CMIs (which had initially produced a combined increase of 17.9 percent in the FY 2006 refinement), would instead result in an overall 9.68 percent increase for FY 2010. Thus, for FY 2010, the aggregate impact of this proposed recalibration of the CMIs would be the difference between payments calculated using the original FY 2006 total CMI increase of 17.9 percent and payments calculated using the recalibrated total CMI increase of 9.68 percent. The

difference is a decrease of $1.05 billion (on an incurred basis) in payments for FY 2010.

Again, we want to emphasize that, by proposing to implement the recalibration on a prospective basis, we have chosen the correction strategy that best mitigates the potential impact on providers. However, we believe that our responsibility for maintaining the fiscal integrity of the SNF PPS requires that we proceed with the adjustment. By using the actual claims data that are now available (rather than the projections upon which we had initially relied in estimating the impact of the case-mix refinements), the SNF PPS would better reflect the resources used, resulting in more accurate payment. To that end, we have developed our proposed recalibration of the parity and NTA adjustments to the CMIs using actual claims distribution data. Although the 2001 data were the best source available at the time the FY 2006 refinements were introduced, the calendar year (CY) 2006 data represent actual RUG–53 utilization for the first full year after implementation (that is, the data that we were trying to project). Therefore, we believe the CY 2006 data provide the most accurate source of RUG–53 utilization for this parity adjustment. We also note that the negative $1.05 billion adjustment described above would be partially offset by the FY 2010 market basket adjustment factor of 2.1 percent, or $660 million, with a net result of a negative annual update of approximately $390 million. Moreover, this proposed recalibration would further the overall objective of the refinement provision implemented in January 2006; that is, to have PPS payments account more accurately for resource utilization in SNFs. We also note that after MedPAC conducted a thorough review of SNF profit margins, it concluded that, in the aggregate, SNFs are operating on a sound financial basis. MedPAC's recent recommendation for a zero percent update for SNFs in FY 2010 (see section 2.D (''Skilled Nursing Facility Services'') of its Report to the Congress on Medicare Payment Policy (March 2009), available online at *http://www.medpac.gov/chapters/Mar09_Ch02D.pdf*) supports our assessment that this recalibration could be made without creating undue hardship on providers.

We list the case-mix adjusted payment rates separately for urban and rural SNFs in Tables 4 and 5, with the corresponding case-mix values. These tables do not reflect the AIDS add-on enacted by section 511 of the MMA, which we apply only after making all other adjustments (wage and case-mix).

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

RUG–III category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUX	1.77	2.25	274.49	262.85		79.15	616.49
RUL	1.31	2.25	203.15	262.85		79.15	545.15
RVX	1.44	1.41	223.32	164.72		79.15	467.19
RVL	1.24	1.41	192.30	164.72		79.15	436.17
RHX	1.33	0.94	206.26	109.81		79.15	395.22
RHL	1.27	0.94	196.95	109.81		79.15	385.91
RMX	1.80	0.77	279.14	89.95		79.15	448.24
RML	1.57	0.77	243.48	89.95		79.15	412.58
RLX	1.22	0.43	189.20	50.23		79.15	318.58
RUC	1.20	2.25	186.10	262.85		79.15	528.10
RUB	0.92	2.25	142.67	262.85		79.15	484.67
RUA	0.78	2.25	120.96	262.85		79.15	462.96
RVC	1.14	1.41	176.79	164.72		79.15	420.66
RVB	1.01	1.41	156.63	164.72		79.15	400.50
RVA	0.77	1.41	119.41	164.72		79.15	363.28
RHC	1.13	0.94	175.24	109.81		79.15	364.20
RHB	1.03	0.94	159.73	109.81		79.15	348.69
RHA	0.88	0.94	136.47	109.81		79.15	325.43
RMC	1.07	0.77	165.94	89.95		79.15	335.04
RMB	1.01	0.77	156.63	89.95		79.15	325.73
RMA	0.97	0.77	150.43	89.95		79.15	319.53
RLB	1.06	0.43	164.38	50.23		79.15	293.76
RLA	0.79	0.43	122.51	50.23		79.15	251.89
SE3	1.72		266.74		15.38	79.15	361.27
SE2	1.38		214.01		15.38	79.15	308.54
SE1	1.17		181.44		15.38	79.15	275.97
SSC	1.14		176.79		15.38	79.15	271.32
SSB	1.05		162.83		15.38	79.15	257.36
SSA	1.02		158.18		15.38	79.15	252.71
CC2	1.13		175.24		15.38	79.15	269.77
CC1	0.99		153.53		15.38	79.15	248.06
CB2	0.91		141.12		15.38	79.15	235.65
CB1	0.84		130.27		15.38	79.15	224.80
CA2	0.83		128.72		15.38	79.15	223.25
CA1	0.75		116.31		15.38	79.15	210.84
IB2	0.69		107.01		15.38	79.15	201.54
IB1	0.67		103.90		15.38	79.15	198.43
IA2	0.57		88.40		15.38	79.15	182.93
IA1	0.53		82.19		15.38	79.15	176.72
BB2	0.68		105.45		15.38	79.15	199.98
BB1	0.65		100.80		15.38	79.15	195.33
BA2	0.56		86.84		15.38	79.15	181.37
BA1	0.48		74.44		15.38	79.15	168.97

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

RUG–III category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
PE2	0.79		122.51		15.38	79.15	217.04
PE1	0.77		119.41		15.38	79.15	213.94
PD2	0.72		111.66		15.38	79.15	206.19
PD1	0.70		108.56		15.38	79.15	203.09
PC2	0.66		102.35		15.38	79.15	196.88
PC1	0.65		100.80		15.38	79.15	195.33
PB2	0.52		80.64		15.38	79.15	175.17
PB1	0.50		77.54		15.38	79.15	172.07
PA2	0.49		75.99		15.38	79.15	170.52
PA1	0.46		71.34		15.38	79.15	165.87

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

RUG–III category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUX	1.77	2.25	262.24	303.08		80.61	645.93
RUL	1.31	2.25	194.09	303.08		80.61	577.78
RVX	1.44	1.41	213.35	189.93		80.61	483.89
RVL	1.24	1.41	183.72	189.93		80.61	454.26
RHX	1.33	0.94	197.05	126.62		80.61	404.28
RHL	1.27	0.94	188.16	126.62		80.61	395.39
RMX	1.80	0.77	266.69	103.72		80.61	451.02
RML	1.57	0.77	232.61	103.72		80.61	416.94
RLX	1.22	0.43	180.76	57.92		80.61	319.29
RUC	1.20	2.25	177.79	303.08		80.61	561.48
RUB	0.92	2.25	136.31	303.08		80.61	520.00
RUA	0.78	2.25	115.56	303.08		80.61	499.25
RVC	1.14	1.41	168.90	189.93		80.61	439.44
RVB	1.01	1.41	149.64	189.93		80.61	420.18
RVA	0.77	1.41	114.08	189.93		80.61	384.62
RHC	1.13	0.94	167.42	126.62		80.61	374.65
RHB	1.03	0.94	152.60	126.62		80.61	359.83
RHA	0.88	0.94	130.38	126.62		80.61	337.61
RMC	1.07	0.77	158.53	103.72		80.61	342.86
RMB	1.01	0.77	149.64	103.72		80.61	333.97
RMA	0.97	0.77	143.72	103.72		80.61	328.05
RLB	1.06	0.43	157.05	57.92		80.61	295.58
RLA	0.79	0.43	117.05	57.92		80.61	255.58
SE3	1.72		254.84		16.43	80.61	351.88
SE2	1.38		204.46		16.43	80.61	301.50
SE1	1.17		173.35		16.43	80.61	270.39
SSC	1.14		168.90		16.43	80.61	265.94
SSB	1.05		155.57		16.43	80.61	252.61
SSA	1.02		151.12		16.43	80.61	248.16
CC2	1.13		167.42		16.43	80.61	264.46
CC1	0.99		146.68		16.43	80.61	243.72
CB2	0.91		134.83		16.43	80.61	231.87
CB1	0.84		124.45		16.43	80.61	221.49
CA2	0.83		122.97		16.43	80.61	220.01
CA1	0.75		111.12		16.43	80.61	208.16
IB2	0.69		102.23		16.43	80.61	199.27
IB1	0.67		99.27		16.43	80.61	196.31
IA2	0.57		84.45		16.43	80.61	181.49
IA1	0.53		78.52		16.43	80.61	175.56
BB2	0.68		100.75		16.43	80.61	197.79
BB1	0.65		96.30		16.43	80.61	193.34
BA2	0.56		82.97		16.43	80.61	180.01
BA1	0.48		71.12		16.43	80.61	168.16
PE2	0.79		117.05		16.43	80.61	214.09
PE1	0.77		114.08		16.43	80.61	211.12
PD2	0.72		106.68		16.43	80.61	203.72
PD1	0.70		103.71		16.43	80.61	200.75
PC2	0.66		97.79		16.43	80.61	194.83
PC1	0.65		96.30		16.43	80.61	193.34
PB2	0.52		77.04		16.43	80.61	174.08
PB1	0.50		74.08		16.43	80.61	171.12
PA2	0.49		72.60		16.43	80.61	169.64

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

RUG–III category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
PA	0.46		68.15		16.43	80.61	165.19

C. Wage Index Adjustment to Federal Rates

Section 1888(e)(4)(G)(ii) of the Act requires that we adjust the Federal rates to account for differences in area wage levels, using a wage index that we find appropriate. Since the inception of a PPS for SNFs, we have used hospital wage data in developing a wage index to be applied to SNFs. We propose to continue that practice for FY 2010, 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 SNF payments.

Finally, we propose to continue using the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in which there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the FY 2010 SNF PPS wage index. For rural geographic areas that do not have hospitals and, therefore, lack hospital wage data on which to base an area wage adjustment, we would use the average wage index from all contiguous CBSAs as a reasonable proxy. This methodology is used to construct the wage index for rural Massachusetts. However, we would not apply this methodology to rural Puerto Rico due to the distinct economic circumstances that exist there, but instead would continue using the most recent wage index previously available for that area. For urban areas without specific hospital wage index data, we would use the average wage indexes of all of the urban areas within the State to serve as a reasonable proxy for the wage index of that urban CBSA. The only urban area without wage index data available is CBSA (25980) Hinesville-Fort Stewart, GA.

To calculate the SNF PPS wage index adjustment, we would apply the wage index adjustment to the labor-related portion of the Federal rate, which is 70.017 percent of the total rate. This percentage reflects the labor-related relative importance for FY 2010, using the revised and rebased FY 2004-based market basket. The labor-related relative importance for FY 2009 was 69.783, as shown in Table 16. We calculate the labor-related relative importance from the SNF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2010. 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 2010 than the base year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2010 in four steps. First, we compute the FY 2010 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 2010 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2010 relative importance for each cost category by multiplying this ratio by the base year (FY 2004) weight. Finally, we add the FY 2010 relative importance for each of the labor-related cost categories (wages and salaries, employee benefits, non-medical professional fees, labor-intensive services, and a portion of capital-related expenses) to produce the FY 2010 labor-related relative importance. Tables 6 and 7 below show the Federal rates by labor-related and non-labor-related components.

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

RUG–III category	Total rate	Labor portion	Non-labor portion
RUX	616.49	431.65	184.84
RUL	545.15	381.70	163.45
RVX	467.19	327.11	140.08
RVL	436.17	305.39	130.78
RHX	395.22	276.72	118.50
RHL	385.91	270.20	115.71
RMX	448.24	313.84	134.40
RML	412.58	288.88	123.70
RLX	318.58	223.06	95.52
RUC	528.10	369.76	158.34
RUB	484.67	339.35	145.32
RUA	462.96	324.15	138.81
RVC	420.66	294.53	126.13
RVB	400.50	280.42	120.08
RVA	363.28	254.36	108.92
RHC	364.20	255.00	109.20
RHB	348.69	244.14	104.55
RHA	325.43	227.86	97.57
RMC	335.04	234.58	100.46
RMB	325.73	228.07	97.66

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

RUG–III category	Total rate	Labor portion	Non-labor portion
RMA	319.53	223.73	95.80
RLB	293.76	205.68	88.08
RLA	251.89	176.37	75.52
SE3	361.27	252.95	108.32
SE2	308.54	216.03	92.51
SE1	275.97	193.23	82.74
SSC	271.32	189.97	81.35
SSB	257.36	180.20	77.16
SSA	252.71	176.94	75.77
CC2	269.77	188.88	80.89
CC1	248.06	173.68	74.38
CB2	235.65	165.00	70.65
CB1	224.80	157.40	67.40
CA2	223.25	156.31	66.94
CA1	210.84	147.62	63.22
IB2	201.54	141.11	60.43
IB1	198.43	138.93	59.50
IA2	182.93	128.08	54.85
IA1	176.72	123.73	52.99
BB2	199.98	140.02	59.96
BB1	195.33	136.76	58.57
BA2	181.37	126.99	54.38
BA1	168.97	118.31	50.66
PE2	217.04	151.96	65.08
PE1	213.94	149.79	64.15
PD2	206.19	144.37	61.82
PD1	203.09	142.20	60.89
PC2	196.88	137.85	59.03
PC1	195.33	136.76	58.57
PB2	175.17	122.65	52.52
PB1	172.07	120.48	51.59
PA2	170.52	119.39	51.13
PA1	165.87	116.14	49.73

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

RUG–III category	Total rate	Labor portion	Non-labor portion
RUX	645.93	452.26	193.67
RUL	577.78	404.54	173.24
RVX	483.89	338.81	145.08
RVL	454.26	318.06	136.20
RHX	404.28	283.06	121.22
RHL	395.39	276.84	118.55
RMX	451.02	315.79	135.23
RML	416.94	291.93	125.01
RLX	319.29	223.56	95.73
RUC	561.48	393.13	168.35
RUB	520.00	364.09	155.91
RUA	499.25	349.56	149.69
RVC	439.44	307.68	131.76
RVB	420.18	294.20	125.98
RVA	384.62	269.30	115.32
RHC	374.65	262.32	112.33
RHB	359.83	251.94	107.89
RHA	337.61	236.38	101.23
RMC	342.86	240.06	102.80
RMB	333.97	233.84	100.13
RMA	328.05	229.69	98.36
RLB	295.58	206.96	88.62
RLA	255.58	178.95	76.63
SE3	351.88	246.38	105.50
SE2	301.50	211.10	90.40
SE1	270.39	189.32	81.07
SSC	265.94	186.20	79.74
SSB	252.61	176.87	75.74
SSA	248.16	173.75	74.41
CC2	264.46	185.17	79.29

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

RUG–III category	Total rate	Labor portion	Non-labor portion
CC1	243.72	170.65	73.07
CB2	231.87	162.35	69.52
CB1	221.49	155.08	66.41
CA2	220.01	154.04	65.97
CA1	208.16	145.75	62.41
IB2	199.27	139.52	59.75
IB1	196.31	137.45	58.86
IA2	181.49	127.07	54.42
IA1	175.56	122.92	52.64
BB2	197.79	138.49	59.30
BB1	193.34	135.37	57.97
BA2	180.01	126.04	53.97
BA1	168.16	117.74	50.42
PE2	214.09	149.90	64.19
PE1	211.12	147.82	63.30
PD2	203.72	142.64	61.08
PD1	200.75	140.56	60.19
PC2	194.83	136.41	58.42
PC1	193.34	135.37	57.97
PB2	174.08	121.89	52.19
PB1	171.12	119.81	51.31
PA2	169.64	118.78	50.86
PA1	165.19	115.66	49.53

Section 1888(e)(4)(G)(ii) of the Act also requires that we apply this wage index in a manner that does not result in aggregate payments that are greater or less than would otherwise be made in the absence of the wage adjustment. For FY 2010 (Federal rates effective October 1, 2009), we would apply an adjustment to fulfill the budget neutrality requirement. We would 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 2009 to the weighted average wage adjustment factor for FY 2010. For this calculation, we use the same 2007 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 proposed budget neutrality factor for this year is 1.0010. The wage index applicable to FY 2010 is set forth in Tables A and B, which appear in the Addendum of this proposed rule.

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

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

D. Updates to the Federal Rates

In accordance with section 1888(e)(4)(E) of the Act, as amended by section 311 of the BIPA, the proposed payment rates in this proposed rule reflect an update equal to the full SNF market basket, estimated at 2.1 percentage points. We would continue to disseminate the rates, wage index, and case-mix classification methodology through the **Federal Register** before the August 1 that precedes the start of each succeeding FY.

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

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

A beneficiary assigned to any of the lower 18 groups is not automatically classified as either meeting or not meeting the definition, but instead

receives an individual level of care determination using the existing administrative criteria. This presumption recognizes the strong likelihood that beneficiaries assigned to one of the upper 35 groups during the immediate post-hospital period require a covered level of care, which would be less likely for those beneficiaries assigned to one of the lower 18 groups.

In this proposed rule, we are continuing the designation of the upper 35 groups for purposes of this administrative presumption, consisting of all groups encompassed by the following RUG–53 categories:

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

A discussion of the relationship of the proposed RUG-IV classification system to existing SNF level of care criteria appears in section III.D. of this proposed rule.

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

Using the hypothetical SNF XYZ described in Table 8 below, the following shows the adjustments made to the Federal per diem rate to compute the provider's actual per diem PPS payment. SNF XYZ's 12-month cost reporting period begins October 1, 2009. SNF XYZ's total PPS payment would equal $30,619. We derive the Labor and Non-labor columns from Table 6 of this proposed rule.

TABLE 8—RUG–53 SNF XYZ: LOCATED IN CEDAR RAPIDS, IA (URBAN CBSA 16300) WAGE INDEX: 0.8992

RUG group	Labor	Wage index	Adj. labor	Non-labor	Adj. rate	Percent adj.	Medicare days	Payment
RVX	$327.11	0.8992	$294.14	$140.08	$434.22	$434.22	14	$6,079.00
RLX	223.06	0.8992	200.58	95.52	296.10	296.10	30	8,883.00
RHA	227.86	0.8992	204.89	97.57	302.46	302.46	16	4,839.00
CC2	188.88	0.8992	169.84	80.89	250.73	*571.67	10	5,717.00
IA2	128.08	0.8992	115.17	54.85	170.02	170.02	30	5,101.00
							100	30,619.00

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

III. Resource Utilization Groups, Version 4 (RUG–IV)

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

As noted previously in section II.B.1 of this proposed rule, section 1888(e)(4)(G)(i) of the Act requires the Secretary to make an adjustment to account for case-mix. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the relative resource use of different patient types, as well as resident assessment and other data that the Secretary considers appropriate. In first implementing the SNF PPS (63 FR 26252, May 12, 1998), 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.

Since that time, we have become concerned that incentives created by the SNF PPS, the public reporting of nursing home quality measures, and the changing beneficiary population using SNF services likely have altered industry practices, and have affected the nursing resources required to treat different types of patients. Changes to technology might also have affected care methods, while more choices in housing alternatives (such as assisted living and community housing) may have altered the population mix served by nursing homes.

In considering changes to the classification system, we considered alternative models. Since the inception of the SNF PPS, we have investigated ways of developing a predictive model for therapy that could replace the existing methodology. During the demonstration that led to the development of the SNF PPS, we considered a therapy model based on need. However, there was a great deal of concern that by separating payment from the actual provision of services, the system, and more importantly, the beneficiaries would be vulnerable to underutilization. In work that the Urban Institute did for CMS, it developed a model that focused on hospital diagnosis and level of function to predict the need for therapy. That proposal was discussed in a CMS Report to the Congress issued in December 2006, which is available online at *http://www.cms.hhs.gov/SNFPPS/Downloads/RC_2006_PC-PPSSNF.pdf*.

While the model had possibilities, it added a level of complexity without increasing the model's predictive power beyond that of the existing RUG–III methodology. In addition, we were concerned about the reliance on data from the prior hospital stay (which is not currently available to SNFs), and the use of hospital diagnosis to predict post-acute therapy needs. MedPAC has retained the Urban Institute researchers to develop the model further, and has presented a refined methodology in its June 2008 Report to the Congress: Reforming the Delivery System, available online at *http://MedPAC.gov/chapters/Jun08_Ch07.pdf*. While we will continue to study this model, we believe it would be premature to include it in the RUG–IV model being proposed in this rule for two reasons.

First, in accordance with section 115 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, Pub. L. 110–173), the Congress has asked us to look at alternatives to a diagnosis-based model for evaluating facility compliance under the IRF PPS. During the past 3 months, we have spoken with a large number of clinicians and other stakeholders who have expressed strong reservations about using diagnosis as a predictor of therapy need. We have contracted with the Research Triangle, Inc. (RTI) to investigate alternatives, and want to review the results of this research before proceeding with a diagnosis-linked model for therapy in SNFs.

Second, we are working closely with CMS staff on the Post Acute Care (PAC) Payment Reform demonstration project. Data are currently being collected from SNFs, IRFs, home health agencies, and

long-term care hospitals that we believe will help us predict the need for post-hospital care across these four settings. We believe that the results of the PAC Payment Reform demonstration project will assist us in developing a more effective model for therapy reimbursement.

We believe that significant changes in the SNF PPS therapy payment model would be most appropriately considered after the conclusion of research on diagnosis-based models and the PAC demonstration described above. Therefore, the STRIVE therapy model utilizes the same basic structure as the current RUG–III model and relies on updated staff time data collected during STRIVE.

1. Data Collection

To help ensure that the SNF PPS payment rates reflect current practices and resource needs, CMS sponsored a national nursing home time study, STRIVE, which began in the Fall of 2005. Information collected in STRIVE includes the amount of time that staff members spend on residents and information on residents' physical and clinical status derived from MDS assessment data.

Two hundred and five nursing homes from the following 15 States and jurisdictions volunteered to participate in STRIVE: the District of Columbia, Nevada, Florida, Illinois, Iowa, Kentucky, Louisiana, Michigan, Montana, New York, Ohio, South Dakota, Texas, Virginia, and Washington. Once the States were identified, we selected a sample of nursing homes using the procedures set forth in the document entitled ''Sampling Methodology'' available on the SNF PPS Web site at *http://www.cms.gov/snfpps/10_timestudy.asp*, and analyzed staff time and MDS assessment data for approximately 9,700 residents. The STRIVE sample is 40 percent greater than the 1994 sample used initially to develop RUG–III, and is 2.5 times larger than the 1995/1997 sample used to revise RUG–III and establish the current CMIs that are the basis for current Medicare rates.

Identifying the level of staff resources needed to provide quality care to nursing home patients was a primary objective. For this reason, nursing homes with poor survey histories or pending enforcement actions were excluded from the sample. In addition, nursing homes with poor quality measure (QM) scores, low occupancy rates, or large proportions of private pay or pediatric patients were also excluded.

Using the procedures set forth in the document entitled ''Sampling Methodology'' that appears on the SNF PPS Web site at *http://www.cms.gov/snfpps/10_timestudy.asp*, nursing homes were recruited within the following five strata: Hospital-based facilities; facilities with high concentrations of residents on ventilators; facilities with high concentrations of residents with Human Immunodeficiency Virus (HIV); facilities with high concentrations of residents on Medicare Part A stays; and all other facilities. Facilities with large concentrations of residents on ventilators, residents with HIV, or residents on Part A stays were over-sampled in order to assure sufficient numbers of residents in those populations. Nursing homes were voluntarily recruited in random order until enough facilities in each targeted category agreed to participate.

Participating facilities included both not-for-profit entities and corporations, chains and independent operators, nursing homes with populations small to large in size, freestanding and hospital-based facilities, and facilities situated in urban and rural locations. STRIVE began on-site data collection at both SNFs and Medicaid nursing facilities (NFs) in the spring of 2006. STRIVE collected data from both types of facilities because almost half of the States use a version of the RUG–III system for their Medicaid reimbursement systems.

Participating facilities submitted both time and MDS assessment data. Nursing staff recorded their time over 48 hours. Nursing staff included registered nurses, licensed practical nurses, and nursing aides. Therapy staff recorded their time over 7 consecutive days. Therapy staff included physical therapists and aides; occupational therapists and aides; and speech-language pathologists. Each nursing home staff member recorded his or her time at the facility in different categories (for example, resident-specific time (RST), non-resident-specific time (NRST), unpaid time, and non-study time).

Additional detailed information on the STRIVE sampling and data collection process has been posted on the SNF PPS Web site at *http://www.cms.hhs.gov/SNFPPS/10_TimeStudy.asp*. In addition, more information on the STRIVE data collection process appears at the following Web site: *https://www.qtso.com/strive.html*. Items posted there include: Assessment forms distributed by STRIVE; ''train the trainer'' materials used to teach the data monitors who, in turn, instructed nursing home staff members on how to record their time; and materials from State teleconferences. Slides presented at STRIVE technical expert panels (TEPs) can also be found on this Web site.

2. Developing the Analytical Data Base

To date, STRIVE has benefited from stakeholder input, starting with the December 2005 Open Door Forum to which the public was invited. The educators, researchers, beneficiary advocates, clinicians, consultants, government experts, and representatives from health care, nursing home, and other related industry associations serving on the STRIVE TEP have provided valuable insights on topics such as sample populations. Beginning in 2005 until its most recent March 2009 meeting, the TEP has met three times and held three teleconferences. Additionally, our contractor established a smaller Analytic Panel consisting of various stakeholders who have met with our researchers to discuss the analysis of the STRIVE data.

In addition, we worked closely with the States to recruit State Medicaid agencies as partners in the data collection process. We held numerous phone conferences with the State agencies to organize the data collection and get State input on potential focus areas for the research. For example, we received suggestions to look at special populations including the ventilator/respirator population, HIV/AIDS, Alzheimers patients and individuals with behavioral problems. We also investigated differences in relative resource costs for the younger population that would typically be reimbursed through Medicaid rather than Medicare, and for patients with long-term chronic conditions such as deafness and/or blindness. We were able to incorporate the results of some of these analyses into the RUG–IV model. For example, we found that the relative resource use for respiratory conditions such as ventilator/respirator use have increased. Reimbursement for these conditions increases under the RUG–IV model. However, the data did not support a change to the RUG–IV model for other patient populations, such as the bariatric population or residents with behavioral issues. However, we plan to share our findings with the States so that they can consider the STRIVE data in evaluating changes to Medicaid payment systems.

Finally, we have been working closely with colleagues in the Canadian government to broaden our data collection effort. CAN–STRIVE (a recent Canadian time study using the same methodology as the STRIVE project described in this proposed rule) has just

begun its data analysis, using some of the preliminary STRIVE data to focus its data collection efforts. We will continue to work with our Canadian colleagues to confirm our findings and, if possible, to continue our analysis of special populations. For example, the CAN–STRIVE population includes a much larger sample of patients with behavior problems than the STRIVE sample, and the Canadian data may be helpful for future policy analysis.

The STRIVE analyses have shown that the RUG–III model is still effective in determining relative nursing resource use generally across a broad range of conditions for which beneficiaries are treated. At the same time, however, we have found that the resource times associated with specific conditions or service categories, such as diabetes and the use of intravenous fluids or medications, has changed significantly. These analyses have confirmed our initial expectations that the RUG–III model needed to be updated to reflect significant changes in SNF care patterns during the past decade. Therefore, in constructing the analytical data base, we have proposed the changes to the RUG–IV model that are discussed below.

a. Concurrent Therapy

Almost 90 percent of patients in a Medicare Part A SNF stay are receiving therapy services. Under the current RUG–III model, therapy services are case mix-adjusted based on the therapy minutes reported on the MDS. When the RUG–III model was developed, most therapy services were furnished on a one-on-one basis, and the minutes reported on the MDS served as a proxy for the staff resource time needed to provide the therapy care. However, we have long been concerned that the incentives of the current RUG–III classification model have created changes in the way therapy services are delivered in SNFs. Specifically, we have been concerned that, as discussed below, there has been a shift from one-on-one therapy to concurrent therapy that may not represent optimal clinical practice.

Concurrent therapy is the practice of one professional therapist treating multiple patients at the same time while the patients are performing different activities. In the SNF Part A setting, concurrent therapy is distinct from group therapy, where one therapist provides the same services to everyone in the group. In a concurrent model, the therapist works with multiple patients at the same time, each of whom can be receiving different therapy treatments. For concurrent therapy, there are currently no MDS coding restrictions regarding either the number of patients that may be treated concurrently, or the amount or percentage of concurrent therapy time that can be included on the MDS, whereas with group therapy there are limitations, as discussed in the July 30, 1999 SNF PPS final rule (64 FR 41662).

There are specific MDS coding instructions that limit the amount of group therapy that can be reported on the MDS, and used to calculate the appropriate payment level. For MDS reporting purposes, in order to report the full time as therapy for each participant, the supervising therapist (or assistant) may treat no more than four participants at a time, and may not be supervising any additional patients outside the group. Group therapy minutes may be counted in the MDS, but are limited to no more than 25 percent of the total weekly minutes per discipline for a particular patient.

In the SNF Part A setting, concurrent therapy can be a legitimate mode of delivering therapy services when used properly based on individual care needs as determined by the therapist's professional judgment. Given that Medicare and Medicaid patients are among the most frail and vulnerable populations in nursing homes, we believe that the most appropriate mode of providing therapy would usually be individual and not concurrent therapy. We believe it is in the beneficiary's best interest that concurrent therapy should never be the sole mode of delivering therapy care to any individual in a SNF setting; rather, it should be used as an adjunct to individual therapy when clinically appropriate, as determined by the individual's current medical and physical status based on a therapist's clinical judgment.

Our concern is that concurrent therapy has become the standard of practice rather than a way to supplement needed individual therapy care. The STRIVE data show that approximately two-thirds of all Part A therapy provided in SNFs is now being delivered on a concurrent basis rather than on the individual basis that we believe to be the most clinically appropriate mode of therapy for SNF and NF patients. We are also concerned that the current method for reporting concurrent therapy on the MDS creates an inappropriate payment incentive to perform concurrent therapy in place of individual therapy, because the current method permits concurrent therapy time provided to a patient to be counted in the same manner as individual therapy time. For example, under the current method of reporting, if a therapist furnishes 60 minutes of therapy time to a group of patients concurrently, then a separate 60 minutes of therapy time is counted for each patient. To test the impact of changing the method of reporting concurrent therapy, we designed the STRIVE analytical data base to distinguish between concurrent and individual therapy minutes. We were also able to identify the number of patients treated under the concurrent model, and allocated the total minutes evenly among the total number of patients receiving concurrent therapy care from the same therapist at the same time.

The data showed that under our current RUG–III methodology, which does not allocate time, patients treated concurrently are typically assigned to higher therapy groups (with higher payments) than appropriate based on the therapy resources actually used to provide care for those patients. In order to eliminate this inappropriate incentive, and to better reflect our policy that individual therapy is usually the most appropriate mode of therapy for SNF residents, we are proposing to use allocated concurrent therapy minutes in developing the RUG–IV therapy model. Thus, a therapist who is treating patients concurrently would allocate the total minutes among the patients based on the therapist's clinical judgment of how much therapist time was actually provided to each patient. We note that this change is consistent with our longstanding policy for payment of timed codes (that is, codes that are billed per time unit rather than per visit) for Part B therapy services. As stated in the *Medicare Benefit Policy Manual*, Pub. 100–2, chapter 15, section 230, ''Contractors pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services (97150). The individuals can be, but need not be performing the same activity.'' Therefore, in outpatient settings, concurrent therapy is billed the same way as group treatment (and the therapist would bill the HCPCS code for group therapy, not individual therapy, for each individual involved).

Consistent with this policy and with our initiative ''to improve consistency in the standards and conditions for Part A and Part B therapy services'' (as discussed in the Medicare Physician Fee Schedule final rule with comment period for CY 2008, 72 FR 66222, 66332, November 27, 2007), effective with the introduction of RUG–IV, concurrent therapy time provided in a Part A SNF

setting would no longer be counted as individual therapy time for each of the patients involved. However, we note that, unlike the Part B policy described above, in the SNF setting we are not proposing to treat concurrent therapy minutes the same way we treat group therapy minutes, and instead are proposing to allocate concurrent therapy minutes among the patients being treated (as stated above, the full therapy time can be reported for each group therapy participant as long as no more than four participants are being treated at a time). As discussed above, we believe that with the frail and vulnerable population in SNFs and NFs, concurrent therapy is appropriate only as an adjunct to individual therapy and that individual therapy is the most appropriate mode of therapy for this population. Therefore, unlike our policy for group therapy, we do not believe it is appropriate to count the full therapy time for each patient being treated concurrently. In a group setting, the patients are performing similar activities. By interacting with one another, the patients observe and learn from each other. They then apply this new information into their own therapy program to progress and, thus, benefit from the group setting. By contrast, during concurrent therapy, the patients are not performing similar activities and often do not interact at all with each other. Therefore, the patients are not benefiting from each other's therapy intervention. Furthermore, as discussed above, we believe that allowing concurrent therapy to be counted as individual therapy would create an inappropriate incentive to replace individual therapy with concurrent therapy.

As we stated previously, in the SNF Part A setting, concurrent therapy can be a legitimate mode of delivering therapy services when used properly based on individual care needs as determined by the therapist's professional judgment. CMS requires that the actual total therapy time be documented on the MDS. However, we have not to date required that the facility staff separately report the amount of time for each individual therapy technique or delivery mode (individual, concurrent, and group). Without this documentation, it is difficult for CMS to evaluate the appropriateness of reimbursement.

As discussed above, we are proposing that, for each discipline, concurrent therapy minutes must be allocated before reporting total therapy minutes on the MDS 3.0. For this reason, we are soliciting comments concerning whether therapy data need to be reported separately by therapy mode (that is, individual, concurrent, or group) on the MDS or whether it will be sufficient to include a record of therapy usage by therapy mode in the medical record. While we are not prescribing the specific facility process for the documentation of therapy services (for example, therapy log, therapy daily progress note), we note that, in the absence of further changes to the MDS 3.0, the amount of time for each mode of therapy would need to be distinguished in the individual's clinical record effective with the MDS 3.0, and it would be up to facility staff to make the correct time allocations for reporting on the MDS.

We want to reiterate that concurrent therapy—

- Can represent a legitimate mode of delivering therapy services when used properly, based on individual care needs as determined by the therapist's professional judgment;
- Should be an adjunct to individual therapy, not the primary mode of delivery of care; and,
- Should represent an exception rather than the standard of care.

As discussed above, while we limit the percentage of group therapy minutes that may be counted on the MDS, and limit the number of patients that may be treated simultaneously in group therapy for purposes of counting therapy minutes in full for each patient (64 FR 41662), we have not, to date, placed a limit on the percentage of concurrent therapy that may be coded on the MDS or on the number of patients that can be treated concurrently. Therefore, we are also inviting public comments on whether there should be other restrictions relating to concurrent therapy such as a limit to the percentage of concurrent therapy minutes that may be counted on the MDS for any individual or to the number of people that can be treated concurrently by the same therapist.

Finally, we are concerned that placing limits on the use of concurrent therapy could result in an inappropriate substitution of therapy aides for therapists and assistants. We note that therapy aides are expected to provide support services to the therapists and cannot be used to provided skilled therapy services. We also note that, under Part B, services rendered by therapy aides are not considered outpatient therapy services. In our analysis of the STRIVE data, it appears that therapy aides are being used appropriately; that is, for supportive services and not for the provision of skilled therapy services. However, we intend to monitor the use of therapy aides and, if necessary, to propose changes to MDS reporting requirements in the future.

b. Adjustments to STRIVE Therapy Minutes

The STRIVE analysis also included an examination of therapy services reimbursed under RUG–III. While nursing services are fully reimbursed using a prospective case-mix adjusted algorithm, payment for therapy services is more closely linked to the amount of therapy actually received at a particular time. In the RUG–III model, there are five levels of therapy services: Ultra High, Very High, High, Medium, and Low therapy. Each of these levels is assigned based on the actual minutes of therapy care provided to a beneficiary as reported on the MDS assessment. Each level of therapy is assigned a CMI. Payment is determined by multiplying the CMI by the therapy portion of the SNF PPS rate. This therapy payment is then included in the SNF PPS bundled per diem payment.

We are aware that there are some inherent limitations associated with the voluntary collection of data at a facility site. During the STRIVE time study, we collected nursing staff time for two weekdays, primarily with hand-held computers called personal data assistants (PDAs). We collected therapy staff time for 7 days, generally with PDAs only for the first three weekdays and then with a paper tool for the remaining 4 days, including weekends. We needed to clean the PDAs of all data and ship them to a new facility for availability at the beginning of the next week, which restricted PDA usage to only 3 days. In addition, during weekend days, different therapy staff were present and received substantially less oversight for the therapy data collection using the paper tools.

There were three different data collection schedules: Therapy data collection on Schedules A and B both began on Tuesday continuing through the following Monday. With Schedule C, data collection began on Wednesday continuing through the following Tuesday. In all cases, the therapy data collection continued for a complete one-week period. Table 9 below shows the percentage of weekly therapy time for the three data collection schedules.

TABLE 9—DATA COLLECTION SCHEDULES WITH PERCENTAGE OF WEEKLY THERAPY BY DAY

Collection schedule	N	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	Mon.	Tues.
A	8012	26%	25%	22%	12%	2%	1%	12%	.....
B	1193	25%	27%	26%	12%	1%	0%	10%	.....
C	516	.....	30%	26%	21%	1%	1%	12%	9%
Total	9721	24%	26%	23%	13%	2%	1%	12%	1%

Shaded cells indicate days where therapy data were collected using the paper tool.

Including only residents present for the full week of therapy data collection, Schedule A and Schedule B show similar percentages of reported weekly therapy across the seven days. Tuesday, Wednesday, and Thursday each had between 22 percent and 27 percent of the total weekly reported therapy, and together had between 73 and 78 percent of the total weekly reported therapy. Of the remaining total, 12 percent occurred on Friday, 10–12 percent on Monday, and very little (zero to two percent) occurred on weekend days.

For Schedules A and B, Tuesday, Wednesday, and Thursday therapy time was collected by PDA; the paper tool was utilized Friday through Monday. For Schedule C, PDAs were used Wednesday through Friday, with paper tools utilized Saturday through Tuesday. While utilizing a PDA, all three schedules reported similar percentages: 22 to 30 percent, for Wednesdays and Thursdays, and 21 percent on Friday for Schedule C. In contrast, utilizing paper tools, Friday therapy time was 12 percent for Schedules A and B, and 9 percent on Tuesday for Schedule C. These observations lead us to believe that it was possible that therapy was being underreported when the paper tool was utilized.

In order to determine if the therapy data collected seemed reasonable, we compared the STRIVE Medicare Part A data to the national distribution of RUG-III rehabilitation groups as reported on Medicare claims. The STRIVE data had fewer patients in the Ultra High, Very High, and High rehabilitation groups and more patients in the Medium rehabilitation groups. This Medicare Part A claims comparison indicated that STRIVE therapy time was probably being underreported. Possible explanations of the underreporting include both the use of paper forms and the less intense oversight on weekends.

In order to mitigate potential paper tool shortfalls with respect to therapy times, we developed a methodology to determine adjusted weekly therapy time based on the PDA time. Our proposed methodology allows us to avoid direct use of the potentially underreported therapy minutes from the paper tools and best match the Medicare Part A claims information.

As discussed in detail in section III.A.2.a. of this proposed rule, we adjusted the therapy minutes to allocate concurrent therapy time; that is, divide the total therapy minutes between the number of patients receiving therapy service from the same therapist at the same time. We then performed separate calculations using the resident time for each of the three therapy disciplines (physical therapy, occupational therapy and speech-language pathology). The steps for making the therapy time adjustment included:

- Totalling each resident's time for each discipline by adding times across the several practitioners of that discipline (for example, for physical therapy we had therapists, assistants, and aides.)
- Computing the resident's average therapy session for each separate discipline computed as the sum of the therapy time reported on PDA days and divided by the count of PDA days. There had to be 15 minutes or more of therapy for inclusion in the computation.
- Estimating the total adjusted number of days the resident received that therapy discipline. We considered it a day of therapy only if 15 minutes or more of therapy time was reported on the PDA or the paper tool.

To determine the number of weekdays where therapy was provided, we adjusted the data as follows:

- Three of three PDA days reported: We treated that resident as if there were five weekdays of therapy for that discipline. A resident receiving therapy on all data collection days would most likely indicate a pattern typical of a person receiving daily therapy.
- Two of three PDA days reported: We treated that resident as if there were three weekdays of therapy for that discipline. We note that residents can only qualify for a therapy group if they have had at least 3 days of therapy per week. Thus, facilities typically provide therapy services for at least 3 days per week, in order to qualify the resident for a therapy group. Accordingly, when therapy was reported on 2 of 3 PDA days, we believed that it was likely that the patient actually received 3 days of therapy during the week. If the paper tool indicated there were 15 or more minutes of a specific therapy on either or both of the remaining weekdays, then an additional day was added for each day with 15 or more minutes; a maximum of two additional weekdays was possible.
- One of three PDA days: We treated that resident as if they had one weekday of that discipline but added additional days for each of the other two weekdays where therapy time of 15 or more minutes was indicated on the paper tool for that discipline.
- No PDA days: We counted any weekday or weekend days reported on a paper tool where there were 15 or more minutes for that discipline.

Generally, therapy was not given on weekends and weekend data collection was always done by the paper tool. We accounted for therapy time on the weekends by counting the days reported on a paper tool where there were 15 or more minutes of therapy for that discipline.

Following the steps described above, we calculated an adjusted number of days for each discipline, for each resident. Then, for each discipline and for each resident, we adjusted the reported therapy minutes by multiplying the average therapy session time for each resident by the adjusted days of therapy to obtain adjusted weekly therapy minutes.

After adjusting the therapy minutes, we performed a similar adjustment to add the estimated amount of therapy staff time that had not been captured during the data collection process. First, we divided the adjusted weekly therapy minutes by the reported weekly therapy minutes to calculate an inflation factor. Then, we applied the inflation factor to the reported per diem staff time resulting in the adjusted per diem therapy staff time. The adjusted staff time was then wage weighted (see discussion in II.G.1.b.v of this proposed rule) to produce the final wage-weighted staff time (WWST) for therapy. The WWST was then used as the dependent

(or cost) variable in the subsequent analyses of therapy staff time and also to derive the therapy CMIs.

TABLE 10—ADJUSTED THERAPY TIME CALCULATION EXAMPLE

Therapy data	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.	Mon.	Total time	Average therapy session	Days with 15+ minutes
Observed	45	40	40	0	0	0	0	125	42	3
Assumed	×	×	×	×	0	0	×	210	42	5

3 days of PDA data with estimated days of therapy = 5.
Adjusted weekly minutes = 5 × 42 = 210 minutes.

When group therapy was reported, we applied the existing 25 percent group time limitation for each discipline, excluding any group time exceeding 25 percent of total time, as follows: First, we calculated the amount of group time exceeding the 25 percent limitation. In order to achieve agreement with the adjusted therapy times, we multiplied the excess group time by the inflation factor before subtracting from the adjusted total time.

This therapy time adjustment provides a better fit to the national RUG–III distribution for rehabilitation groups, and better accounts for all reported therapy staff times. 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.

We used the adjusted therapy time to determine the number of residents classifying into the ''Rehabilitation'' and ''Rehabilitation plus Extensive Services'' categories in the RUG–IV model and to calculate the CMIs. Though we propose to adjust for therapy time by developing the inflation factor described above, we evaluated the effect of two alternatives. The first alternative we considered was using the reported (unadjusted) times from the PDAs and paper tools. We also looked at therapy CMIs for nursing facilities where the therapy time data collection appeared consistent across the entire week, and examined the wage-weighted unadjusted times from only those 50 facilities. We evaluated the alternatives by determining whether the alternative produced a substantial difference in the CMI computation for the ''Rehabilitation'' and ''Rehabilitation plus Extensive Services'' categories compared to the proposed adjusted therapy time methodology.

The three different scenarios produce roughly the same CMIs because the RUG therapy groups use therapy time cutoffs, for example, the High rehabilitation groups require 325 minutes of therapy per week and the Very High rehabilitation groups require 500 minutes of therapy per week. While the therapy adjustment will not significantly influence the CMIs, it will change our estimated distribution of residents by increasing the number of residents in the higher level rehabilitation RUG groups.

This adjustment methodology benefits providers that provide a substantial quantity of rehabilitation. Without taking this into consideration, we run the risk of undercounting the actual amount of therapy provided. Therefore, we propose the adjustment methodology because the RUG distribution after application of the adjustment of therapy time more closely matches the expected therapy RUGs national distribution. The adjustment methodology is described in detail in the slides presented at the March 2009 TEP posted on *http://www.qtso.com/strive.html*.

We then included the adjusted therapy minutes in the STRIVE analytic database used to construct the RUG–IV classification structure and CMIs. We are confident that the STRIVE sample gave us the information we needed to evaluate changes we are proposing in this rule to the existing RUG–III model and to the therapy CMIs for RUG–IV. Still, as we discussed above, we believe that it would be premature to recommend a comprehensive restructuring of the SNF PPS therapy methodology based on a predictive model for therapy services. Thus, in this rule, we are proposing incremental, targeted changes that we believe will improve the accuracy of the existing RUG model. We plan to revisit alternatives to the current methodology used to reimburse therapy as additional information from the Post Acute Care demonstration and the analysis of IRF utilization patterns becomes available.

c. ADL Adjustments

RUG–IV, like RUG–III, uses a scale measuring Activities of Daily Living (ADLs) to identify residents with similar levels of physical function. This scale is used to sub-divide (''split'') each of the major hierarchical categories except Extensive Services. It is also used as part of the qualification criteria for many of the RUG–IV hierarchical categories (Extensive Services, Special High, Special Low, and Cognitive Performance and Behavioral Symptoms), and is used as part of the specific criteria for classifying patients to RUGs within certain categories.

As discussed below, we are proposing revisions to the RUG–IV ADL Index that reflect both clinical and statistical considerations, with the aim of scoring similarly those residents with similar function. As discussed further below, we changed component scores to make the scale more proportional to physical function (linear). In addition, we increased the range of the RUG–IV ADL Index (17 points), as compared to the RUG–III ADL Index (15 points), to allow somewhat greater distinction in physical function. An improvement of the categorization of the RUG–IV ADL scale is suggested by the results of the regression of the ADL scale (linear) after adjusting for the RUG–IV major hierarchical categories (R^2 = 11.1 percent for the RUG–IV ADL Index versus R^2 = 10.5 percent for the RUG–III ADL Index).

In addition, as discussed further below, we made certain revisions in the eating component score to achieve better categorization of residents receiving assistance in feeding. The RUG–III ADL Index used component scores of 1, 2, and 3 with artificial feeding mechanisms; that is, Parenteral Feeding/IV Feeding or the use of feeding tubes, used to classify patients into the most dependent category. In the STRIVE analysis, we found that patients receiving One Person Physical Assist or more needed comparable staff resources to those patients who were being fed by artificial means. During RUG–IV development, we found that the inclusion of artificial feeding services in the ADL Index slightly reduced the effectiveness of the model fit. In fact, the regressions discussed immediately above dropped slightly from an R^2 of 11.1 percent to 11.0 percent for the best alternative model (with the eating

component score = 2). Therefore, we modified the ADL component for eating so that the RUG–IV ADL component score for eating does not use Parenteral/IV feeding or feeding tube items. In addition, we made certain other revisions to the ADL component for eating as discussed below.

As in RUG–III, in the RUG–IV model an ''ADL Index'' is determined by combining the ''component ADL scores'' for certain items. The RUG–IV ADL Index, like the RUG–III ADL Index, combines ''component ADL scores'' based on the MDS ADL items for bed mobility, transfer, eating, and toilet use. A higher score represents a greater functional dependence and a need for more assistance. However, in contrast with the RUG–III ADL scale which ranges from 4 to 18, the RUG–IV scale ranges from 0 to 16. Starting the RUG–IV ADL Index at 0 is intended to improve ease of use and interpretation, and the addition of 2 ADL levels is intended to capture a patient's functional status more effectively.

TABLE 11A—ADL VALUES: BED MOBILITY, TOILET, TRANSFER

Bed Mobility, Toilet, Transfer ADL			
Performance	Support		
	None/setup	1-person	2-person
Independent/Supervision	0		
Limited Assistance	1		
Extensive Assistance	2		4
Total Dependence	3		

TABLE 11B—ADL VALUES: EATING

Eating ADL			
Performance	Support		
	None/setup	1-person	2-person
Independent/Supervision	0	2	
Limited Assistance			
Extensive Assistance	2	3	
Total Dependence		4	

To compute the RUG–IV ADL Index, we sum the component ADL scores for bed mobility, transfer, eating, and toilet use. We obtain each component ADL score by using both the Self-Performance and Support Provided for all four of the MDS items. This is a minor change from the RUG–III ADL Index (which did not use the Support Provided item for eating), intended to capture a patient's functional status more effectively. In addition, RUG–IV ADL Index component ADL scores range from 0 to 4 for all four areas, whereas RUG–III ADL Index scores ranged from 1 to 5 for bed mobility, transfer, and toilet use, and 1 to 3 for eating. Thus, although many specific combinations of MDS items remain the same, the corresponding component scores are slightly different.

As with the RUG–III ADL Index, in RUG–IV, bed mobility, transfer, and toilet use are treated identically. The ADL for eating had a different relationship with resource use than the toileting, transfer, and bed mobility ADLs. Therefore, we chose to develop a separate eating ADL scale, consistent with the current ADL system.

For the ADL Index component for bed mobility, transfer, and toilet use, when a Self-Performance item (for example, G1aa—Bed Mobility Self-Performance) indicates Independent (0) or Supervision (1), the component ADL score is 0, regardless of the level of support provided (for example, G1ab—Bed Mobility Support Provided). The data indicated that there was no significant change in resource use when the level of support provided increased, until the Extensive Assistance and Total Dependence levels. When the Self-Performance item indicates Limited Assistance (2), the component score is 1 (again, regardless of the level of support provided). For Self-Performance levels that indicate greater functional dependence than Limited Assistance (that is, Extensive Assistance and Total Dependence), the component ADL score is based on the level of support provided. When the Self-Performance item indicates Extensive Assistance (3) and the Support Provided is One Person Physical Assist or less (0, 1, 2), the component score is 2; when a Two+ Persons Physical Assist (3) is indicated, the component score is 4. Finally, when a Self-Performance item indicates Total Dependence (4) and the corresponding Support Provided item indicates One Person Physical Assist or less (0, 1, 2), the corresponding component score is 3; when a Two+ Persons Physical Assist (3) is indicated, the component score is 4. When the ADL Activity Did Not Occur During the Entire 7-day Period, Self-Performance (8) or Support Provided (8), the component ADL score is 0.

As mentioned previously, in the RUG–IV model, the eating component ADL score is obtained by using the Self-Performance and Support Provided items for eating. At each Self-Performance level, component scores differ by the level of Support Provided: Setup Help Only or less (0, 1) versus One Person Physical Assist or more (2, 3). When the Self-Performance item indicates Independent (0), Supervision (1), or Limited Assistance (2) and the Support Provided indicates Setup Help Only or less (0, 1), the eating component ADL score is 0. For the same three values of eating Self-Performance (that is, 0–2) where the Support Provided is One Person Physical Assist (2) or Two+ Persons Physical Assist (3), the eating component ADL score is 2. When the Self-Performance item indicates Extensive Assistance (3) or Total Dependence (4) and the Support Provided is Setup Help Only or less (0, 1), the component ADL score is 2. When the Self-Performance is Extensive Assistance (3) and the Support Provided is either a One Person Physical Assist (2) or Two+ Persons Physical Assist (3), the component ADL score is 3. When the Self-Performance is Total Dependence (4) and the Support Provided is One Person Physical Assist or more (2, 3), the component ADL score is 4. The component ADL score of 1 is not used for eating. The pattern is similar to the ADL scores in RUG–III for bed mobility, transfer, and toileting, which have values of 1, 3, 4, and 5, but not 2. The STRIVE data indicate that not every ADL level is correlated with the same increase in resource time. We found that using a scale without an ADL level of 1 for eating provided slightly higher variance explanation and a closer relationship between the final RUG–IV ADL Scale and nursing WWST.

As with the other 3 ADLs, when the eating items indicate Activity Did Not Occur During the Entire 7-Day Period, Self-Performance (8) or Support Provided (8), the component ADL score is 0. The RUG–IV eating ADL component score differs from the RUG–III in 2 ways. First, as discussed above, the RUG–III ADL component score does not use the Support Provided item, whereas the RUG–IV ADL component score does. Second, the RUG–IV eating ADL component score does not use the Parenteral/IV feeding or the Feeding tube items, as discussed above.

The ADL levels used to subdivide patients classified in each major category of the RUG–IV hierarchy into the actual RUG–IV groups is shown below in Table 12. We invite comments

on the proposed changes to the ADL index.

Table 12. RUG-IV Category Level ADL Splits

RUG Category	Rehab Level	ADL Levels				
		0-1	2-5	6-10	11-14	15-16
Rehabilitation+ Extensive	Ultra High		RUL		RUX	
	Very High		RVL		RVX	
	High		RHL		RHX	
	Medium		RML		RMX	
	Low		RLX			
Rehabilitation	Ultra High	RUA		RUB	RUC	
	Very High	RVA		RVB	RVC	
	High	RHA		RHB	RHC	
	Medium	RMA		RMB	RMC	
	Low	RLA			RLB	
Extensive Services			ES1, ES2, ES3			
Special High			HB	HC	HD	HE
Special Low			LB	LC	LD	LE
Clinically Complex		CA	CB	CC	CD	CE
Behavioral Symptoms and Cognitive Performance		BA	BB			
Reduced Physical Function		PA	PB	PC	PD	PE

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d. ''Look-Back'' Period

The RUG–III case-mix classification system includes items in the MDS 2.0 that may be coded for services provided to the resident prior to admission into the SNF. When RUG–III was developed, these items were deemed to be a proxy for medical complexity. In the SNF PPS final rule for FY 2000 (64 FR 41668–69, July 30, 1999), a commenter suggested that we eliminate the ''look-back'' period for completion of items in the MDS, as its use could trigger a RUG assignment based on services that occurred solely during the prior acute hospital stay and were no longer being furnished by the time of SNF admission. This would result in SNF coverage even though the resident was no longer receiving any skilled care at that point. While we did not have the data needed to evaluate the impact of making this change to the RUG–III model, we continued to monitor how the inclusion of pre-admission services affected the RUG–III classification model.

In the FY 2000 SNF final rule (64 FR 41668 through 41669, July 30, 1999), we stated that

> * * * the use of the 'look-back' period in making RUG–III assignments is essentially a clinical proxy that is designed to serve as an indicator of situations that involve a high probability of the need for skilled care. Thus, our expectation is that the occurrence of one of the specified events during the 'look-back' period, when taken in combination with the characteristic tendency * * * for an SNF resident's condition to be at its most unstable and intensive state at the outset of the SNF stay, should make this a reliable indicator of the need for skilled care upon SNF admission in virtually all instances * * *. If it should become evident in actual practice that this is not the case, it may become appropriate at that point to reassess the validity of the RUG–III system's use of the 'look-back' period in making assignments.

We subsequently discussed changing the ''look-back'' period on specific items in the MDS in the SNF PPS proposed and final rules for FY 2006 (70 FR 29079 through 29080 and 70 FR 45034 through 45035). Some commenters stated that changing the look-back period for some items in the MDS would negatively affect the care planning process for individuals. Many recommended that any changes should be coordinated with other CMS initiatives, such as MDS 3.0 and the STRIVE project. We agreed to address the issue of the look-back period within the broader context of the MDS 3.0 and the STRIVE project.

In addition, MedPAC, in its reports (for example, Report to the Congress: Promoting Greater Efficiency in Medicare, June 2007; *http://www.medpac.gov/documents/Jun07_EntireReport.pdf*), recommended that we eliminate the look-back period for specific treatments and that we include in the RUG payment system only those services that are provided after admission to the SNF.

As part of the STRIVE project, we expanded the data collection by adding a STRIVE addendum that allowed us to distinguish between preadmission and postadmission utilization of a specific set of MDS items that serve as qualifiers to classify residents into the highest levels of the RUG–III hierarchy. In order to minimize burden on the nursing homes participating in the study, we limited the number of additional data

items collected, and concentrated on those special treatments that are often provided in a hospital but are not often provided in a SNF after hospital discharge. For these reasons, we concentrated on the use of IV medications, tracheostomy care, suctioning and ventilator/respirator services, and transfusions (which are rarely performed in SNFs). We did not collect pre- and post-admission data on those special treatments we expected to require longer term care such as dialysis, IV feeding, radiation therapy and chemotherapy. However, in all cases, the staff time data collected through STRIVE reflects the care furnished after admission to the facility.

Analysis of the STRIVE data shows that: (1) the ''look-back'' period does in fact capture services that are provided solely prior to admission to the SNF; and (2) there is a much lower utilization of staff resources for individuals who received certain treatments solely prior to the SNF stay (that is, during the qualifying acute hospital stay) compared to those who received these services while a resident of the SNF. In fact, the STRIVE data showed that those patients who received specific services solely prior to admission to the SNF have similar resource utilization to those who never received the service (prior to admission or during the SNF stay). Therefore, the capture of preadmission services by the ''look-back'' does not provide an effective proxy for medical complexity for SNF residents. Instead, it results in payments that are inappropriately high for many non-complex medical cases.

Accordingly, we now propose to modify the look-back period under RUG–IV for those items in section P1a of the MDS 2.0, Special Treatments and Procedures, to include only these services that are provided after admission (or readmission) to the SNF. The modified look-back would apply to all treatments and procedures that are currently listed in section P1a of MDS 2.0. As discussed above, in order to reduce the burden on facilities, the STRIVE study looked at preadmission and postadmission utilization for a subset of P1a services. Because the STRIVE project data showed that the capture of preadmission services by the ''look-back'' does not provide an effective proxy for medical complexity and thus is not an effective predictor of subsequent resource intensity during the SNF stay, we believe that it would be appropriate, and consistent with the STRIVE data, to modify the look-back period for all P1a services. Thus, the proposed change to the look-back period is supported by the STRIVE data. In addition, the proposed change to the look-back period is consistent with the policy that has been in effect for reporting therapy services, another critical component of the RUG model, since the start of the SNF PPS in July 1998.

On the MDS 3.0 item set, there will be two ways to code for each of these procedures and treatments. In the first column (while not a resident) the provider would mark each treatment and procedure that was provided to the patient within the last 14 days while not a resident of the facility and would only be required to complete this column if the patient were admitted within the last 14 days. In the second column (while a resident) the provider would mark those procedures and treatments that have been performed while a resident of the facility within the last 14 days.

We agree that information regarding the resident's status prior to admission to the SNF is important to develop a comprehensive care plan. We note that the MDS collects information on numerous clinical items that affect a person's condition (medical, physical, psychological, etc.), which need to be taken into account in developing care plans but do not significantly alter the staff resources needed to provide quality care to that patient. It is the responsibility of all providers to properly assess, care for, and provide treatment for all patient care needs regardless of whether these needs/services are specifically included in the case-mix classification model used for payment. Furthermore, to make sure that comprehensive information is available to facility staff for the care planning process, as noted above, we have expanded the MDS 3.0 for the Special Treatments and Procedures items to 2 columns instead of only one. The first column allows the provider to code those services that were provided prior to the individual being admitted to the facility, while the second would be completed for only those services that are provided to the patient after admission/readmission to the facility. In this way, we capture information that may be important for care planning while continuing to provide adequate and appropriate payments for those patients who actually receive these services while a SNF resident. At the same time, modifying the look-back period eliminates inappropriately high reimbursement for services that are solely provided prior to admission to the SNF. We solicit comments on our proposed changes to the look-back period.

e. Organizing the Nursing and Therapy Minutes

The proposed RUG–IV model uses the same basic methodology that was used to develop the RUG–III model that is in use today. A detailed description of the RUG–III model is included in the May 1998 interim final rule with comment period (63 FR 26252). In addition, a detailed comparison between the RUG–II and RUG–IV models has been included in the Addendum to this proposed rule, in Table C.

In developing the RUG model, we look for clinical conditions that show a difference in mean staff time resource use (that is, wage weighted staff time or WWST) between residents with a clinical characteristic and residents without the condition. For a detailed description of the methods used to calculate the WWST for nursing and therapy, please see section III.C. of this proposed rule. In the STRIVE study, we linked nursing and therapy staff time collected on site at 205 facilities with contemporaneous MDS data for those same residents. Facility staff generally completed the STRIVE MDS during the same week as the time study was being collected. In the STRIVE study, we did have certain advantages that were not available when the RUG–III staff time measurement study was conducted. At that time, there was no national MDS data collection process. We now have a repository of MDS data covering the same period as each of the STRIVE time studies. Thus, we were able to use the national MDS data base to correct for missing data or other minor discrepancies in the ''as reported'' STRIVE MDSs.

In addition, in the STRIVE study, we were able to assign average hourly wage rates more appropriately to the different staff categories (as explained below), and use this data to construct the wage-weighted staffing time (WWST) used to compare the resource intensity of different conditions and services during the analysis discussed below, and to establish the CMIs or relative weights for each group in the proposed RUG–IV hierarchy.

For STRIVE, we used the 2006 U.S. Department of Labor, Bureau of Labor Statistics Occupational Employment Statistics survey (North American Industry Classification System 623100—Nursing Care facilities) wage data to determine the relative wages for the staff types participating in the STRIVE study. The RUG–III model relied primarily on data furnished by industry sources that provided fewer staff categories and wage weights. Thus, the WWST used in the STRIVE study better represents actual

staffing and wage rates in SNFs across the country.

The purpose of linking the clinical and staff resource data is to identify differences in relative resource use for those conditions and sets of conditions treated in Medicare SNFs and Medicaid nursing facilities. Thus, we sorted each record by each of the RUG–III qualifying items reported on the MDS, summed the WWST minutes, and calculated an average number of nursing and therapy minutes for each condition. For example, we identified and summed the WWST resource minutes associated with providing suctioning. We then divided the total WWST minutes by the number of MDS records on which suctioning was reported to obtain average WWST minutes for the service. As part of the analysis, we looked at comorbidities commonly associated with the condition as well as records where suctioning was the only RUG qualifier reported on the MDS. We then used the WWST minutes and the mean minutes for each current or potential payment qualifier to examine and ultimately update the RUG–III model.

The current RUG–III model was created as a hierarchy from highest to lowest resource use. Clinical conditions and services were assigned to a hierarchy level based on similarity of staff time required to treat a beneficiary with that condition. Thus, while there might be no direct clinical relationship between items assigned to the same level of the RUG hierarchy, SNFs will generally incur similar costs for providing nursing and therapy services within that RUG. The RUG–III hierarchy consists of eight levels: Rehabilitation plus Extensive Services, Rehabilitation, Extensive Services, Special Care, Clinically Complex Services, Impaired Cognition, Behavior Problems, and Reduced Physical Function. For detailed information on the development of the RUG–III classification system, please see the May 12, 1998 interim final rule with comment period (63 FR 26252). A comprehensive list of the MDS items used to classify patients into a RUG–III grouper is included in Chapter 6 of the MDS 2.0 Manual and can also be found on the SNF PPS Web site at *www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp*.

As a first step, we examined the current RUG–III structure in a hierarchical manner starting with the Rehabilitation plus Extensive Services category. We evaluated each category by first looking at the current qualifiers for that category and determining if the average WWST based on the STRIVE data for any RUG–III qualifier was either significantly higher or significantly lower than the average WWST for that category. If a condition had significantly higher or lower WWST, it could indicate that the condition would better fit into the category above or below in the hierarchy. The second step was to evaluate potential items to add to each category based on the WWST for that item by considering qualifying conditions from the category below or investigating conditions that had not previously been included in the classification system.

Then, we evaluated other major components of the RUG–III model to determine where enhancements could be made. The STRIVE research confirmed findings of CMS's multi-year RUG–III demonstration that showed the importance of patient functional deficits, that is, the ability to perform activities of daily living (ADLs), in assessing patient care needs and total staff time needed to provide care. We found that ADL levels have a significant impact for specific conditions and across the group of conditions included in almost every level of the hierarchy. Therefore, the RUG–III model includes an ADL scale that is used to create secondary classification splits within each level of the hierarchy.

For RUG–IV, the ADL scale remains a critical part of the model. We are proposing two modifications to the existing ADL methodology. First, in RUG–IV, we will standardize the ADL categories across the various levels of the hierarchy. Second, we revised the ADL scale to make it more sensitive to differences in functional levels. The proposed ADL changes are discussed in section III.B. of this proposed rule.

In addition, we reassessed the effectiveness of the incremental refinement implemented in the FY 2006 final rule that added nine new RUG–III groups effective January 2006. We also looked at changes in the delivery of therapy services, and its impact on the classification system. Our findings and recommendations in this regard are set forth in section IV.D. of this proposed rule.

The RUG–IV model presented in this proposed rule incorporates both the results of the STRIVE analysis and the stakeholder input received during the course of the project. A detailed description of proposed changes to the RUG classification structure, and the introduction of proposed new FY 2011 case-mix weights are presented later in this section.

B. The RUG–IV Classification System

As discussed above, we are proposing to implement changes in FY 2011 to the RUG classification structure and relative weights. In the proposed RUG–IV classification system, patient characteristics and health status information from the proposed MDS 3.0 (discussed in section IV. of this proposed rule) would be used to assign the patient to a resource group for payment. Like RUG–III, the new RUG–IV system is a hierarchy of major patient types, and reflects current medical practice and staff resource use in SNFs across the country. We believe that the RUG–IV model is more sensitive to differences in patient complexity and the SNF resources needed to provide quality care than the existing RUG-III model. In the RUG–IV model, we propose modifying the eight levels of the hierarchy and increasing the number of case-mix groups from 53 to 66. Expanding the model allows us to better distinguish between relative resource use both within and between RUG groups. For example, the RUG–IV model is more sensitive to the high level of resources associated with those medically complex conditions involving respiratory illness and infections.

In addition, RUG–IV allows us to capture a patient's functional status more effectively. Functional status is a key component of both the existing RUG–III model and the proposed RUG–IV, and is used to distinguish the level of resource need between patients with similar conditions. Thus, if a patient is assigned to a RUG group at the Clinically Complex level of the hierarchy, we use that patient's level of functional status as a secondary classifier (commonly referred to as a secondary split) to assign a more precise classification into one of the 8 proposed Clinically Complex groups.

RUG–IV, like RUG–III, uses a scale measuring Activities of Daily Living (ADLs) to identify residents with similar levels of physical function. This scale is used to sub-divide (''split'') each of the major hierarchical categories except Extensive Services. It is also used as part of the qualification criteria for many of the RUG–IV hierarchical categories (Extensive Services, Special High, Special Low, and Cognitive Performance and Behavioral Symptoms), and is used as part of the specific criteria for classifying patients to RUGs within certain categories. A complete description of the methodology used to develop the RUG–IV ADL Index is included in section III.A.2.c. of the proposed rule.

The RUG–IV model reflects changes in how particular clinical conditions or services are assigned to the 66 levels of the RUG hierarchy. Since the CMIs assigned to each RUG group are based on average resource time for the conditions and services included in that RUG group, it is very important to make the individual RUG groups as homogeneous as possible with respect to the resource times associated with the conditions and services included in each RUG group. In this way, we enhance the accuracy of the payment structure and maximize the relationship between the RUG hierarchy and the accuracy of the payments made for each of the conditions included in a particular level of the hierarchy. Therefore, we are proposing to move certain existing conditions and/or services currently used to assign patients to RUG–III groups up or down within the RUG hierarchy (as described in more detail later in this section) to better reflect the average resource time for those conditions, and to enhance the accuracy of RUG payments.

Finally, we have evaluated a broad range of clinical services and conditions, and are recommending several additions and deletions to the existing RUG–III model based on the results of the STRIVE research, and described in more detail later in this section. Since approximately 90 percent of the days of service for Medicare Part A SNF stays include the provision of therapy, we looked carefully at utilization patterns and changes in the practice of therapy identified through the STRIVE research. We also carefully evaluated the methodology used to assign patients to the Rehabilitation plus Extensive Services category that was implemented in January 2006. This category was established to promote access for a small group of high-cost beneficiaries with both extensive medical and rehabilitation needs. The STRIVE analysis has shown us that the RUG–III model for classifying patients into Extensive Services, a prerequisite for placement in one of the nine combined Rehabilitation plus Extensive Services groups, is no longer effective in identifying the type of patient for whom these groups were created. Instead, the STRIVE data showed that most of the patients classifying into these nine new groups had some type of IV treatment in the hospital that was neither needed nor provided after admission to the SNF. Thus, most of the beneficiaries who were classified into one of these nine groups were actually treated in the SNF for less complex medical conditions than had been expected. We believe that the large percentage of SNF patients receiving IV services during the hospital stay prior to SNF admission reflects changes in hospital care practices since the development of the RUG–III system that are unrelated to increased patient severity in the subsequent SNF stay. Accordingly, as discussed in detail in section III.A.2.d., the proposed RUG–IV Extensive Services category would include only those nursing services actually received during the SNF stay itself. By correcting for this unanticipated effect, the RUG–IV model would more effectively distribute payment to patients with greater care needs. The proposed new RUG–IV groups are included in Table 12.

The RUG–IV classification model is an iterative process where patients are assigned first to one of eight major categories which indicate the primary patient nursing and/or therapy needs. Each case is assigned to the highest major category for which it qualifies. In hierarchical order, from highest to lowest, the categories are Rehabilitation plus Extensive Services, Rehabilitation, Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Cognitive Performance, and Reduced Physical Function. These major categories are further differentiated into more specific patient groupings; that is, secondary splits. Except for the Extensive Services category, we use a secondary split based on the patient's Activities of Daily Living (ADL) score discussed earlier in this section. As described below, the RUG–IV groups may be further differentiated based on nursing rehabilitation services and signs of depression. Thus, a record for a patient who is admitted to a SNF for treatment that qualifies for the Special Care High major category will be further evaluated to assign the most appropriate of the eight Special Care High groups. The final group selection will be made based on the patient's ADL level and on the existence of signs/symptoms of depression.

The initial RUG–IV category of Rehabilitation plus Extensive Services is used to classify residents who both qualify for Extensive Services and need rehabilitation therapy. In RUG–IV, changes made to either the Extensive Services or Rehabilitation major categories affect the number and type of patients who can qualify for this group. We discuss changes to the Extensive Services and Rehabilitation major categories below.

The second RUG–IV category is Rehabilitation. This includes residents receiving a certain number of physical or occupational therapy or speech language pathology service minutes per week. In RUG–IV, we are proposing to maintain the existing RUG–III rehabilitation category, as well as the existing subcategories and criteria as described below. We note that, as discussed in greater detail in section III.A.2.a. of this proposed rule, we are proposing to require the allocation of concurrent therapy minutes. While this allocation proposal would affect the number of therapy minutes reported on the MDS, it does not affect the construction of the RUG–IV model. In addition, similar to the methodology used for RUG–III, the RUG–IV model we are proposing would not use ADL limitations to qualify for the Rehabilitation category. In the Rehabilitation category, ADLs are only used as a threshold for assignment into the sub-category.

There are five subcategories within the Rehabilitation category. They are Ultra High, Very High, High, Medium, and Low, which require 720, 500, 325, 150, or 45 minutes of rehabilitation therapy per week, respectively. In addition, Ultra High, Very High, and High subcategories also require at least 1 rehabilitation discipline 5 days per week. The Ultra High subcategory requires a second rehabilitation discipline 3 days per week. The Medium and Low Rehabilitation subcategories require 5 and 3 days per week, respectively, of any combination of 3 rehabilitation disciplines. In addition, the Low Rehabilitation subcategory requires nursing rehabilitation 6 days per week, 2 services (see Reduced Physical Function category below for nursing rehabilitation services count).

The third RUG–IV category is Extensive Services. Under the current RUG–III model, patients are classified into the Extensive Services category if they exhibit one of the following five conditions: ventilator care, tracheostomy care, suctioning, IV medications, and IV feeding. Then, comorbidities are identified and used to subdivide the case into one of the three Extensive Services groups. Comorbidities are determined by identifying whether an Extensive Services patient also has one of the conditions needed to qualify for a Special Care, Clinically Complex Care, or Impaired Cognition group. All of the existing Extensive Services qualifying conditions were examined as part of the STRIVE project.

We found that, while ventilator care and tracheostomy care still require intensive staff resources, the remaining RUG–III qualifiers are no longer appropriate for the Extensive Services

category. Our analysis showed significant differences between services furnished in the prior hospital stay and the same types of services provided in the SNF. In fact, we found no statistical difference between resources needed to treat patients who had an Extensive Services qualifying service in the prior hospital stay (but not in the SNF) and patients who did not have the service in either the hospital or the SNF. In addition, the resource minutes were considerably lower when services were only provided during the prior hospital stay. Similarly, we found that the existence of comorbidities (additional clinical conditions that qualified the patient for inclusion in the Special Care, Clinically Complex, or Impaired Cognition groups) did not change the nursing resources associated with the Extensive Services qualifiers in any meaningful way. Specifically, we did not find that the inclusion of comorbidities increased the staff time necessary to treat Extensive Services residents who also have conditions qualifying them for treatment in the other categories. Consistent with the proposed changes discussed in section III.A.2.d. of this proposed rule, in the RUG–IV model, ventilator/respirator care, and tracheostomy care qualify only when they are administered post-admission to the SNF. The same post-admit time constraint will apply for the new infection/isolation addition to Extensive Services. Some prior Extensive Services qualifiers have been moved to a new location in RUG–IV, in order to better reflect the average resource time for these conditions (as discussed above): the parenteral/IV feeding qualifier moves to the Special Care High category and the IV medications qualifier moves to the Clinically Complex category. Furthermore, for the reasons discussed above, the inclusion of comorbidities has been eliminated as a secondary split. In addition, suctioning has been dropped as a qualifier in RUG–IV because the use of suctioning is highly correlated with the other two Extensive Services, ventilators and tracheostomies. Generally, in the STRIVE study, suctioning was associated with some type of respiratory condition coded on the MDS. In those few instances where suctioning had been coded without any other indication of a respiratory condition (such as respiratory therapy or oxygen therapy), the nursing WWST minutes were much lower than suctioning furnished with other respiratory conditions. Based on the low resource use for suctioning independent of any respiratory condition, and the absence of any other non-respiratory RUG qualifier associated with suctioning, we believe it is appropriate to exclude suctioning as an independent qualifier. Finally, we retain the ADL qualifier for inclusion in the Extensive Services category. We have modified the ADL qualifier from 7 to 2 in order to reflect the change in calculating ADLs described above.

For RUG–IV, we have divided the RUG–III Special Care category into Special Care High and Special Care Low categories to better reflect the differences in resource use. The Special Care High category includes residents receiving complex care or those with serious medical conditions, including the following: quadriplegia, respiratory therapy for 7 days, and fever in combination with dehydration, or pneumonia, or vomiting, or weight loss. Added to this category are the following: the parenteral/IV feedings qualifier, which has moved from the Extensive Services category; septicemia, which has moved from the Clinically Complex category; diabetes with injections and physician order changes on 2 or more days, which have moved from the Clinically Complex category; and, the comatose qualifier, which has moved from the Clinically Complex category. As discussed above, we moved these qualifiers based on the results of our STRIVE study so that the RUG–IV model better reflects the average resource use for these conditions. In addition, the Special Care High category includes a minimum ADL requirement of *2*. We dropped fever with tube feeding with food/fluid requirements as a qualifier because in the STRIVE study, tube feeding resource use fell below that of fever. Therefore, based on resource use, we believe it is no longer appropriate to include tube feeding with fever.

The RUG–IV Special Care Low category includes residents receiving complex care or those with significant medical conditions, including the following: multiple sclerosis; cerebral palsy; ulcers (2 or more stage II or one or more stage III or IV pressure ulcers) with treatment; surgical wounds or open lesions with treatment; and tube feeding with requirements. In the RUG–III model, aphasia was used as a qualifier when linked to the use of feeding tubes. The aphasia requirement has been dropped because, based on the results of our STRIVE analysis, aphasia no longer correlates with tube feeding. For this reason, we have retained tube feeding as a qualifier, but have dropped aphasia. In addition, the following conditions are moved to this category from the Clinically Complex category so that the RUG–IV model better reflects the average resource times associated with these conditions: dialysis, burns, pneumonia, and oxygen therapy; shortness of breath with emphysema/chronic obstructive pulmonary disease (COPD); and Parkinson's disease. In addition, the Special Care Low category includes a minimum ADL requirement of 2. We ran Mean Nursing WWST and variance explanations for all possible ADL thresholds for all hierarchy categories. After balancing the statistical results with the relative ease of understanding the system, we determined that a relatively consistent ADL threshold from the Extensive Services category down through the Special Care Low category would be most appropriate. Also, the ADL cut-off value of 2 for Special Care Low is close to the cut-off used in RUG–III.

RUG–III had included radiation therapy in the Special Care category; however, for the reasons discussed below, in RUG–IV, this has been moved to the Clinically Complex category. Internal Bleeding is no longer a qualifier in any category because of its unreliability. The RAND Corporation recently completed an analysis of MDS 2.0 items, and recommended changes for use in the MDS 3.0 as shown at *http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp*. RAND found that there were no standardized definitions of internal bleeding, and that the item was vulnerable to misinterpretation, that is, inappropriately coding routine situations (such as minor nosebleeds) as ''internal bleeding.''

The sixth RUG–IV category is Clinically Complex. This includes residents receiving complex clinical care who do not meet the minimum ADL requirement for classification in the Extensive Services or the Special Care categories, or residents with conditions requiring skilled nursing management and interventions for conditions and treatments, such as: foot infections/wounds with treatment; transfusions; hemiplegia; and chemotherapy. This category also includes radiation therapy, which moved from the Special Care category, and post-admit IV medications. These qualifiers were moved because the average resource times for these conditions, as determined in the STRIVE analysis, are more reflective of conditions in the Clinically Complex category than for the higher levels of the hierarchy in which they classified under the RUG–III model. Dehydration was dropped as a qualifier in any category, based on the American Medical

Association's finding (see Faes, MC, ''Dehydration in Geriatrics,'' *Geriatric Aging*, 2007: 10(9): 590–596, available online at *http://www.medscape.com/viewarticle/567678* that there is no standard definition of dehydration among providers, and that the signs and symptoms of dehydration may be vague and even absent in older adults. We believe that this qualifier is subject to a wide range of interpretation (and, therefore, is unreliable as a standard for RUG classification), as borne out by our MDS review, which showed instances of patients being coded for dehydration for long periods of time, that is, far beyond the time period in which we would expect the issue to be resolved through treatment. Thus, we believe continuing to use dehydration as a qualifier could result in inaccuracy in RUG classification. (This is not to minimize the potentially serious nature of dehydration and the need for prompt medical attention in some cases, but rather to improve coding accuracy). Finally, physician orders were dropped as a qualifier. Because of the lack of specificity and the variable nature of this qualifier, we do not believe that the presence of physician orders is a reliable predictor of resource use.

The seventh RUG–IV category is Behavioral Symptoms and Cognitive Performance. Residents in this category display cognitive impairment in decision-making, recall, and short-term memory. They score above the threshold amount on the MDS 3.0 with respect to the brief interview for mental status. Alternatively, or in addition, these residents display one of the following behavior patterns: wandering; verbal abuse; physical abuse; socially inappropriate traits; resistance to care on 4 or more days; hallucinations or delusions. In addition, these residents may not exceed a maximum ADL cut-off of *5*. In the RUG–III model, Impaired Cognition and Behavior represented separate levels in the hierarchy. However, the STRIVE data showed that the same level of resources is needed to treat patients in either the cognitive or behavioral groups. Thus, we combined the groups into a single level of the RUG hierarchy.

The final RUG–IV category is Reduced Physical Function. This category includes residents whose needs are primarily for ADLs and general supervision. For the Reduced Physical Function major category, all records are sorted into subgroups by ADL level. Once this secondary split has been done, the records are sorted into still more discrete groups using a tertiary split that identifies residents who are receiving restorative nursing. Restorative nursing services are coded on the MDS, and include passive and/or active range of motion (ROM); amputation/prosthesis training; splint or brace assistance; dressing or grooming training; transfer training; bed mobility and/or walking training; communication training; scheduled toileting plan and/or bladder retraining program.

We believe that restorative nursing programs benefit all nursing home patients, and consider the use of a tertiary split for restorative nursing to be a positive incentive in fostering quality care. However, in the STRIVE analysis, we found that, for approximately half the Reduced Physical function groups, the nursing minutes were lower for patients where restorative nursing was reported on the MDS than for patients who were not receiving the service as shown in Table 13. While we are proposing to retain the tertiary split for restorative nursing in the RUG–IV model, we are soliciting comments that may shed light of the discrepancy between the reported service and the nursing minutes.

TABLE 13

RUG category	Nursing rehabilitation	N	Average nursing WWST
Physical E	Yes	82	157.7
	No	396	159.0
Physical D	Yes	153	129.6
	No	691	125.5
Physical C	Yes	17	105.4
	No	88	100.5
Physical B	Yes	14	73.1
	No	117	82.6
Physical A	Yes	24	60.7
	No	462	62.2

The RUG–IV classification system shown in Table 14 is being proposed for use in the national Medicare SNF PPS. State Medicaid agencies are not required to adopt the RUG–IV model. However, we believe that most States will give the model careful consideration because it includes features that will promote accurate payment. For example, based on our STRIVE study results, inclusion of services furnished prior to the SNF/NF admission when assigning a RUG payment group has resulted in excess payments by both Medicare and Medicaid for services that were not actually furnished to the patient during the SNF stay. Similarly, as discussed in section IV.D. of this proposed rule, the RUG–III classification into the therapy groups overstates in some cases the actual staff time needed and used to provide therapy services. Further, most State Medicaid agencies have been using the same RUG–III model currently used by Medicare. While many of the high-acuity patients are covered under Medicare Part A for all or part of their nursing home stays, Medicaid has its share of this same high-acuity population. By identifying current nursing home practices and resource use, the RUG–IV model more closely ties payments to the relative severity and needs of the Medicaid as well as Medicare populations. We intend to work closely with State Medicaid agencies during the next year to assist them in evaluating the RUG–IV model for Medicaid use.

We expect that most States will continue their existing payment systems until they have more time to evaluate the RUG–IV model. For this reason, we have already started work on support systems that will allow States to convert or crosswalk the MDS 3.0 data to the current MDS 2.0 structure for use in the State Medicaid payment systems. These crosswalks contain the data specifications that States will need to continue running their MDS 2.0/RUG–III-based systems after October 1, 2010. Our Center for Medicaid and State Operations has initiated monthly calls with State Medicaid agencies and has established an ongoing dialogue to

address the States' systems support needs. Representatives from the MDS 3.0 team in the Office of Clinical Standards and Quality and the RUG–IV development team in the Center for Medicare Management participate on these calls. All three Centers for Medicare & Medicaid Services (CMS) components are working together to support the State agencies and assist them in making the transition to the MDS 3.0 and, where applicable, to the RUG–IV system.

In this proposed rule, we are soliciting comments from State Medicaid agencies on their preferred method(s) of transferring MDS 3.0 data between CMS and the State Medicaid agency, and on any new systems developments needed to run their RUG–based payment systems. In addition, for those States that wish to adopt the proposed RUG–IV model in FY 2011, we are soliciting comments on the type of detailed RUG–IV specifications and technical support they will need in order to prepare for an October 2010 implementation. To assist in this effort, we have prepared a detailed RUG–IV/RUG–III comparison that can be found in the Addendum (Table C) to this rule. We invite comment on these proposed changes.

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Table 14
Crosswalk of MDS 3.0 Items and RUG-IV Groups

CATEGORY	ADL INDEX	END SPLITS	MDS RUG-IV CODES
ULTRA HIGH REHABILITATION PLUS EXTENSIVE SERVICES **Rehabilitation Rx 720 minutes/week minimum** **AND** At least 1 rehabilitation discipline 5 days/week AND A second rehabilitation discipline 3 days/week AND Tracheostomy care, ventilator/respirator, or isolation for active infectious disease while a resident AND ADL score of 2 or more	11-16 2-10	Not Used Not Used	RUX RUL
VERY HIGH REHABILITATION PLUS EXTENSIVE SERVICES: **Rehabilitation Rx 500 minutes/week minimum** AND **At least 1 rehabilitation discipline 5 days/week** AND Tracheostomy care, ventilator/respirator, or isolation for active infectious disease while a resident AND ADL score of 2 or more	11-16 2-10	Not Used Not Used	RVX RVL
HIGH REHABILITATION PLUS EXTENSIVE SERVICES **Rehabilitation Rx 325 minutes/week minimum** AND **At least 1 rehabilitation discipline 5 days/week;** AND Tracheostomy care, ventilator/respirator, or isolation for active infectious disease while a resident AND ADL score of 2 or more	11-16 2-10	Not Used Not Used	RHX RHL
MEDIUM REHABILITATION PLUS EXTENSIVE SERVICES **Rehabilitation Rx 150 minutes/week minimum** AND **5 days any combination of 3 rehabilitation disciplines;** AND Tracheostomy care, ventilator/respirator, or isolation for active infectious disease while a resident AND ADL score of 2 or more	11-16 2-10	Not Used Not Used	RMX RML
LOW REHABILITATION PLUS EXTENSIVE SERVICES **Rehabilitation Rx 45 minutes/week minimum** **AND** **3 days any combination of 3 rehabilitation disciplines;** AND **Restorative nursing 6 days/week, 2 services (see Reduced Physical Function (below) for**	2-16	Not Used	RLX

CATEGORY	ADL INDEX	END SPLITS	MDS RUG-IV CODES
restorative nursing services); AND Tracheostomy care, ventilator/respirator, or isolation for active infectious disease while a resident AND ADL score of 2 or more			
ULTRA HIGH REHABILITATION Rehabilitation Rx 720 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week AND A second rehabilitation discipline 3 days/week	11-16 6-10 0-5	Not Used Not Used Not Used	RUC RUB RUA
VERY HIGH REHABILITATION Rehabilitation Rx 500 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week	11-16 6-10 0-5	Not Used Not Used Not Used	RVC RVB RVA
HIGH REHABILITATION **Rehabilitation Rx 325 minutes/week minimum** AND At least 1 rehabilitation discipline 5 days/week	11-16 6-10 0-5	Not Used Not Used Not Used	RHC RHB RHA
MEDIUM REHABILITATION **Rehabilitation Rx 150 minutes/week minimum** AND 5 days any combination of 3 rehabilitation disciplines	11-16 6-10 0-5	Not Used Not Used Not Used	RMC RMB RMA
LOW REHABILITATION **Rehabilitation Rx 45 minutes/week minimum** **AND** **3 days any combination of 3 rehabilitation disciplines;** AND Restorative nursing 6 days/week, 2 services (see Reduced Physical Function for restorative nursing services)	11-16 0-10	Not Used Not Used	RLB RLA
EXTENSIVE SERVICES Tracheostomy care, ventilator/respirator, or isolation for active infectious disease while a resident AND ADL score of 2 or more	2-16 2-16 2-16	Tracheostomy care and ventilator/respirator Tracheostomy care or ventilator/respirator Isolation for active infectious disease	ES3 ES2 ES1
SPECIAL CARE HIGH **Comatose; septicemia; diabetes with daily injections and order change on 2 or more days; quadriplegia with ADL score >=5; chronic obstructive pulmonary disease and shortness of breath when lying flat; fever with pneumonia, vomiting, dehydration, or weight loss; parenteral/IV feedings; respiratory therapy for 7 days** AND ADL score of 2 or more	15-16 15-16 11-14 11-14 6-10 6-10 2-5 2-5	Signs of Depression No Signs Signs of Depression No Signs Signs of Depression No Signs Signs of Depression No Signs	HE2 HE1 HD2 HD1 HC2 HC1 HB2 HB1

CATEGORY	ADL INDEX	END SPLITS	MDS RUG-IV CODES
SPECIAL CARE LOW	15-16	Signs of Depression	LE2
Cerebral palsy, multiple sclerosis, or Parkinson's disease with ADL score >=5; feeding tube (calories >= 51% or calories = 26-50% and fluid >= 501cc); ulcers (2 or more stage II or 1 or more stage III or IV pressure ulcers) with 2 or more skin care treatments; foot infection/diabetic foot ulcer/open lesions of foot with treatment; radiation therapy while a resident; oxygen therapy while a resident; dialysis while a resident	15-16	No Signs	LE1
	11-14	Signs of Depression	LD2
	11-14	No Signs	LD1
	6-10	Signs of Depression	LC2
AND	6-10	No Signs	LC1
ADL score of 2 or more	2-5	Signs of Depression	LB2
	2-5	No Signs	LB1
CLINICALLY COMPLEX	15-16	Signs of Depression	CE2
Extensive Services, Special Care High or Special Care Low qualifier and ADL score of 0 or 1	15-16	No Signs	CE1
	11-14	Signs of Depression	CD2
	11-14	No Signs	CD1
OR	6-10	Signs of Depression	CC2
Pneumonia; hemiplegia with ADL score >=5; surgical wounds or open lesions with treatment; burns; chemotherapy while a resident; IV medications while a resident; transfusions while a resident	6-10	No Signs	CC1
	2-5	Signs of Depression	CB1
	2-5	No Signs	CB2
	0-1	Signs of Depression	CA2
	0-1	No Signs	CA1
BEHAVIORAL SYMPTOMS and COGNITIVE PERFORMANCE	2-5	2 or more restorative nursing on 6+ days/wk	BB2
Cognitive impairment BIMS score <=9 or CPS >=3	2-5	Less restorative nursing	BB1
OR			
hallucinations or delusions	0-1	2 or more restorative nursing on 6+ days/wk	BA2
OR			
physical or verbal behavioral symptoms toward others, other behavioral symptoms, rejection of care, or wandering	0-1	Less restorative nursing	BA1
AND			
ADL score <=5			
See Reduced Physical Function for restorative nursing services			
REDUCED PHYSICAL FUNCTION	15-16	2 or more restorative nursing on 6+ days/wk	PE2
Restorative nursing services:			
• Urinary and/or bowel training program	15-16	Less restorative nursing	PE1
• passive and/or active ROM	11-14	2 or more restorative nursing on 6+ days/wk	PD2
• amputation/prosthesis care training			
• splint or brace assistance	11-14	Less restorative nursing	PD1
• dressing or grooming training	6-10	2 or more restorative nursing on 6+ days/wk	PC2
• eating or swallowing training			
• transfer training	6-10	Less restorative nursing	PC1
• bed mobility and/or walking training	2-5	2 or more restorative nursing on 6+ days/wk	PB2
• communication training			
NOTES:	2-5	Less restorative nursing	PB1
No clinical variables used	0-1	2 or more restorative nursing on 6+ days/wk	PA2
	0-1	Less restorative nursing	PA1
Default			AAA

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C. Development of the FY 2011 Case-Mix Indexes

As indicated previously, section 1888(e)(4)(G)(i) of the Act requires that the Federal rates be adjusted for case mix. Pursuant to the statute, such adjustment must be based on a resident classification system, established by the Secretary, that accounts for the relative resource utilization of different patient types. The case-mix adjustment must be based on resident assessment data and other data the Secretary considers appropriate.

As discussed previously, the RUG–III system uses clinical data from the MDS, and wage-adjusted staff time measurement data, to assign a case-mix group to each record that is then used to calculate a per diem payment under the SNF PPS. The existing RUG–III grouper logic was based on clinical data collected in 1995 and 1997. We are proposing to implement in FY 2011 a RUG–IV update that uses data collected in 2006–2007 during the STRIVE project, and reflects current medical practice and resource use in SNFs across the country.

The proposed RUG–IV classification is a patient classification system that accounts for the relative resource utilization of different patient types. To adjust for the relative resource utilization of patients (that is, the case mix), direct patient care would be represented by an index score (case-mix index) that is based on the amount of staff time, weighted by salary levels, associated with each group. That is, each RUG–IV group would be assigned an index score that represents the amount of nursing time and rehabilitation treatment time associated with caring for the patients who qualify

for the group. The nursing weight would include both patient-specific time spent daily on behalf of each patient type by registered nurses, licensed practical nurses, and aides, as well as patient non-specific time spent by these staff members on other necessary functions such as staff education, administrative duties, and other tasks associated with maintenance of the caregiving environment.

The case-mix indexes would be applied to the unadjusted rates resulting in 66 separate rates, each corresponding with one of the 66 RUG–IV classification groups. To determine the appropriate payment rate, SNFs would classify each of their patients into a RUG–IV group based on assessment data from the MDS 3.0. The design and structure of RUG–IV and the methodology and policy associated with the classification of patients into RUG–IV groups, including the completion of assessments (MDS 3.0) for Medicare patients under the SNF PPS, are described in sections III.B. and IV.A. of this proposed rule.

As explained in sections III.A. and III.B. of this proposed rule, we collected measures of the staff time required to care for nursing home patients and used them to identify specific clinical characteristics that are predictive of patient resource use. In order to do this, we combined and analyzed characteristics of the patients in the STRIVE study and the time it took to care for them. We then used these analyses to identify the patient characteristics that best explain weighted patient-specific time. From this, we created the 66 RUG–IV groups and calculated separate nursing and rehabilitation therapy case-mix indexes for each group. In determining the case-mix indexes for each group, we first obtained the salaries of all staff types from the 2006 U.S. Department of Labor, Bureau of Labor Statistics Occupational Employment Statistics survey. Next, we computed the ratio of median salaries for different nursing and rehabilitation therapy staff to the median salary of a certified nurse aide. These ratios were used as the salary weights for each staff category. The basic calculation performed for each patient was to take the minutes spent providing patient care and multiply them by the weight that represents the staff person's salary. Thus, we multiplied the registered nurse's minutes by 2.58, the licensed practical nurse's minutes by 1.65 and the aide's minutes by 0.85, 1.0, or 1.20 (depending on the specific aide's job title) and then summed to yield salary-weighted nursing time for the patient.

For example, to compute the WWST for the ES3 RUG–IV group, we use the mean minutes per day for each of the nursing staff roles providing staff time for the ES3 group.

For the ES3 group, we collected staff time from the following staff types: Registered Nurses (RNs)—97.83, Licensed Practical Nurses (LPNs)—39.35, Certified Nursing Assistants (CNA)—108.84, and Restorative Aides—0.88.

We then multiplied the minutes for each of these roles by the relative wage weight for the respective role, standardized by the wage rate for CNA. The standardized weights are as follows:

RN—$27.52/$10.67 = 2.58, LPN—$17.57/$10.67 = 1.65, CNA—1.0, and Restorative Aide—$12.80/$10.67 = 1.2. Standardizing to the rate of a CNA allows us to refer to the wage rates relative to the staff role generally providing the most minutes.

The wage-weighted staff time for the ES3 group would be computed as follows:

$$(97.83*2.58) + (39.35*1.65) + (108.84*1) + (0.88*1.2) = 427.22$$

For therapy, we multiplied the physical therapist's time by 2.98, the occupational therapist's time by 2.72, the speech pathologist's time by 2.60, the licensed physical therapy assistant's time by 1.86, the licensed occupational therapy assistant's time by 1.90, and the therapy aide's time by 0.99 (physical therapy aide), 1.13 (occupational therapy aide), or 1.06 (therapy aide or therapy transport aide) and then summed to yield salary-weighted therapy time for the patient. We then averaged the salary-weighted nursing time for each group to yield an array of 66 nursing case-mix index scores and averaged the salary-weighted therapy time for the five different levels of therapy (Ultra High, Very High, High, Medium, and Low) to yield therapy case-mix indexes for those levels. These indexes comprise the unadjusted nursing and therapy weights for RUG–IV.

Our intent in implementing RUG–IV is to allocate payments more accurately based on current medical practice and updated staff resource data obtained during the STRIVE study, and not to decrease or increase overall expenditures. Thus, consistent with the policy in place when we transitioned to the RUG–III 53-group model in FY 2006 (as discussed in section II.B.2), we believe that overall expenditures under the RUG–IV model should maintain parity with overall expenditures under the RUG–III 53-group model. Therefore, we simulated payments under the RUG–III 53-group model and the RUG–IV 66-group model to ensure that the change in classification systems did not result in greater or lesser aggregate payments.

We used the resource minute data collected from STRIVE to create a new set of unadjusted relative weights, or case-mix indexes (CMIs), for the RUG–IV model as described above. We then compared the CMIs for the RUG–53 and RUG–66 models in a way that was intended to ensure that estimated total payments under the 66-group RUG–IV model would be equal to those payments that would have been made under the 53-group RUG–III model. We used STRIVE data with sample weights applied and FY 2007 claims data (the most recent final claims data available at the time) to compare the distribution of payment days by RUG category in the 53-group model with the anticipated payments by RUG category in the new 66-group RUG–IV model. Our projections of future utilization patterns under the new case-mix system indicated that the 66-group RUG–IV model would produce lower overall payments than under the original RUG–III 53-group model. Therefore, consistent with the policy in place when we transitioned to the RUG–III 53-group model in FY 2006 (as discussed in section II.B.2 of this proposed rule), we propose to provide for an adjustment to the nursing CMIs that would achieve ''parity'' between the old and new models (that is, would not cause any change in overall payment levels). The adjustment to the nursing weights necessary to achieve ''parity'' is an upward adjustment of 52.6 percent.

The parity adjustment relies on projecting the utilization for a new classification system, RUG–IV, based on a new assessment instrument, MDS 3.0. Our calculation of the parity adjustment uses the most recent data available to estimate RUG–IV utilization for FY 2011. In the absence of actual RUG–IV utilization data for this timeframe, we believe the most recent data is the best source available, as it is closest to the FY 2011 timeframe. As actual data for RUG–IV utilization becomes available, we intend to assess the effectiveness of the parity adjustment in maintaining budget neutrality and, if necessary, to recalibrate the adjustment in future years.

The final RUG–IV CMIs reflecting the parity adjustment are displayed in Table 15 and, as discussed above, we are proposing to apply them beginning in FY 2011.

TABLE 15—RUG–IV CASE-MIX INDEXES

RUG	Nursing index	Therapy index
RUX	3.42	1.90
RUL	3.07	1.90
RVX	3.40	1.34
RVL	2.85	1.34
RHX	3.27	0.91
RHL	2.75	0.91
RMX	3.20	0.58
RML	2.72	0.58
RLX	2.79	0.30
RUC	2.00	1.90
RUB	2.00	1.90
RUA	1.30	1.90
RVC	1.98	1.34
RVB	1.43	1.34
RVA	1.43	1.34
RHC	1.83	0.91
RHB	1.57	0.91
RHA	1.21	0.91
RMC	1.79	0.58
RMB	1.56	0.58
RMA	1.13	0.58
RLB	1.95	0.30
RLA	0.92	0.30
ES3	3.43	
ES2	2.56	
ES1	2.21	
HE2	2.09	
HE1	1.68	
HD2	1.91	
HD1	1.53	
HC2	1.77	
HC1	1.42	
HB2	1.75	
HB1	1.40	
LE2	1.82	
LE1	1.45	
LD2	1.62	
LD1	1.30	
LC2	1.48	
LC1	1.19	
LB2	1.27	
LB1	1.01	
CE2	1.62	
CE1	1.45	
CD2	1.42	
CD1	1.28	
CC2	1.31	
CC1	1.18	
CB2	1.10	
CB1	0.99	
CA2	0.82	
CA1	0.73	
BB2	0.93	
BB1	0.87	
BA2	0.66	
BA1	0.61	
PE2	1.45	
PE1	1.34	
PD2	1.31	
PD1	1.24	
PC2	1.05	
PC1	0.98	
PB2	0.79	
PB1	0.75	
PA2	0.56	
PA1	0.52	

We intend to actively monitor the changes in beneficiary access and utilization patterns as a response to the proposed implementation of RUG–IV. For example, we anticipate that the changes to the Extensive Services category could result in increased beneficiary access for patients with severe respiratory conditions. In addition, we intend to monitor utilization for any potential coding changes that could occur as a result of the proposed changes to the SNF PPS. If, in future years, evidence becomes available that indicates that a change in aggregate payments are a result of changes in the coding or classification of residents that do not reflect real changes in case mix, CMS will consider the authority given to the Secretary under Section 1888(e)(4)(F) of the Act to provide for an adjustment to the unadjusted federal per diem rates so as to eliminate the effect of such coding and classification changes.

a. Relationship of RUG–IV Classification System to Existing Skilled Nursing Facility Level-of-Care Criteria

As discussed previously in section I.A of this proposed rule, the establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because the case-mix adjustment aspect of the SNF PPS is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have utilized it to coordinate claims review procedures with the existing resident assessment process and case-mix classification system. Under RUG–III, this approach includes an administrative presumption that utilizes a beneficiary's initial classification in one of the upper 35 RUGs of the RUG–III 53-group system to assist in making certain SNF level of care determinations (see section *II.E.* of this proposed rule for a discussion of the relationship between the case-mix classification system and SNF level of care determinations). As discussed in § 413.345, we include in each update of the Federal payment rates in the **Federal Register** the designation of those specific RUGs under the classification system that represent the required SNF level of care, as provided in § 409.30. In addition, in the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the RUG–III classification structure.

Under RUG–IV, we propose to adopt this same approach, by including an administrative presumption that utilizes a beneficiary's initial classification in one of the upper 52 RUGs of the refined RUG–IV 66-group system to assist in making certain SNF level of care determinations. This designation reflects an administrative presumption under the refined RUG–IV 66 group system that beneficiaries who are correctly assigned to one of the upper 52 of the RUG–66 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 groups is not automatically classified as either meeting or not meeting the definition, but instead receives an individual level of care determination using the existing administrative criteria. This presumption recognizes the strong likelihood that beneficiaries assigned to one of the upper 52 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 groups. For purposes of this administrative presumption, the upper 52 RUG–IV groups would consist of all groups encompassed by the following 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.

E. Prospective Payment for SNF Nontherapy Ancillary Costs

1. Previous Research

We have conducted several studies since 1999 to refine the SNF PPS's reimbursement methodology for nontherapy ancillary (NTA) services. At the inception of the SNF PPS, payment for NTA services was included in the 44-group RUG system of case-mix groups. Analysis showed that there is only a weak correlation between NTA services costs and the RUG–III classification group. In addition, within the same RUG–III group, the NTA costs vary greatly. Thus, the data show that our present methodology of using the nursing CMIs to case-mix adjust the NTA payment amount may not be an accurate predictor of NTA costs. We are particularly concerned that the present system could underestimate NTA costs for the patients with the highest NTA needs, and that inadequate reimbursement could lead to restricted access to care for those patients who require them.

As a result of research conducted in the late 1990s, one proposal included in the FY 2001 proposed rule was to modify the RUG system by adding 14 additional groups (65 FR 19103 through 19194, 19203, April 10, 2000). These additional groups were designed to recognize that patients qualifying for both a Rehabilitation RUG and an Extensive Services RUG incurred NTA costs estimated to be as much as three times higher than those for patients qualifying solely for a rehabilitation RUG.

As noted in the 2006 Report to Congress on case-mix refinements (available online at *http://www.cms.hhs.gov/SNFPPS/Downloads/RC_2006_PC-PPSSNF.pdf*), additional research conducted by Abt Associates in the late 1990s experimented with several mathematical models of NTA costs. Results from this work could have practical application as an ancillary ''add-on'' index based on the beneficiary's predicted, per-diem NTA costs. As discussed in the FY 2001 SNF PPS proposed rule (65 FR 19195, April 10, 2000), NTA index models (both weighted and unweighted) were tested after exploring MDS variables that appeared to be predictive of NTA costs. In the unweighted model, cost predictions were based on counts of qualifying patient characteristics (characteristics such as respiratory infection or skin wounds). In the weighted models, a small set of payment groups were defined from ''index models'' that weighted the predictors, where the weights were proportional to the marginal impact of a patient characteristic on estimated NTA costs. The array of predicted costs generated by the equation could be subdivided into ranges of cost, or intervals, in order to define a small number of payment groups. As discussed in the Technical Appendix to the FY 2001 proposed rule (65 FR 19240, 19248, April 10, 2000), variations were created by applying the index models to alternative sets of RUG groups. As further discussed in the FY 2001 proposed rule (65 FR 19196), we proposed a separate unweighted NTA index to be applied to certain RUG categories based on clinical variables on the MDS. In addition, to facilitate the incorporation of this proposed refinement into the case-mix classification system, we proposed to create a new component of the payment rates to account for NTA services (65 FR 19192).

As explained in the FY 2001 SNF PPS final rule (65 FR 46773, July 31, 2000), while the expanded RUG groups approach and the NTA index approach initially appeared to improve payment accuracy in comparison to the existing case-mix system, attempts to validate the results on a later national PPS data set did not confirm the initial findings. As a result, we did not finalize the proposals made in April 2000.

We sponsored subsequent research by the Urban Institute using claims samples from 2001. This work led to the FY 2006 final rule (70 FR 45026, 45030–34, August 4, 2005), which implemented a variation on the 58-group RUG proposal developed by Abt Associates. In that rule, we finalized a system composed of 53 groups, by augmenting the original 44-group system with nine additional groups identifying patients simultaneously qualifying for the Extensive Services and Rehabilitation groups. This incremental change to the grouping system was accompanied by an across-the-board increase in the case-mix weights for the payment component that includes NTA costs. Both of these modifications were designed to enable the original RUG–III payment system to account more accurately for variation in NTA costs.

Using the 2001 data set, the Urban Institute also experimented with prediction models that were extensions of the original Abt Associates NTA index approaches. A small number of additional variables (for example, age) and improvements to the methodology for measuring independent variables in the data base led to potential improvements over the earlier Abt Associates models. The Urban Institute also explored substantially more complex models that incorporated variables derived from qualifying hospital stay claims; these models were estimated separately for patients after subdividing them into one of three groups: acute, chronic, or rehabilitation.

In 2008, the Medicare Payment Advisory Commission (MedPAC) sponsored analyses by researchers from the Urban Institute extending some of the Institute's earlier work. This led to a MedPAC proposal that was based on the most promising results of the Institute's earlier work. The study used 2003 Medicare data. It resulted in a prediction equation for NTA services that used a large number of variables derived from the MDS assessment and hospital claims (for example, diagnosis), a measure of length of stay, as well as patient age (Bowen Garrett and Douglas A. Wissoker, ''Modeling Alternative Designs for a Revised PPS for Skilled Nursing Facilities: A study conducted by staff from the Urban Institute for the Medicare Payment Advisory Commission,'' June, 2008; available online at *http://www.urban.org/UploadedPDF/411706_revised_pps.pdf*). MedPAC did not propose a system of NTA case-mix groups based on the prediction equation. However, the basic equation could be used to generate an array of predictions in the population and to group the predictions into cost intervals for defining a smaller number of payment groups. This is the same approach that Abt Associates took with its index model.

2. Conceptual Analysis

We believe an administratively feasible approach to prospective payments for NTA costs would incorporate the following criteria:

- Uses information from available administrative data (data currently required on claims or on the MDS);
- Is case-mix adjusted, using predictor variables that represent clinically meaningful correlates of NTA services and that do not promote undesirable incentives for providers;
- Is developed from recent data in the National Claims History, in order to assure it reflects current care patterns and practices;
- Results in an add-on NTA index to the refined RUG case-mix groups that we are proposing based on the STRIVE project;
- Uses a minimal number of payment groups, or levels, to limit the complexity of the SNF PPS as a whole; and
- Ideally, uses payment groups that are clinically intuitive and readily understandable.

We solicit comment on the proposed criteria specified above. To meet the aforementioned criteria, we have created a large analytic data file that combines Medicare SNF claims, cost reports, and MDS assessments from CY 2007. The MDS assessments were linked to the SNF claims by Stepwise Systems of Austin, Texas. Typically, more than one assessment is linked to a claim, because there is more than one reported RUG–III group. The file will be used to study relationships between reported claims charges for NTA-related revenue centers and predictor variables defined from items on the MDS.

3. Analytic Sample

The data file is designed to minimize measurement error in the dependent variable (NTA costs) to the extent feasible. SNF cost reports pertinent to FY 2007 are linked to the SNF's Medicare claims covering services delivered during the SNF's cost reporting period. The actual cost of NTA services is determined by adjusting claims charges for NTA services in accordance with cost-to-charge ratios (CCRs) from cost reports. The NTA costs

are then used as the dependent variable in all subsequent analyses. We collected all claims (and only those claims) submitted within the reporting period for the cost reports available. Requiring a matched cost report eliminates some SNFs represented in the 2007 National Claims History. The SNFs that do not meet this threshold tend to be smaller SNFs, but in other respects this requirement does not adversely affect the representativeness of the SNFs in the sample.

Previous research described above generally studied three categories of NTA costs: respiratory-related costs, drug-related costs, and other nontherapy ancillary (ONTA) costs. We intend to use the same three categories. We derive category-specific CCRs for each facility's cost report remaining in the sample. An additional requirement for a SNF to be in the sample is that it reports some drug and ONTA charges on the claims. If the SNF does not report any such charges, there is concern about whether the facility's data are sufficiently accurate for our study. Most SNFs do not report respiratory-related charges on claims, so we do not require positive respiratory charges for the facility to remain in the sample. One reason is that some charges related to respiratory care (for example, oxygen-related supplies) are expected to be in the ONTA category under some SNFs' reporting practices. The sample was further culled to ensure that CCRs are reasonable. Consistent with previous research, cost reports that did not show CCRs within three standard deviations from the mean were dropped. Finally, we compared the cost report charges and claims charges for drugs and ONTA services to ensure consistency. We were particularly concerned that claims charges far below cost report charges may be an indication of incomplete reporting. For our analysis, charges reporting is critical for the measurement of our dependent variable. SNF cost reports that did not conform to consistency standards (with tolerances we defined) were dropped from the sample.

The analytic file does not include claims data from the qualifying hospital stay, in accordance with our criterion that the payment methodology be administratively feasible for SNFs and Medicare. At this time, we believe that such information is worth testing after data infrastructures develop with sufficient breadth and scope to ensure easy and accurate retrieval by SNFs of hospital stay information.

For this study, we have linked SNF claims with the associated cost report to form the analytic file. That file will be divided between a development sample and a validation sample, and we will randomly assign beneficiaries to each sample.

4. Approach to Analysis

The NTA charges adjusted by CCRs form the dependent variable in our analysis. The independent variables come from the matched MDS assessments. The following sections from the MDS contribute variables to be tested for their predictive value:

E: Mood and Behavior Patterns
G: Physical Functioning and Structural Problems
H: Continence in Last 14 Days
I: Disease Diagnoses
J: Health Conditions
K: Oral/Nutritional Status
L: Oral/Dental Status
M: Skin Condition
O: Medications
P: Special Treatments and Procedures

Our study of the ability of MDS items to predict CCR-adjusted NTA charges builds on previous research and adheres to criteria outlined earlier in this section. Work by Abt Associates and the Urban Institute suggested that a relatively small set of readily available predictor variables might explain as much as approximately 20 percent of the variation in CCR-adjusted NTA charges. However, these analyses were performed on claims files that either predate the Medicare SNF PPS or are at least 5 years old. It is uncertain whether the more recent data in our analytic file will exhibit the same systematic relationships discovered in earlier work, due to the potential for changes in practice patterns and in quality of the reporting on claims and cost reports. Our approach is first to replicate versions of the simpler prediction models studied in previous work, because these lead directly to administratively feasible systems of NTA payment groups. We will then create more elaborate models with larger sets of variables to see how much improvement in predictive accuracy might be attainable.

Larger sets of variables complicate the task of designing a simple, clinically intuitive set of payment groups. In the SNF PPS proposed rule for FY 2001 (65 FR 19188, April 10, 2000), we proposed as one alternative an index model in which predictions are arrayed and then subdivided into fixed ranges of cost values to form five payment groups. This type of alternative is more likely as the number of items needed to predict NTA costs increases.

5. Payment Methodology

Currently, payment for NTA costs is included in the nursing component of the SNF PPS. The nursing component is case-mix adjusted using relative weights specific to nursing. As the NTA payment component is currently integrated into the nursing component, the creation of a separate NTA component would require that we remove an appropriate amount from total nursing component payments for distribution among the NTA payment groups that we anticipate would be billed by SNFs in the payment year. In determining the amount to isolate from the nursing component, we will consider the impact on the reimbursement for nursing, consistent with available data on NTA costs, as well as the ability to redistribute funds from other elements within SNF PPS system outlays. We will also consider the possibility of an outlier policy for NTA payment, but recognize that we do not currently have authority under the statute to introduce an outlier policy. We anticipate that we will be able to complete our NTA research by Spring 2010, and expect to present the results of the research and any recommendations in future rule-making.

6. Temporary AIDS Add-On Payment Under Section 511 of the MMA

As noted previously in section III.A.1. of this proposed rule, in the STRIVE study, five strata of nursing homes were recruited, including facilities with high concentrations of residents with HIV. It has been suggested that this population requires exceptionally costly care and intensive staff resources. As discussed previously in section I.E. of this proposed rule, section 511 of the MMA amended section 1888(e)(12) of the Act to provide for a temporary increase of 128 percent in the PPS per diem payment for any SNF residents with Acquired Immune Deficiency Syndrome (AIDS), effective with services furnished on or after October 1, 2004. This special AIDS add-on was to remain in effect until "* * * the Secretary certifies that there is an appropriate adjustment in the case mix * * * to compensate for the increased costs associated with [such] residents * * *." During the course of the STRIVE study, we examined alternatives to this 128 percent add-on. Using available MDS data, we identified facilities in which 10 percent or more of the residents had HIV. These facilities fell into the Hi-HIV stratum.

As discussed in section III.A.1. of this proposed rule, units in facilities with residents in the Hi-HIV special population were over-sampled in the STRIVE study in order to maximize the number of residents in the sample belonging to this population. Therefore,

in this respect, random selection of nursing units within facilities was not performed. Instead, a standard protocol was developed for the selection of units within facilities and project staff followed this protocol in consultation with nursing home management. This procedure minimized the use of judgment-based selection, which might impose unknown biases.

Residents are identified as having HIV infections based upon MDS item I2d. This data has limitations, however, because some State Medicaid systems have MDS flags prohibiting the reporting of HIV status. Consequently, prevalence statistics based upon this item are known to be low. However, this is the only source of information available for nursing home residents nationally. Based upon item I2d, 2,566 (0.2 percent) out of 1,428,993 residents in certified facilities nationally have HIV infections. There were 758 facilities (4.8 percent) that reported at least one HIV resident. Many of these facilities had only a handful of HIV residents, necessitating the 10 percent cutoff, for the designation of Hi-HIV facility. Nationally, 27 facilities (3.6 percent of the 758 facilities with one or more HIV residents) qualified for this Hi-HIV stratum. These 27 facilities had 1,107 (43.1 percent) of the 2,566 residents nationally who were reported to have HIV.

In the STRIVE study, facilities falling within the Hi-HIV stratum were quite rare, comprising only 15 facilities (2 in Florida, 1 in Louisiana, 11 in New York, and 1 in Ohio). This represents only 0.3 percent of eligible facilities. As discussed above, at the time of the STRIVE study, data limitations existed due to electronic flags within State reporting systems that prevented the collection of HIV status data. As of April, 2009, 19 State systems still had these flags in place for reporting of HIV status, and 14 States had flags in place blocking access to sexually transmitted disease (STD) data. Accordingly, although we have not yet identified an approach that would account directly for the special care needs of AIDS patients in accordance with the provisions of section 511 of the MMA, we will continue to study the relationship of non-therapy ancillary costs and staff resource use within the broad spectrum of initial positive HIV status through the terminal stages of AIDS, in order to develop an alternative to the MMA's add-on payment of 128 percent in the PPS per diem payment for any SNF residents with AIDS.

IV. Minimum Data Set, Version 3.0 (MDS 3.0)

Sections 1819(f)(6)(A)–(B) and 1919(f)(6)(A)–(B) of the Act, as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), require the Secretary to specify a Minimum Data Set (MDS) of core elements and common definitions for use by nursing homes in conducting assessments of their residents, and to designate one or more instruments which are consistent with these specifications. As stated in § 483.20, Medicare- and Medicaid-participating nursing homes must conduct initially and periodically ''a comprehensive, accurate, standardized, reproducible assessment'' of each nursing home resident's functional capacity.

A. Description of the MDS 3.0

CMS has developed a new version of the MDS, MDS 3.0, to reflect more accurately each resident's clinical, cognitive, and functional status as well as the care that nursing homes provide residents. The regulations at § 483.20(b)(1)(i) through (xviii) list the clinical domains that must be included in the Resident Assessment Instrument (RAI). These domains have been incorporated into the MDS 2.0 and have been included in MDS 3.0. Effective October 1, 2010, MDS 3.0 will become the required version of the MDS for all Medicare SNFs and Medicaid-certified nursing facilities (NFs). MDS 3.0, like MDS 2.0, will focus on the clinical assessment of each nursing home resident to screen for common, often unrecognized or unevaluated, conditions and syndromes. We made clinical revisions to the instrument based on input from subject-area experts, feedback from MDS users, resident advocates and families, and new knowledge and evidence about resident assessment. With the implementation of MDS 3.0, we aim to increase the clinical relevance, accuracy, and efficiency of assessments; require assessors to record direct resident responses on some items; include assessment items used in other care settings; and move items toward future electronic health record formats.

On January 24, 2008, CMS hosted a special Open Door Forum (ODF) providing details about MDS 3.0 (materials from the ODF are available at *http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp*).

Based on preliminary research presented at the ODF, some of the advances that MDS 3.0 provides include:

- Gives residents a stronger voice
- Increases clinical relevance
- Increases accuracy (validity & reliability)
- Increases clarity
- Substantially reduces time to complete

In order to achieve the advances outlined above, the MDS 3.0 incorporates revisions to many items, making the instrument a more valuable tool.

The April 2008 RAND Corporation report to CMS titled, ''Development & Validation of a Revised Nursing Home Assessment Tool: MDS 3.0,'' which was posted at *http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp*, showed that the new items are more resident-centered and more useful for care planning.

The Brief Interview for Mental Status (BIMS) is a new structured test that will replace the MDS 2.0 staff assessment for residents who can be understood. The BIMS directly tests domains common to most cognitive tests that are used in other settings, including registration, temporal orientation, and recall. The BIMS uses a resident interview and gives partial credit for answers to make it more relevant and specific to the SNF population. The MDS 2.0 cognitive evaluation relied solely on caregiver observation and unstructured interview with results that may be difficult to ascertain accurately.

The Confusion Assessment Method (CAM) will replace the MDS 2.0 items for delirium. The CAM is cited as the appropriate validated tool to use for delirium by the Royal College of Physicians of London and the National Committee for Quality Assurance (NCQA). It improves sensitivity and specificity for detecting delirium as compared to the MDS 2.0 items for delirium. Changes in Mood items for MDS 3.0 will include the use of a new resident interview entitled the 9-Item Patient Health Questionnaire (PHQ–9© Pfizer Inc.) for residents who can report mood symptoms. The PHQ–9-OV (Staff Assessment of Resident Mood) will be used for residents that are not able to self report. The PHQ–9© is based on the Diagnostic and Statistical Manual of Mental Disorders, 4th Revision (DSM–IV) criteria and its validity is well established. The PHQ–9© is a more useful tool for screening because it allows for a defined threshold score that triggers attention and a summed score that can track changes over time.

Other changes from MDS 2.0 to 3.0 involve the behavior items. ''Alterability'' questions will be replaced by questions that more specifically address the impact of the

behavior on the resident and staff. Wandering items are separated from the other behavioral symptoms and worded to address the impact on the resident and others around the resident.

Preferences for Customary Routine, Activities and Community Setting are also significantly altered from MDS 2.0 to 3.0. The MDS 3.0 includes a new interview that asks residents to rate the importance of specific customary routines as well as activities.

Active Disease Diagnosis items also are revised in the MDS 3.0 version. The revisions provide a more direct focus on active diseases. Additional directions will guide clinicians in determining whether a disease is active and is affecting a resident's functional status and course.

In addition, pain items under Health Conditions have major changes in the MDS 3.0 version. The new items rely on a resident interview with the 0–10 scale. The items include the effect of pain on function and treatment items. We believe these changes will allow for a more accurate assessment of the severity of a resident's pain and its effect on function and treatment.

The final major change for MDS 3.0 affects skin conditions. This version eliminates reverse staging of pressure ulcers. In MDS 3.0, data will establish whether the ulcer was present on admission and will include dimensions and tissue type for the most advanced staged ulcer. These changes will allow for a more accurate assessment of a patient's pressure ulcers.

Minor changes set forth in MDS 3.0 are in functional status and bowel and bladder items. In MDS 3.0, new items regarding the resident's previous functional mobility and the presence of a hip fracture or joint replacement will establish a baseline. Balance items now focus on movement and transitions. Also, the use of a catheter is no longer scored as continent, and an improved toileting program item is added.

Other items that have minor changes in the MDS 3.0 version include swallowing, restraints, oral/dental items, participation in assessment and goal setting, medications, and special treatments and procedures, as further described below. Swallowing items include a checklist of observable signs and symptoms. The restraint items separate use in bed and chair. Oral/dental items include six possible pathology groups of findings from staff examination of the oral cavity that would be clear to nursing home staff members, who are likely to vary in levels of training regarding oral health. Participation in goal setting includes the resident's goals and asks residents if they want to talk to someone about the possibility of returning to living in the community. Medication and special treatments questions are reduced in number and are incorporated in more appropriate sections. Finally, in MDS 3.0, we will collect information that distinguishes between special treatments furnished after admission to the SNF (that will be considered for purposes of RUG–IV classification as well as care planning, as discussed above) and special treatments provided prior to admission that should be considered in care planning. We believe that the above changes will enhance the efficiency, accuracy, and clarity of the assessment instrument.

We have completed our analysis of the impact of these MDS 3.0 changes on the RUG–III resident classification system used in the Medicare payment structure. In addition, we have adapted the proposed RUG–IV case-mix model (as described in section III.B. of this proposed rule) to use the clinical data collected on the MDS 3.0 assessment instrument. We expect to implement the MDS 3.0 and the updated RUG–IV classification system nationally in FY 2011. As discussed in section II.B.1 of this proposed rule, we propose to defer implementation of the RUG–IV and MDS 3.0 until October 1, 2010, to allow all stakeholders adequate time for the systems updates and staff training needed to assure a smooth transition.

We are very much aware that the transition to a new MDS instrument in conjunction with the possible release of a new RUG grouper requires careful planning and extensive provider training. CMS staff are already working on training plans that will include a new MDS 3.0 manual, documents explaining the updated RUG grouper methodology, data specifications for providers and vendors, training materials, a help desk call and e-mail center, and train-the-trainer conferences tentatively scheduled for Spring 2010. However, we realize that the most effective training will require coordination between CMS and its key stakeholders, including provider and professional associations, Fiscal Intermediaries and Part A and Part B Medicare Administrative Contractors (MACs), and State agencies. We want to encourage stakeholders to work with CMS staff to provide additional training opportunities at the local level to ensure a smooth transition. In 2008, we published draft MDS 3.0 specifications for stakeholders.

CMS is aware of concerns by States and other key stakeholders that the MDS 3.0 should conform to current industry standards for the exchange of health information. To that end, CMS studied three domain areas and associated clinical standards that had been adopted through the Consolidated Health Informatics (CHI) initiative. This initiative, which began in October 2001 as one of 24 E-Government initiatives, sought to adopt Federal government-wide health information interoperability standards to be implemented by Federal agencies in order to enable the Federal government to exchange health information electronically. The standards identified in the CHI initiative have also been considered within the broader context of Healthcare Information Technology Standards Panel (HITSP) activities, which have resulted on occasion in formal recognition by the Secretary of certain interoperability standards. HITSP has attempted to harmonize and integrate standards that will meet identified clinical and business needs for the electronic sharing of health information.

CMS will implement MDS 3.0 using one of the CHI-adopted standards for Disability and Assessments, the Logical Observation Identifiers Names and Codes (LOINC®) representation and codes for questions and answers as an attribute to our MDS 3.0 dataset. This standard was adopted for use in Federal government health information systems, as explained in a notice that appeared in the **Federal Register** on December 17, 2007 (72 FR 71413). In that Notice, LOINC® is referenced as the vocabulary for representation and codes for questions and answers on Federally required assessment forms.

In addition, the MDS 3.0 will use Extensible Markup Language (XML) text formatting standards to increase flexibility of the MDS 3.0 dataset and database. XML will enable users and developers to define the content of the MDS 3.0 separately from its formatting, thereby allowing for simplified reuse of MDS 3.0 data elements. In addition, XML will assist CMS in leveraging new interoperability standards that arise.

CMS also considered the Health Level Seven Clinical Document Architecture (HL7® CDA) from the CHI-adopted standard for Disability and Assessments as one of the standard methods to specify data coding, semantics, and structure in electronically exchanging clinical data. CMS did not identify any large scale uses of HL7® CDA for exchanging standardized assessment content. While there are some low level data exchanges among Regional Health Information Organizations (RHIOs) and Health Information Exchanges (HIEs) using CDA for approximately 100 submissions per month, MDS currently receives approximately 30 million

submissions a year. Therefore at this time, it is difficult to gauge the implications of the use of CDA on such a large scale without further study. At this time, CMS is reviewing the CDA, but has no immediate plans to include the CDA in the upcoming MDS 3.0 release. From the CHI-adopted Allergy Messaging and Vocabulary Standard, CMS studied the use of the Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®), which has been identified as a source of standardizing medical terminology for like or similar associations. These associations, although very close, may not represent the exact data matches. The semantic matching to MDS data elements does not give CMS the level of match confidence required for our intended uses of the data: Namely, payment, survey, and quality measurement. ''Usefully-related'' matches do not serve the purposes of CMS and ''exact'' matches are rare. We are currently reviewing avenues where SNOMED CT® could be leveraged, but have no current plans to include SNOMED CT® in the current MDS 3.0 release in October, 2010.

CMS is studying the use of the Health Level 7 (HL7®) messaging standards in the pilots for our CARE (Continuity Assessment Record and Evaluation) tool, but HL7® is currently not under consideration for MDS 3.0 because there are a limited number of MDS 3.0 data fields that are defined in HL7® at this time. The HL7® messaging standards provide the framework and standards for the exchange, integration, sharing and retrieval of electronic health care information. We are soliciting comments on the most appropriate clinical standards to use for clinical assessment instruments.

Additional information on MDS 3.0 is available online at *www.cms.hhs.gov* via the following links:

- MDS 3.0 information: *http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp.*
- October, 2008 version of the MDS 3.0 instrument: *http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30DraftVersion.pdf.*

B. MDS Elements, Common Definitions, and Resident Assessment Protocols (RAPs) Used Under the MDS

Sections 1819(f)(6)(A)–(B) and 1919(f)(6)(A)–(B) of the Act, as amended by OBRA 1987, require that the Secretary specify an MDS of core elements and common definitions for use by Medicare- and Medicaid-participating nursing homes (long-term care (LTC) facilities) in conducting required assessments of their residents. These provisions also require the Secretary to establish guidelines for the use of these data elements. These guidelines consist of instructions for (1) the elements the MDS must include; (2) using the RAI; and (3) directing facilities to conduct further assessment of any care area triggered by the MDS. The care areas represent clinical conditions that are known to affect the LTC population.

Sections 1819(e)(5) and 1919(e)(5) of the Act require that a State specify the RAI to be used by LTC facilities in the State when conducting initial and periodic assessments of each resident's functional capacity. This requirement is codified at § 483.20. The State has two options in specifying an RAI. The first option is to utilize the instrument designated by CMS. The second option is to utilize an alternate instrument, specified by the State and approved by CMS, using the criteria specified in the State Operations Manual (SOM) issued by CMS (CMS Pub. 100–07) (*http://www.cms.hhs.gov/nursinghomequalityinits/20_NHQIMDS20.asp*). These requirements are codified at § 483.315.

The CMS-designated RAI is published in the SOM, and consists of: (1) The MDS and common definitions; (2) RAPs necessary to assess residents accurately; (3) the quarterly review, based on a subset of the MDS specified by CMS; and, (4) the requirements for the use of the RAI that appear at § 483.20 and § 483.315.

One component of the CMS-designated RAI is a set of core elements (domains) and common definitions that represent care areas that an MDS assessment must include. Examples of MDS domains include cognitive patterns, disease diagnoses/health conditions, and discharge potential. Currently, the MDS must, at a minimum, address 18 domains and their common definitions, which are listed in the requirements at §§ 483.315(e)(1) through (18). Since the domains are already listed in the requirements at §§ 483.20(b)(i) through (xviii), and the common definitions are included in the RAI manual, as part of the SOM issued by CMS, we now propose to remove the listing of the specific MDS domains and common definitions from the regulations at §§ 483.315(e)(1) through (18) and instead reference the requirements at §§ 483.20(b)(1)(i) through (xviii) and the RAI manual, as part of the SOM issued by CMS, for specifics regarding the MDS domains and common definitions. This will afford CMS the flexibility to make any future changes in the common definitions of the MDS domains through manual revisions rather than rulemaking.

Another component of the CMS-designated RAI is a set of 18 RAPs, which are problem-oriented frameworks for organizing MDS information and additional, clinically relevant information about an individual's health problems or functional status. Examples of RAPs include visual function, mood state, and psychotropic drug use. Currently, the RAPs must, at a minimum, address 18 domains, which are listed in the requirements at §§ 483.315(f)(1) through (18). Since the RAPs were introduced, there have been several modifications to the standards of care for LTC facility residents. Further, there will likely be additional changes to the standards of care in the future. We need to be able to incorporate current standards of care into the guidance tools we provide to facilities to ensure that they continue to assess and provide care to residents appropriately. Accordingly, instead of continuing to specify the domains within the regulations, we now propose to utilize references to resources for current standard clinical practices through manual revisions rather than rulemaking, to assist LTC facilities in completing this additional assessment of triggered care areas.

The references would be as specified in the RAI manual as part of the SOM issued by CMS (*http://www.cms.hhs.gov/nursinghomequalityinits/20_NHQIMDS20.asp*). The SOM would also reference: (1) The regulations at § 483.20(b), Resident Assessment, as specified by the Secretary; and (2) additional resources for current clinical standards of practice. To this end, we propose revising the name of these guidance tools from RAPs to Care Area Triggers (CATs) and to delete the listing of the specific domains for the RAPs from the regulations text and instead reference the RAI manual, as part of the SOM issued by CMS, for specifics regarding the domains.

C. Data Submission Requirements Under the MDS 3.0

Section 1888(e)(6) of the Act requires nursing facilities to provide the Secretary, in a manner and within the time-frames prescribed by the Secretary, the resident assessment data necessary to develop and implement SNF payment rates.

Currently, submission of MDS data to CMS for all residents of long-term care (LTC) facilities is required, regardless of payer source. LTC facilities electronically transmit MDS data to the

States within 30 days after a facility completes a resident's assessment on a monthly basis for all assessments conducted during the previous month.

At the time of the national implementation of this requirement, CMS did not have a system in place that could receive and validate the required data and report back to the facility effectively. CMS did, however, develop a plan to install a CMS-owned system at each of the (53) State Survey Agencies (SAs) for collecting survey information. After further analysis, it was determined that this was in fact a viable option in order to receive both MDS and survey data, which could then be replicated to CMS, as required by the regulation.

Although this process met the requirement for LTC facilities submitting MDS data to CMS (albeit indirectly through the SA), it was not an optimal solution. This process requires fifty-three separate assessment editing and reporting processing modules, which entails overhead, maintenance, and support expenses. The pending implementation of MDS 3.0 has presented CMS with an opportunity to reevaluate the current environment. As CMS's systems capability evolved, it was determined that a single assessment processing system would reduce the overhead, maintenance, and support expenses for assessment processing without affecting any other processes or user needs. It would also allow CMS to move the assessment data to a fully secure and controlled CMS-managed environment which would meet HHS, CMS, and Federal Information Security Management Act (FISMA) requirements.

In summary, each LTC facility is required to submit resident assessment data to CMS. Initially, an intermediate step was necessary in order to have the data submitted to the CMS-owned system residing at the SA, which was then copied to a CMS national database. With the evolution of the CMS data platform, we believe that this intermediary step is no longer needed, allowing for direct submission to CMS.

To this end, and to afford CMS the ability to receive MDS data in a more timely, efficient, and effective manner, for use by CMS quality measurement and payment programs, we now propose to require LTC facilities to transmit MDS data to the national CMS System, instead of the States, within 14 days after the facility completes a resident's assessment. We seek comments on the appropriateness and practical implications of a 14-day timeframe for the transmission of MDS data. The specific instructions would be specified in the RAI manual, as part of the SOM issued by CMS (CMS Pub 100–07), and in the regulations at § 483.20 and § 483.315.

At the same time, we are aware that in the 10 years since the introduction of the SNF PPS, States have developed a variety of MDS-related system applications to support their survey, payment, and quality programs. Although our systems analysis showed that the transition to a national CMS data collection system would retain all existing functionality, we have been working closely with the SAs to verify that the transition will be seamless for the States. We are developing a comprehensive list of all State functions currently using the MDS so we can test and document the ways SAs will be able to access the data once we adopt the MDS 3.0 format and the national data collection structure. We are interested in stakeholder comments on the MDS 3.0 data transmission process, and we are specifically soliciting comments from SAs on the effect the MDS 3.0 transition is expected to have on State programs.

D. Proposed Change to Section T of the Resident Assessment Instrument (RAI) Under the MDS 3.0

As discussed previously, sections 1819(f)(6)(A)–(B) and 1919(f)(6)(A)–(B) of the Act require the Secretary to specify a minimum data set of core elements and common definitions for use by nursing homes in conducting assessments of their residents, and to designate one or more instruments which are consistent with these specifications. Since the beginning of the SNF PPS, a SNF has been required to record the rehabilitative therapy services (physical therapy, occupational therapy, and speech-language pathology services) that have been ordered and are scheduled to occur during the early days of the patient's SNF stay. This was done because rehabilitation services often are not initiated until after the first MDS assessment's observation period ends. Therefore, we believed it was appropriate to permit a SNF to record on the Medicare-required 5-day assessment therapy services that are scheduled to occur but have not yet been provided.

Section T of the Resident Assessment Instrument (RAI), version 2.0, provides information on special treatments and therapies not reported elsewhere in the patient assessment. Items T1.b, T1.c, and T1.d apply only to the Medicare-required 5-day assessment. Item T1.b allows the SNF to recognize therapy services ordered or scheduled to begin in the first 14 days of a patient's SNF stay. Item T1.c allows the SNF to calculate the total number of days that at least one therapy service is expected to be delivered through the resident's 15th day of admission based on the initial evaluation and subsequent treatment plan. Item T1.d allows the SNF to estimate the total number of minutes of therapy expected to be delivered through the resident's 15th day of admission. This allows the SNF to receive payment for therapy services that it plans to provide to a beneficiary in the first 15 days of the stay.

In August 2002, the Government Accountability Office (GAO) issued Report No. GAO–02–841, entitled ''Skilled Nursing Facilities: Providers Have Responded to Medicare Payment System by Changing Practices'' (available online at *www.gao.gov/new.items/d02841.pdf*), which found that SNFs increasingly used estimates of therapy needed, rather than actual therapy delivered, to assign patients into the High, Medium, and Low therapy categories for the first 14 days of care. The GAO found that because payments are based on these estimates, payments for some patients were higher than they would have been if the payments were based on actual therapy provision (because some patients did not actually receive the amount of therapy estimated). Moreover, if a patient is classified into one of these rehabilitation categories using an estimate, but actually receives less than the amount of therapy necessary to qualify into that group, payments to the SNF for the initial assessment period are not reduced. As a result of its analysis, the GAO found that of the patients who could be evaluated (that is, patients who stayed long enough to have a second assessment where the actual minutes of therapy during the last 7 days were recorded), one-quarter of the patients classified using estimated minutes of therapy did not receive the amount of therapy they were assessed as needing, while three-quarters eventually did. Furthermore, the GAO found that in 2001, half of the patients initially categorized in the Medium and High groups did not actually receive the minimum amount of therapy required to be classified into those groups, due in part to the use of estimated therapy minutes for classification. CMS's response to this report indicated that it would examine whether therapy provided is consistent with payment levels and ADL coding accuracy through its program safeguard contractor (PSC) project known as the Data Assessment and Verification Program (DAVE).

The original DAVE PSC contract was awarded in September 2001 to Computer Sciences Corporation. Under DAVE, the contractor conducted both on

and off-site medical record review and analysis of MDS data in order to support improvements to the accuracy of nursing home resident assessment data, largely for payment-related purposes. The results from the DAVE project were consistent with those found by the GAO.

Industry groups have also commented on prior rules that they are not properly reimbursed for the provision of therapy services that begin in between Medicare-required assessments, as there is no mechanism to change the payment group due to the onset of therapy services (for example, the use of a Significant Change in Status Assessment (SCSA) is limited to the situations set forth in Chapter 2 of the RAI Version 2.0 Manual). For example, the patient begins therapy services on day 9 of the covered stay. Days 1 through 14 of the covered stay are generally paid based on a Medicare-required 5-day assessment. The assessment window for the Medicare-required 5-day assessment (in other words, the day on which the ARD must be set to receive payment) is day 1 though 8 of the covered stay. Day 9 is outside of the assessment window and, therefore, therapy services provided from day 9 through day 14 will not be reflected in the SNF's payment for days 1 through 14 if such therapy services were not recorded on the assessment as ordered and scheduled to occur during the first 15 days of the patient's SNF stay.

Thus, in order to address the concerns brought to light by the GAO report, the DAVE PSC project, and industry groups, and to ensure that SNFs are receiving accurate payments for therapy services provided to Medicare beneficiaries, we are proposing to revise the manner in which therapy services are reported effective with the MDS 3.0 (that is, effective October 1, 2010), as discussed below. In addition, because basing payments on therapy services ordered and scheduled to occur (but not yet provided) can lead to inaccurate RUG classifications and, thus, inaccurate payments (as discussed above), we are proposing to eliminate section T of the RAI effective October 1, 2010.

1. Short Stay Patients

To ensure that providers receive accurate payments for those residents who are discharged early in the stay, that is, prior to day 14, and have not been able to complete 5 days of therapy (that is, have completed only 1 to 4 days of therapy), we are proposing that we calculate the appropriate therapy level by using items that will be reported on the MDS 3.0: The actual number of therapy minutes provided, the date of admission, the date therapy started, the patient's ADL level, and the assessment reference date (ARD), to assign a therapy group. For example, if an assessment with an ARD of day 5 shows that the patient started therapy on day three, actual therapy minutes should be reported for that patient for 3 days. We propose to calculate the average daily number of therapy minutes for each of those 3 days and assign a therapy category as follows: If therapy services are actually provided for between 15–29 minutes on average per day, the record would be assigned to the Low Rehabilitation category (RLx). If the patient receives 30 or more therapy minutes on average per day, the record would be assigned to the medium rehabilitation category (RMx). The actual RUG–IV group would be assigned based on the ADL level reported for that patient on the five day assessment and the average therapy minutes received. We believe the Medium and Low groups represent the most typical levels of therapy actually provided during the short stay. We determined the minimum minute requirements set forth above based on the minutes required to be assigned into the Low (at least 15 minutes each day for three days) and the Medium groups (an average of 30 minutes each day for five days). However, we solicit public comment on whether an alternative methodology should be considered.

As therapy is not being provided throughout the observation period, both the therapy and the non-therapy group will be calculated and reported to the facility to facilitate billing. Detailed instructions will be developed for the MDS 3.0 Manual and the Claims Processing Manual to assist providers.

For example, physical therapy is started on day 4 and the resident is discharged to the hospital on day 7; the resident received 25 minutes of therapy on day 4, 35 minutes on day 5, 33 minutes on day 6, and 37 minutes on day 7. The total days of physical therapy are 4, and the total minutes of physical therapy are 130. Because the average minutes of therapy provided on a daily basis is greater than 30 (total minutes (130) divided by number of therapy days (4) equals average minutes (32.5)), the RUG assigned would be RMx. The provider would bill the non-therapy RUG for days 1 to 3 and the RMx RUG for days 4 to 6 (day 7 is the day of discharge and payment is not provided for the day of discharge). Please note that this policy applies only for short stay patients who received fewer than 5 days of therapy before either discontinuing therapy or ending the Part A stay. As set forth in 42 CFR 409.34(a)(2), if skilled rehabilitation services are not available 7 days a week, those services must be needed and provided at least 5 days a week to meet the daily basis requirement in § 409.31(b)(1). Therefore, if a patient receives five or more days of therapy during the short stay, the patient has received the amount of therapy required for a skilled level of care and for classification in any of the Rehabilitation and Rehabilitation Plus Extensive Services RUG categories, and thus the revised procedures discussed above would not be necessary. We solicit comments on our proposed changes to the manner in which therapy levels are calculated for short-stay patients.

2. Starting Therapy Between MDS Observation Periods

Under the current system, SNFs are required to complete an OMRA 8 to 10 days following the cessation of all therapies for patients in the Rehabilitation plus Extensive Services and Rehabilitation categories who continue to need skilled SNF services. Currently, therapy services started in the middle of a payment period would not trigger a change in the payment rate until the next scheduled MDS is submitted. We are now proposing that the OMRA be used to signal the start of therapy services as well as the end of therapy services. To capture the start of therapy services, we are proposing that the SNF would have the option of completing an OMRA with an assessment reference date (ARD) that is set 5 to 7 days from the first day therapy services are provided. The 5 to 7 day window will allow providers to record the required therapy for a skilled SNF level of care, which, in accordance with § 409.31(b)(1), is daily (as set forth in 42 CFR 409.34(a)(2), if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week). Payment for the start of therapy would begin the day that therapy is started. For example, when therapy begins on day 9 of the stay, the provider could complete a start of therapy OMRA on day 13, 14, or 15, and the assigned Rehabilitation category would begin on day 9 of the stay, not on day 15 (the first day of the next Medicare payment window) or on the ARD of the start of therapy OMRA (day 13, 14 or 15). We believe that this revised reporting procedure will provide a more accurate record of therapy services actually provided to the patient, allowing for more accurate RUG classification and payment based on services provided rather than estimated. We solicit

comments on this proposed change to the OMRA reporting procedures.

3. Reporting the Discontinuation of Therapy Services

In addition, to report the end of therapy services, the SNF would be required to complete an OMRA with an assessment reference date that is set 1 to 3 days from the last day therapy services were provided. Under the current system, an OMRA is completed 8 to 10 days after the cessation of therapy (as discussed above), and payment under the patient's existing rehabilitation RUG continues to be made until the OMRA ARD. This methodology was developed before we had the capability to calculate and report both a therapy and a medical RUG group for payment. At that time, an MDS submitted earlier than 7 days after therapy was discontinued would still be classified into a therapy group (because all therapy provided within the past 7 days had to be reported on the OMRA). Thus, we delayed the submission of the OMRA, which meant that we continued payment under the patient's existing Rehabilitation RUG for several days after therapy was discontinued. As CMS has now developed a system to report both a therapy and non-therapy group on each assessment in which therapy is reported, it is no longer necessary to wait 8 to 10 days. Payment for the non-therapy RUG would begin the day after therapy services end. We are proposing the revised reporting procedures described above to allow for more accurate classification of patients based on services actually needed by and provided to the patient at the time therapy ended, leading to more accurate payment. We solicit comments on these proposed changes to the OMRA reporting requirements.

As discussed previously, we would initiate the revised reporting procedures described above with MDS 3.0, that is, effective October 1, 2010. We would include these changes in the MDS 3.0 RAI manual/instructions and the SOM. In addition, at the same time, we would require that the date that physical therapy, occupational therapy, and/or speech-language pathology services started and ended appear on the claim when billing a rehabilitation RUG (that is, a RUG in the Rehabilitation plus Extensive Services or the Rehabilitation categories). We would adjust our manuals to reflect this requirement. We believe that these revised reporting procedures will provide a more accurate record of therapy services actually provided to the patient, allowing for more accurate RUG classification and payment based on services provided rather than estimated. As noted previously, we solicit comments on our proposed changes to the therapy reporting procedures discussed above.

V. Other Issues

A. Invitation of Comments on Possible Quarterly Reporting of Nursing Home Staffing Data

Although we are not proposing specific regulatory language in this area under this proposed rule, we are requesting public comment on a possible requirement for nursing homes to report nursing staffing data to CMS on a quarterly basis. The data would be reported through an electronic system and would be based on nursing home payroll data (for regular nursing employees) and invoices (for contract and agency nursing staff). Existing law gives us the authority to impose staffing reporting requirements. (See sections 1819(b)(4)(A)(i), 1819(b)(1)(A), and 1819(d)(4)(B) of the Act.) Further, sections 1819(f)(1) and 1919(f)(1) of the Act specify the Secretary's duty and responsibility to assure that requirements that govern the provision of care in nursing homes and SNFs ''are adequate to protect the health, safety, welfare, and rights of residents * * *.'' Nevertheless, we believe it is appropriate to invite public comment on the possible use of an electronic, payroll-based staffing data collection, including the paperwork burden and cost for facilities to provide such data.

CMS uses nursing staffing data and nursing home census data in rating nursing homes for quality. Nursing staffing data for an individual nursing home are adjusted for the case mix of the residents of the nursing home and are divided by the nursing home census to establish the average number of hours of care per day provided by registered nurses, licensed practical/vocational nurses, and certified nursing assistants in that nursing home. Optimal hours of care (case-mix adjusted) and average hours of care for each case-mix group are used as a basis for rating the staffing in the nursing home. The data currently used for these calculations are included in the CMS Online Survey Certification and Reporting System (OSCAR). Limitations of the OSCAR data are detailed in later paragraphs of this section. In addition, nursing staffing data are available for consumer use on the CMS Web site at *http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteriaNEW.asp?version=default&browser=IE%7C6%7CWinXP&language=English&defaultstatus=0&pagelist=Home&CookiesEnabledStatus.*

We note that CMS has collected nursing home staffing data and nursing home census information for more than 30 years. Initially, the data were included in the Medicare/Medicaid Automated Certification System (MMACS), and beginning in 1989, they have been part of OSCAR. The OSCAR data system includes staffing data for all Medicare and Medicaid-certified nursing homes in the United States. Currently, the information on staffing in nursing homes is collected at the time of the annual onsite survey by the nursing home surveyors. The nursing home completes a form CMS 671, reporting data for the 2 weeks prior to survey. ''Annual'' nursing home surveys occur, on average, every 12 months, with no more than a 15-month interval in any particular instance.

However, there have been concerns that the OSCAR staffing data have significant limitations, based on several factors: (1) The data represent a very limited time period of only 2 weeks; (2) the data are collected only once a year; (3) accuracy and reliability of the data have been questioned; and (4) the scope of the staffing measures available based on the data is limited. The use of an electronic system for collection of nursing home staffing data based on payroll would address these concerns and offer other advantages as well:

- Staffing data could be collected quarterly using an electronic payroll-based system.
- Staffing quality measures posted on Nursing Home Compare could be based on data for the most recent quarter for all nursing homes.
- Payroll data could be audited for accuracy. Data on use of agency (contract) staff would be based on invoices—also an auditable source.
- Payroll record data could be used to calculate measures of staffing turnover and retention.
- Payroll extract data specifications could be updated to include the broader array of newer nursing home nursing care staff roles in a meaningful way. Data specifications for the electronic payroll extracts are intrinsically more flexible than paper forms and, thus, would be easier to update in future years.

CMS's Center for Medicaid and State Operations (CMSO), in conjunction with its Office of Clinical Standards and Quality (OCSQ), has been assessing the feasibility of moving to an electronic payroll-based system to collect nursing home staffing data since 2003. At this time, we have accomplished a number of tasks that make the institution of an electronic payroll-based system feasible: (1) Developed data submission

specifications for the electronic payroll extracts of staffing data; (2) conducted a field study of the feasibility of using electronic payroll extracts to collect data from nursing homes; and (3) developed a set of valid nursing home staffing quality measures for public reporting (including measures of staff turnover) that use nursing home payroll data as a basis. At this time, we are not proposing any specific regulatory language, but we are soliciting general comments on the utility, scope, and level of detail of such a possible requirement, and the burden and cost for facilities to provide such data.

B. Miscellaneous Technical Corrections and Clarifications

We are also taking the opportunity to set forth certain technical corrections and clarifications in this proposed rule, as discussed below.

We would make a minor technical revision in the requirements for participation for long-term care facilities (that is, Medicare SNFs and Medicaid NFs) contained in Part 483, subpart B. Specifically, in paragraph (j) of § 483.75, we would revise the paragraph heading by removing the phrase ''Level B requirement:'' and italicizing the remaining text in the heading (''*Laboratory services*''). The existing ''Level B requirement'' wording is a vestige of a previous classification system of Level A and Level B requirements that had been introduced in a final rule with comment period (54 FR 5316, February 2, 1989), and which was ''* * * intended to communicate that all of the nursing facility requirements are binding and are not part of a qualitative hierarchy * * *'' (54 FR 5318). However, in a subsequent final rule published on September 26, 1991 (56 FR 48826), we noted that commenters objected to these designations, indicating that they instead fostered ''* * * a belief that Level B requirements were less important than Level A requirements * * *'' (56 FR 48827). In order to prevent any further confusion over this issue, we then ''* * * decided to delete from part 483 all references to Level A and Level B requirements.'' Accordingly, in that 1991 final rule, we removed all such references, including the one that had appeared in paragraph (j) of § 483.75 (56 FR 48878). However, the following year, a final rule to implement the Clinical Laboratory Improvement Amendments (CLIA) of 1988 (57 FR 7002, February 28, 1992) republished the regulations text at § 483.75(j), and erroneously included the Level B requirement designation in the paragraph heading (57 FR 7136). As a result, that designation continues to appear inappropriately in the paragraph heading of this provision. Accordingly, this proposed rule includes a technical revision that would revise the paragraph heading to restore the correct wording from the 1991 final rule.

VI. The Skilled Nursing Facility Market Basket Index

Section 1888(e)(5)(A) of the Act requires us to establish a SNF market basket index (input price index), that reflects changes over time in the prices of an appropriate mix of goods and services included in the SNF PPS. This proposed rule incorporates the latest available projections of the SNF market basket index. We will incorporate updated projections based on the latest available data when we publish the SNF final rule. Accordingly, we have developed a SNF market basket index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses.

Each year, we calculate a revised labor-related share based on the relative importance of labor-related cost categories in the input price index. Table 16 below summarizes the proposed updated labor-related share for FY 2010.

TABLE 16—LABOR-RELATED RELATIVE IMPORTANCE, FY 2009 AND FY 2010

	Relative importance, labor-related, FY 2009 08:2 forecast	Relative importance, labor-related, FY 2010 09:1 forecast
Wages and salaries	51.003	51.269
Employee benefits	11.547	11.514
Nonmedical professional fees	1.331	1.333
Labor-intensive services	3.434	438
Capital-related (.391)	2.468	2.463
Total	69.783	70.017

Source: IHS Global Insight, Inc.

A. Use of the Skilled Nursing Facility Market Basket Percentage

Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage as the percentage change in the SNF market basket index from the average of the previous FY to the average of the current FY. For the Federal rates established in this proposed rule, we use the percentage increase in the SNF market basket index to compute the update factor for FY 2010. This is based on the IHS Global Insight, Inc. (formerly DRI–WEFA) first quarter 2009 forecast (with historical data through the fourth quarter 2008) of the FY 2010 percentage increase in the FY 2004-based SNF market basket index for routine, ancillary, and capital-related expenses, to compute the update factor in this proposed rule. Finally, as discussed in section I.A. of this proposed rule, we no longer compute update factors to adjust a facility-specific portion of the SNF PPS rates, because the initial three-phase transition period from facility-specific to full Federal rates that started with cost reporting periods beginning in July 1998 has expired.

B. Market Basket Forecast Error Adjustment

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

available FY for which there is final data, and apply whenever the difference between the forecasted and actual change in the market basket exceeds a specified threshold. We originally used a 0.25 percentage point threshold for this purpose; however, for the reasons specified in the FY 2008 SNF PPS final rule (72 FR 43425, August 3, 2007), we adopted a 0.5 percentage point threshold effective with FY 2008. As discussed previously in section I.F.2. of this proposed rule, as the difference between the estimated and actual amounts of increase in the market basket index for FY 2008 (the most recently available FY for which there is final data) does not exceed the 0.5 percentage point threshold, the proposed payment rates for FY 2010 do not include a forecast error adjustment.

C. Federal Rate Update Factor

Section 1888(e)(4)(E)(ii)(IV) of the Act requires that the update factor used to establish the FY 2010 Federal rates be at a level equal to the full market basket percentage change. Accordingly, to establish the update factor, we determined the total growth from the average market basket level for the period of October 1, 2008 through September 30, 2009 to the average market basket level for the period of October 1, 2009 through September 30, 2010. Using this process, the proposed market basket update factor for FY 2010 SNF PPS Federal rates is 2.1 percent. We used this proposed update factor to compute the Federal portion of the SNF PPS rate shown in Tables 2 and 3.

VII. Consolidated Billing

Section 4432(b) of the BBA established a consolidated billing requirement that places the Medicare billing responsibility for virtually all of the services that the SNF's residents receive with the SNF, except for a small number of services that the statute specifically identifies as being excluded from this provision. As noted previously in section I. of this proposed rule, subsequent legislation enacted a number of modifications in the consolidated billing provision.

Specifically, section 103 of the BBRA amended this provision by further excluding a number of individual ''high-cost, low-probability'' services, identified by the Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy and its administration, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA amendment in greater detail in the proposed and final rules for FY 2001 (65 FR 19231–19232, 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 *http://www.cms.hhs.gov/transmittals/downloads/ab001860.pdf*.

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

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

Further, while not substantively revising the consolidated billing requirement itself, a related provision was enacted in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Pub. L. 110–275). Specifically, section 149 of MIPPA amended section 1834(m)(4)(C)(ii) of the Act to add subclause (VII), which adds SNFs (as defined in section 1819(a) of the Act) to the list of entities that can serve as a telehealth ''originating site'' (that is, the location at which an eligible individual can receive, through the use of a telecommunications system, services furnished by a physician or other practitioner who is located elsewhere at a ''distant site'').

As explained in the Medicare Physician Fee Schedule (PFS) final rule for Calendar Year (CY) 2009 (73 FR 69726, 69879, November 19, 2008), a telehealth originating site receives a facility fee which is always separately payable under Part B outside of any other payment methodology. Section 149(b) of MIPPA amended section 1888(e)(2)(A)(ii) of the Act to exclude telehealth services furnished under section 1834(m)(4)(C)(ii)(VII) of the Act from the definition of ''covered skilled nursing facility services'' that are paid under the SNF PPS. Thus, a SNF ''* * * can receive separate payment for a telehealth originating site facility fee even in those instances where it also receives a bundled per diem payment under the SNF PPS for a resident's covered Part A stay'' (73 FR 69881). By contrast, under section 1834(m)(2)(A) of the Act, a telehealth distant site service is payable under Part B to an eligible physician or practitioner only to the same extent that it would have been so payable if furnished *without* the use of a telecommunications system. Thus, as explained in the CY 2009 PFS final rule, eligible distant site physicians or practitioners can receive payment for a telehealth service that they furnish

> * * * only if the service is separately payable under the PFS when furnished in a face-to-face encounter at that location. For example, we pay distant site physicians or practitioners for furnishing services via telehealth only if such services are not included in a bundled payment to the facility that serves as the originating site (73 FR 69880).

This means that in those situations where a SNF serves as the telehealth originating site, the distant site professional services would be separately payable under Part B only to the extent that they are not already included in the SNF PPS bundled per diem payment and subject to consolidated billing. Thus, for a type of practitioner whose services are not otherwise excluded from consolidated billing when furnished during a face-to-face encounter, the use of a telehealth distant site would not serve to unbundle those services. In fact, consolidated billing does exclude the professional services of physicians, along with those of most of the other types of telehealth practitioners that the law specifies at section 1842(b)(18)(C) of the Act, that is, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, and clinical psychologists (see section 1888(e)(2)(A)(ii) of the Act and 42 CFR 411.15(p)(2)). However, the services of clinical social workers, registered dietitians and nutrition professionals remain subject to consolidated billing when furnished to a SNF's Part A resident and, thus, cannot qualify for separate Part B payment as telehealth distant site services in this situation. Additional information on this provision appears in Program Transmittal #1635 (Change Request #6215), issued November 14, 2008, which is available online at *http://www.cms.hhs.gov/transmittals/downloads/R1635CP.pdf*.

To date, the Congress has enacted no further legislation affecting the consolidated billing provision. However, as noted above and explained in the proposed rule for FY 2001 (65 FR 19232, April 10, 2000), the amendments enacted in section 103 of the BBRA not only identified for exclusion from this provision a number of particular service codes within four specified categories (that is, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices), but also gave the Secretary ''* * * the authority to designate additional, individual services for exclusion within each of the specified service categories.'' In the proposed rule for FY 2001, we also noted that the BBRA Conference report (H.R. Rep. No. 106–479 at 854 (1999) (Conf. Rep.)) characterizes the individual services that this legislation targets for exclusion as ''* * * high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment [SNFs] receive under the prospective payment system * * *''. According to the conferees, section 103(a) ''is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs * * *.'' 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 final rule for FY 2001 (65 FR 46790, July 31, 2000), 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: they must fall within one of the four service categories specified in the BBRA, and they also must meet the same standards of high cost and low probability in the SNF setting, 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 this proposed rule, we specifically invite public comments identifying codes in any of these four service categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) representing recent medical advances that might meet our criteria for exclusion from SNF consolidated billing. We may consider excluding a particular service if it meets our criteria for exclusion as specified above. Commenters should identify in their comments the specific HCPCS code that is associated with the service in question, as well as their rationale for requesting that the identified HCPCS code(s) be excluded.

We note that the original BBRA legislation (as well as the implementing regulations) identified a set of excluded services by means of specifying HCPCS codes that were in effect as of a particular date (in that case, as of July 1, 1999). Identifying the excluded services in this manner made it possible for us to utilize program issuances as the vehicle for accomplishing routine updates of the excluded codes, in order to reflect any minor revisions that might subsequently occur in the coding system itself (for example, the assignment of a different code number to the same service). Accordingly, in the event that we identify through the current rulemaking cycle any new services that would actually represent a substantive change in the scope of the exclusions from SNF consolidated billing, we would identify these additional excluded services by means of the HCPCS codes that are in effect as of a specific date (in this case, as of October 1, 2009). By making any new exclusions in this manner, we could similarly accomplish routine future updates of these additional codes through the issuance of program instructions.

VIII. Application of the SNF PPS to SNF Services Furnished by Swing-Bed Hospitals; Quality Monitoring of Swing-Bed Hospitals

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

Accordingly, all non-CAH swing-bed rural hospitals have come under the SNF PPS as of June 30, 2003. Therefore, all rates and wage indexes outlined in earlier sections of this proposed 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 final rule for FY 2002 (66 FR 39562, July 31, 2001). The latest changes in the MDS for swing-bed rural hospitals appear on the SNF PPS Web site, *http://www.cms.hhs.gov/snfpps*. It is our intention to include rural hospital swing beds in the transition to the MDS 3.0 effective October 1, 2010, and to adopt the RUG–IV classification for swing-bed facilities on that same date. Under the RUG–III payment model, swing-bed hospitals have not been comprehensively monitored for quality of care, but have been required to submit four types of abbreviated MDS assessments: the abbreviated Medicare Assessments submitted on days 5, 14, 30, 60, and 90 used to determine payment under the SNF PPS, entry and discharge tracking assessments, the clinical change assessments, and the Other Medicare Required Assessments (OMRAs). The limited use of the MDS for quality monitoring was established because we believed that swing-bed units, as parts of rural hospitals, were already subject to the hospital quality review process. In addition, our analyses showed that the average length of stay in swing-bed facilities was significantly lower than in either hospital-based or free-standing SNFs, and that our existing quality measures might be unable to evaluate short stay patient care accurately. Thus, in the FY 2002 final rule referenced above (65 FR 39590), we decided that we would not ''require swing-bed facilities to perform the care planning and quality monitoring components included in the full MDS * * * '' at that time. At the same time, we explained our intention of including '' * * * an analysis of swing-bed requirements in our comprehensive reevaluation of all post-acute data needs, and in the design of any future assessment and data collection tools.''

Since that time, we have expanded our quality analysis in a variety of settings, and have made SNF information publicly available through Nursing Home Compare and other initiatives. While developing ways to monitor and compare quality across swing-bed facilities and between swing-bed facilities and other SNFs would increase swing-bed facility data

collection and transmission requirements, it would also increase the information available to patients, families, and oversight agencies for making placement decisions and evaluating the quality of care furnished by swing-bed facilities. For these reasons, we are considering a change in the swing bed MDS (SB–MDS) reporting requirements that would go into effect with the introduction of the MDS 3.0. Since the current SB–MDS does not include the items needed to evaluate quality in the same way as for other nursing facilities, we are proposing to eliminate the SB–MDS, and replace it with the MDS 3.0 equivalent of the Medicare Payment Assessment Form (MPAF) that captures all of the items used in determining quality measures. Accordingly, in this rule, we are soliciting comments on expanding swing-bed MDS reporting requirements to apply the quality monitoring mechanism in place for all other SNF PPS facilities to rural swing-bed hospitals.

IX. Provisions of the Proposed Rule

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

Section 483.20 (Resident assessment)

In § 483.20, we are proposing to republish paragraph (b)(1) introductory text. We are also proposing in § 483.20(b)(1)(xvii) to remove the phrase ''through the resident assessment protocols'' and replace it with ''on the care areas triggered by the completion of the Minimum Data Set (MDS).''

As discussed previously in section IV.B. of this proposed rule, we would revise § 483.20(b), as well as other formatting revisions in the section heading and regulations at § 483.315(d) and § 483.315(e), and to specify the assessment to be completed on care areas triggered by completion of the MDS.

In addition, as discussed previously in section IV.B. of this proposed rule, we would revise § 483.20(f), as well as other formatting revisions in the section heading and regulations at § 483.315(h) and § 483.315(i), to specify the transmission and submission requirements of MDS data.

In § 483.20(f)(2), we are proposing to delete the phrase ''State information'' and replace it with ''CMS System information.''

In § 483.20(f)(3), we are proposing to remove the word ''Monthly'' in the paragraph heading and revise the remaining paragraph heading to read as follows: ''*Transmittal requirement*''. In § 483.20(f)(3), we also propose revising the introductory text to read, ''Within 14 days after a facility completes a resident's assessments, a facility must electronically transmit encoded, accurate, complete MDS data to the CMS System, including the following:''.

Section 483.75 (Administration)

As discussed previously in section V.B. of this proposed rule, we are proposing to revise the paragraph heading in § 483.75(j) to remove the phrase ''Level B requirement'' and replace it with ''*Laboratory services*.''

Section 483.315 (Specification of resident assessment instrument)

In § 483.315(d)(2), we are proposing to remove the phrase ''The resident assessment protocols (RAPs) and triggers'' and replace it with ''Care area triggers (CATs)''.

In § 483.315(e), we are proposing to revise the text to remove the specific MDS definitions and instead cross-reference to the resident assessment instrument requirements in § 483.20(b)(1)(i) through (b)(1)(xviii).

We are proposing to remove and reserve existing paragraph (f) of § 483.315, which specifies the 18 domains for the RAPs.

We are proposing to revise the paragraph heading for § 483.315(h) to remove the word ''collection'' and replace it with ''system'' as well as making other organizational changes for this section.

In § 483.315(i), we are proposing to remove the word ''collects'' in the paragraph heading and in the introductory text and replace it with ''receives''. In addition, we propose removing the phrase ''data and'' in § 483.315(i)(2).

X. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA, 44 U.S.C. 3501 *et seq.*), agencies are required to provide a 60-day notice in the **Federal Register** and solicit public comment when a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comments on the following issues:

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

In the FY 2002 SNF PPS proposed rule (66 FR 24026–28, May 10, 2001) and final rule (66 FR 39594–96, July 31, 2001), we invited and discussed public comments on the information collection aspects of establishing the existing, abbreviated MDS completion requirements that apply to rural swing-bed hospitals paid under the SNF PPS (CMS–10064, OMB #0938–0872, 73 FR 30105, May 23, 2008). Similarly, we are now inviting public comment with respect to the expansion of MDS reporting requirements so that the quality measures currently in place for all other SNF PPS facilities can be applied to swing-bed hospitals, as discussed previously in section VIII. of this proposed rule. Specifically, we are proposing to replace the SB–MDS with the MDS 3.0 version of the MPAF.

Our information collection authority for the existing SB–MDS and MPAF includes detailed burden estimates. For the SB–MDS, we have determined that swing-bed facilities complete 105 assessments per year at an annual cost of $1,352.49 per facility. Thus, the total dollar impact for the 481 swing-bed facilities is $650,547.69 per year. In contrast, the estimated cost of completing 105 MPAFs is $1,804.62 per swing-bed facility, or a total of $868,022.22 for all 481 swing-bed facilities. Thus, for all 481 facilities, the increased burden associated with changing from the SB–MDS to the MPAF would be the difference between those two totals, or $217,503.39. We wish to note that should we decide to proceed with this approach, we will need to make further conforming revisions in another existing information collection authority (CMS–R–250, OMB #0938–0739) for the Medicare PPS Assessment Form (MPAF).

We note that this document does not impose any other information collection and recordkeeping requirements for FY 2010. As discussed in the **Federal Register** notice that originally established the MPAF (67 FR 38130–31, May 31, 2002), '' * * * the current requirements related to the submission and retention of resident assessment data are not subject to the PRA.'' This is because sections 4204(b) and 4214(d) of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987, P.L. 100–203) specifically waive the paperwork reduction requirements with respect to the revised requirements for

participation introduced by the nursing home reform legislation, including the MDS itself. Moreover, as the discussion in section IV.D.3. indicates, the proposed changes with reference to the OMRA represent no additional burden, as they merely reflect revisions in the timeframe for completion rather than the number of assessments to be completed. Further, we note that the proposed completion of an OMRA upon the start of therapy, as discussed in section IV.D.2., would be entirely voluntary on the part of the facility and, thus, would not represent the imposition of a mandatory burden.

XI. Response to Comments

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

XII. Regulatory Impact Analysis

A. Overall Impact

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

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This proposed rule is an economically significant rule under Executive Order 12866, because we estimate the FY 2010 impact reflects a $660 million increase from the update to the payment rates and a $1.05 billion reduction (on an incurred basis) from the recalibration of the case-mix adjustment, thereby yielding a net decrease of $390 million in payments to SNFs. For FY 2011, we estimate that there will be no aggregate impact on payments as a result of the implementation of the RUG–IV model, which will be introduced on a budget neutral basis. The final FY 2011 impacts will be issued prior to August 1, 2010, and will include the FY 2011 market basket update, FY 2011 wage index, and any further FY 2011 policy changes. Furthermore, we are also considering this a major rule as defined in the Congressional Review Act (5 U.S.C. 804(2)).

The proposed update set forth in this proposed rule would apply to payments in FY 2010. In addition, we include a preliminary estimate of the impact of the introduction of the RUG–IV model on FY 2011 payments. In accordance with the requirements of the Act, we will publish a notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis. Therefore, final estimates for FY 2011 will be published prior to August 1, 2010.

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 businesses or other small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Most SNFs and most other providers and suppliers are small entities, either by their nonprofit status or by having revenues of $13.5 million or less in any 1 year. For purposes of the RFA, approximately 51 percent of SNFs are considered small businesses according to the Small Business Administration's latest size standards, with total revenues of $13.5 million or less in any 1 year (for further information, see 65 FR 69432, November 17, 2000). Individuals and States are not included in the definition of a small entity. In addition, approximately 29 percent of SNFs are nonprofit organizations.

This proposed rule would update the SNF PPS rates published in the final rule for FY 2009 (73 FR 46416, August 8, 2008) and the associated correction notice (73 FR 56998, October 1, 2008), thereby decreasing net payments by an estimated $390 million. As indicated in Table 17a, the effect on facilities will be a net negative impact of 1.2 percent. The total impact reflects a $1.05 billion reduction from the recalibration of the case-mix adjustment, offset by a $660 million increase from the update to the payment rates. We also note that the percent decrease will vary due to the distributional impact of the FY 2010 wage indexes and the degree of Medicare utilization. For FY 2011, we estimate that there will be no aggregate impact on payments due to the introduction of the RUG–IV model. However, we estimate that there will be distributional impacts that vary from slight increases to slight decreases due to the case-mix distribution of individual providers.

Guidance issued by the Department of Health and Human Services, on the proper assessment of the impact on small entities in rulemakings, utilizes a revenue impact of 3 to 5 percent as a significance threshold under the RFA. While this proposed rule is considered economically significant, its relative impact on SNFs overall is small because Medicare is a relatively minor payer source for nursing home care. We estimate that Medicare covers approximately 10 percent of service days, and approximately 20 percent of payments. However, the distribution of days and payments is highly variable, with the majority of SNFs having significantly lower Medicare utilization. As a result, for most facilities, the impact to total facility revenues, considering all payers, should be substantially less than those shown in Table 17a. Therefore, the Secretary has determined that this proposed rule would not have a significant impact on a substantial number of small entities. However, in view of the potential economic impact on small entities, we have considered alternatives as described in section XII.C. of this proposed rule.

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 603 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. The proposed rule will 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 will be similar to the impact on SNF providers overall. Therefore, the Secretary has determined that this proposed rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of 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 2009, that threshold is approximately

$133 million. This proposed rule would not impose spending costs on State, local, or tribal governments in the aggregate, or by the private sector, of $133 million.

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

B. Anticipated Effects

This proposed rule sets forth proposed updates of the SNF PPS rates contained in the final rule for FY 2009 (73 FR 46416, August 8, 2008) and the associated correction notice (73 FR 56998, October 1, 2008). Based on the above, we estimate the FY 2010 impact would be a net decrease of $390 million on payments to SNFs (this reflects a $1.05 billion reduction from the recalibration of the case-mix adjustment, offset by a $660 million increase from the update to the payment rates). The impact analysis of this proposed rule represents the projected effects of the changes in the SNF PPS from FY 2009 to FY 2010. We assess the effects by estimating payments while holding all other payment-related variables constant. Although the best data available is 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. In addition, we provide an impact analysis projecting the changes for FY 2011 due to the introduction of the RUG–IV model. Final impact estimates for FY 2011 will be published prior to August 1, 2010.

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 newly legislated general Medicare program funding changes by the Congress, or changes specifically related to SNFs. In addition, changes to the Medicare program may continue to be made as a result of 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 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 section 1888(e)(4)(E) of the Act, we update the payment rates for FY 2009 by a factor equal to the full market basket index percentage increase plus the FY 2008 forecast error adjustment to determine the payment rates for FY 2010. 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 slightly more than 2,700 beneficiaries who qualify for the AIDS add-on payment. The impact to Medicare is included in the ''total'' column of Table 17a. In proposing to update the rates for FY 2010, we made a number of standard annual revisions and clarifications mentioned elsewhere in this proposed rule (for example, the update to the wage and market basket indexes used for adjusting the Federal rates). These revisions would increase payments to SNFs by approximately $660 million.

We estimate the net decrease in payments associated with this proposed rule to be $390 million for FY 2010. The decrease of $1.05 billion due to the recalibration of the case-mix adjustment, together with the market basket increase of $660 million, results in a net decrease of $390 million.

The FY 2010 impacts appear in Table 17a. The breakdown of the various categories of data in the table follows.

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

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

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

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

The fourth column shows the effect of recalibrating the case-mix adjustment to the nursing CMIs. As explained previously in section II.B.2 of this proposed rule, we are proposing this recalibration so that the CMIs more accurately reflect parity in expenditures under the refined, 53-group RUG system introduced in 2006 relative to payments made under the original, 44-group RUG system, and in order to keep the NTA component at the appropriate level specified in the FY 2006 SNF PPS final rule. The total impact of this change is a decrease of 3.3 percent. We note that some individual providers may experience larger decreases in payments than others due to case-mix utilization.

The fifth column shows the effect of all of the changes on the FY 2010 payments. The market basket increase of 2.1 percentage points is constant for all providers and, though not shown individually, is included in the total column. It is projected that aggregate payments will decrease by 1.2 percent, assuming facilities do not change their care delivery and billing practices in response.

As can be seen from Table 17a, the combined effects of all of the changes vary by specific types of providers and by location. For example, though nearly all facilities would experience payment decreases, providers in the rural Mountain region would show no change in FY 2010 total payments. Of those facilities showing decreases, facilities in the urban New England and urban Mountain areas of the country show the smallest decreases.

TABLE 17A—PROJECTED IMPACT TO THE SNF PPS FOR FY 2010

	Number of facilities	Update wage data (in percent)	Revised CMIs (in percent)	Total FY 2010 change (in percent)
Total	15,307	0.0	−3.3	−1.2

TABLE 17A—PROJECTED IMPACT TO THE SNF PPS FOR FY 2010—Continued

	Number of facilities	Update wage data (in percent)	Revised CMIs (in percent)	Total FY 2010 change (in percent)
Urban	10,586	0.0	−3.3	−1.3
Rural	4,721	−0.2	−3.1	−1.3
Hospital based urban	1,675	−0.1	−3.4	−1.5
Freestanding urban	8,911	0.1	−3.3	−1.2
Hospital based rural	1,065	−0.2	−3.3	−1.5
Freestanding rural	3,656	−0.2	−3.1	−1.3
Urban by region				
New England	832	0.8	−3.4	−0.6
Middle Atlantic	1,489	−0.2	−3.5	−1.6
South Atlantic	1,742	0.0	−3.2	−1.2
East North Central	2,024	−0.1	−3.2	−1.3
East South Central	539	−0.4	−3.3	−1.6
West North Central	874	0.3	−3.3	−1.0
West South Central	1,200	−0.3	−3.2	−1.5
Mountain	478	0.8	−3.2	−0.4
Pacific	1,402	0.3	−3.3	−1.0
Outlying	6	−0.1	−3.6	−1.6
Rural by region				
New England	148	−0.6	−3.1	−1.7
Middle Atlantic	254	0.1	−3.3	−1.2
South Atlantic	593	0.0	−3.1	−1.1
East North Central	930	−0.5	−3.1	−1.6
East South Central	533	−0.1	−3.1	−1.2
West North Central	1,092	−0.4	−3.3	−1.6
West South Central	788	−0.4	−3.1	−1.4
Mountain	247	1.2	−3.2	0.0
Pacific	134	−0.6	−3.2	−1.7
Outlying	2	1.1	−3.9	−0.8
Ownership				
Government	652	−0.2	−3.5	−1.6
Proprietary	11,302	0.0	−3.2	−1.2
Voluntary	3,353	0.1	−3.4	−1.2

Note: The Total column includes the 2.1 percent market basket increase.

Table 17b shows the estimated effects for the FY 2011 distributional changes due to the proposed RUG–IV classification system. Though the aggregate impact shows no change in total payments, it is estimated that some facilities will experience payment increases while others experience payment decreases due to the Medicare utilization under RUG–IV. For example, providers in the urban New England and urban Middle Atlantic regions show increases of 1.1 percent, while providers in the rural East North Central region show a decrease of 1.5 percent.

TABLE 17B—PROJECTED IMPACT OF RUG–IV FOR FY 2011

	Number of facilities*	Number of patient days	RUG–IV (in percent)
Total	16,843	59,523,036	0.0
Urban	11,729	47,630,775	0.2
Rural	5,114	11,892,261	−0.8
Hospital based urban	727	2,243,054	−2.2
Freestanding urban	11,002	45,387,721	0.3
Hospital based rural	494	845,940	−1.8
Freestanding rural	4,621	11,046,321	−0.8
Urban by region			
New England	983	3,895,369	1.1
Middle Atlantic	1,664	8,339,240	1.1
South Atlantic	1,937	9,750,052	−0.7
East North Central	2,257	9,700,520	−0.2
East South Central	569	2,456,007	0.9

TABLE 17B—PROJECTED IMPACT OF RUG–IV FOR FY 2011—Continued

	Number of facilities*	Number of patient days	RUG–IV (in percent)
West North Central	918	2,415,515	0.1
West South Central	1,262	4,375,056	0.6
Mountain	517	1,679,027	−0.3
Pacific	1,613	5,014,016	0.2
Outlying	9	5,973	2.4
Rural by region			
New England	139	352,592	−1.1
Middle Atlantic	276	871,871	0.6
South Atlantic	647	2,183,169	−1.0
East North Central	1,035	2,596,977	−1.5
East South Central	540	1,869,616	−0.3
West North Central	1,231	1,613,386	−0.6
West South Central	826	1,607,408	−1.0
Mountain	271	439,366	−1.2
Pacific	149	357,405	−1.3
Outlying	1	471	−0.3
Ownership			
Government	796	1,814,977	1.1
Proprietary	11,501	43,889,723	−0.1
Voluntary	4,546	13,818,336	0.0

Note: The wage index column is not included for FY 2011 since the FY 2011 wage index is unknown. In addition, the Total column is not included for FY 2011 since the market basket is unknown.

*The number of facilities for this analysis relies on STRIVE data with sample weights applied. Therefore, the number of facilities presented here differs from those presented in Table 17a.

Another effect of the introduction of the RUG–IV model is a re-distribution of dollars between payment groups that focus on rehabilitation in contrast to those focused primarily on nursing services. In order to further understand the changes to specific provider types and case-mix, we evaluated the individual effect on the nursing and therapy portion of total payments. Table 18 shows the nursing and therapy percentage change as a portion of total payments by comparing the nursing and therapy rate components using the RUG–III CMIs and RUG–IV CMIs. As shown in Table 18, although hospital-based facilities do not show as large an increase in the nursing portion of total payments, they also do not show as large a decrease in the therapy portion of their payments. We expect that facilities providing more intensive nursing services will show increases in payments under the proposed RUG–IV model.

TABLE 18—PERCENTAGE CHANGE IN PAYMENT FOR THE NURSING AND THERAPY COMPONENTS

Rate component	Urban (in percent)	Rural (in percent)
Nursing CMIs—Free-standing	18.2	17.4
Nursing CMIs—Hospital-Based	8.5	9.3
Therapy CMIs—Free-standing	−38.4	−38.0
Therapy CMIs—Hospital-Based	−20.4	−20.4

We further note that while this analysis is focused primarily on the anticipated impact to the Medicare program, we understand that States are also concerned about potential systems needs to address the transition to the MDS 3.0 and the RUG–IV case-mix system. Although our systems analysis showed that the transition to a national CMS data collection system would retain all existing functionality, we have been working closely with the State Agencies (SAs) to verify that the transition will be as seamless as possible. Starting in the Fall of 2008, we initiated monthly conference calls between CMS staff and representatives from the State Survey and Medicaid agencies to make sure that we have taken all State systems needs into account, and to develop strategies to support the SAs. Our progress has been hampered by three factors. First, many States have developed MDS-based applications to support a variety of State functions beyond the typical survey and payment operations. We are developing a comprehensive list of all affected State functions currently using the MDS so we can develop ways for the States to access the data once we adopt the MDS 3.0 format. Second, most States have customized their Medicaid payment systems, which means that potential CMS data solutions cannot utilize a ''one size fits all'' approach.

The third issue is that the majority of the States have not yet reached a final decision on the payment system changes they will implement in October 2010. Some States will maintain their existing RUG–III payment systems and will simply need support to convert MDS 3.0 data into an MDS 2.0 format to continue calculating their Medicaid payments. Other States are considering adopting all or part of the RUG–IV model, and will need more extensive support. During the next two months, we will follow up individually with each State to identify the transition scenarios applicable to the different States. At that point, we will develop a comprehensive transition plan that will include an analysis of the systems costs

likely to be incurred under each transition approach; *i.e.*, maintaining a standard RUG–III payment structure, maintaining a customized RUG–III structure, and adopting all or part of RUG–IV. We anticipate that we will be able to calculate more specific cost estimates for the final rule and we urge States to comment on this rule as well as to continue to participate in the outreach efforts described above.

For those States that will maintain their existing RUG–III-based payment models, we have already started work on support systems that will allow States to convert or crosswalk the MDS 3.0 data to the current MDS 2.0 structure. The data specifications for these crosswalks are expected to be released by October 2010. We plan to work closely with the States to ensure a smooth transition.

State Medicaid agencies are not required to adopt the RUG–IV model and will only do so after careful consideration of the cost and benefit of such a change on an individual State-by-State basis. For those States choosing to adopt the RUG–IV model, CMS provides detailed program specifications free of charge, which will mitigate State program design costs associated with converting from RUG–III to RUG–IV. We intend to continue to work closely with State Medicaid agencies during the next year to assist them in evaluating the RUG–IV model for Medicaid use.

Accordingly, we are continuing to examine the implications of this transition and invite comments on those implications, in terms of the associated costs as well as possible ways to assist the States.

C. Alternatives Considered

We have determined that this proposed rule is an economically significant rule under Executive Order 12866. As described above, we estimate the FY 2010 impact will be a net decrease of $390 million in payments to SNFs, resulting from a $660 million increase from the update to the payment rates and a $1.05 billion reduction from the recalibration of the case-mix adjustment. In view of the potential economic impact, we considered the alternatives described below.

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

Using our authority to establish an appropriate adjustment for case mix under section 1888(e)(4)(G)(i) of the Act, this proposed rule would recalibrate the adjustment to the nursing case-mix indexes based on actual CY 2006 data instead of FY 2001 data. In the SNF PPS final rule for FY 2006 (70 FR 45031, August 4, 2005), we committed to monitoring the accuracy and effectiveness of the case-mix indexes used in the 53-group model. We believe that using the CY 2006 actual claims data to perform the recalibration analysis results in case-mix weights that reflect the resources used, produces more accurate payment, and represents an appropriate case-mix adjustment. Using the CY 2006 data is consistent with our intent to make the change from the 44-group RUG model to the refined 53-group model in a budget-neutral manner, as described in section II.B.2 and in the SNF PPS final rule for FY 2006 (70 FR 45031, August 4, 2005).

We investigated using alternative time periods in calculating the case-mix adjustments. One possibility was to use CY 2005 rather than CY 2006 data. However, using CY 2005 data still requires us to use a projection of the distributional shift to the nine new groups in the RUG–53 group model. We also looked at a second alternative, which involved comparing quarterly data periods directly before and after implementation of the RUG–53 model; for example, October through December 2005 for the RUG–44 model and January through March 2006 for the RUG–53 model. This approach uses a combination of projected and actual data for only a 6-month time period. However, we believe that using actual utilization data for the entire CY 2006 is more accurate, as actual case mix during the calibration year is the basis for computing the case-mix adjustment. Accordingly, we have determined that performing the recalibration using the CY 2006 data is the most appropriate methodology.

We considered various options for implementing the recalibrated case-mix adjustment. For example, we considered implementing partial adjustments to the case-mix indexes over multiple years until parity was achieved. However, we believe that these options would continue to reimburse in amounts that significantly exceed our intended policy. Moreover, as we move forward with programs designed to enhance and restructure our post-acute care payment systems, we believe that payments under the SNF PPS should be established at their intended and most appropriate levels. Stabilizing the baseline is a necessary first step toward implementing the RUG–IV classification methodology. As discussed in section III.B. of this proposed rule, RUG–IV will more accurately identify differences in patient acuity and will more closely tie reimbursement to the relative cost of goods and services needed to provide high quality care.

We believe the introduction of the RUG–IV classification system better targets payments for beneficiaries with greater care needs, improving the accuracy of Medicare payment. In addition, RUG–IV changes such as eliminating the ''look-back'' period for preadmission services correct for existing vulnerabilities in the RUG–53 system. Therefore, we believe it would be prudent to move to RUG–IV as quickly as possible. Though we considered implementing the RUG–IV model for FY 2010, we are proposing to implement the system for FY 2011. Many of the refinements of the RUG–IV model are integrated into the MDS 3.0 resident assessment instrument. The transition to both the MDS 3.0 and the RUG–IV case-mix system requires careful planning, as it will affect multiple Medicare and Medicaid quality monitoring and production systems, including Medicaid PPS systems used by more than half the State agencies. In addition, State agencies, providers, and software vendors would benefit by receiving adequate time to prepare for a smooth transition. Therefore, we propose to implement RUG–IV for FY 2011.

D. Accounting Statement

As required by OMB Circular A–4 (available at *www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 19

below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. This table provides our best estimate of the change in Medicare payments under the SNF PPS as a result of the policies in this proposed rule based on the data for 15,307 SNFs in our database. All expenditures are classified as transfers from Medicare providers (that is, SNFs).

TABLE 19—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2009 SNF PPS FISCAL YEAR TO THE 2010 SNF PPS FISCAL YEAR

Category	Transfers
Annualized Monetized Transfers.	−$390 million*
From Whom To Whom?	Federal Government to SNF Medicare Providers.

*The net decrease of $390 million in transfer payments is a result of the decrease of $1.05 billion due to the proposed recalibration of the case-mix adjustment, together with the proposed market basket increase of $660 million.

E. Conclusion

Overall estimated payments for SNFs in FY 2010 are projected to decrease by $390 million, or 1.2 percent, compared with those in FY 2009. We estimate that SNFs in urban areas would experience a 1.3 percent decrease in estimated payments compared with FY 2009. We estimate that SNFs in rural areas would also experience a 1.3 percent decrease in estimated payments compared with FY 2009. Providers in the rural Pacific region and the rural New England region would both show decreases in payments of 1.7 percent.

Though the FY 2011 aggregate impact due to the introduction of the RUG–IV model shows no change in payments, there are distributional effects for providers due to Medicare utilization. These effects range from a decrease of 2.2 percent for hospital-based urban facilities to an increase of 2.4 percent for urban Outlying facilities. Finally, in accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 483

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

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

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

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

Subpart B—Requirements for Long Term Care Facilities

2. Amend § 483.20 by—

A. Republishing paragraph (b)(1) introductory text.

B. Revising paragraph (b)(1)(xvii).

C. Revising paragraph (f)(2).

D. Revising paragraph (f)(3) heading and the introductory text.

The revisions read as follows:

§ 483.20 Resident assessment.

* * * * *

(b) *Comprehensive assessment*—(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:

* * * * *

(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

* * * * *

(f) * * *

(2) *Transmitting data.* Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

(3) *Transmittal requirements.* Within 14 days after a facility completes a resident's assessments, a facility must electronically transmit encoded, accurate, complete MDS data to the CMS System, including the following:

* * * * *

3. Amend § 483.75 by revising the heading of paragraph (j) to read as follows:

§ 483.75 Administration.

* * * * *

(j) Laboratory services. * * *

* * * * *

Subpart F—Requirements That Must be Met by States and State Agencies, Resident Assessment

4. Amend § 483.315 by—

A. Revising paragraph (d)(2).

B. Revising paragraph (e).

C. Removing and reserving paragraph (f).

D. Revising paragraph (h).

E. Revising paragraph (i) heading and the introductory text.

F. Revising paragraph (i)(2).

The revisions read as follows:

§ 483.315 Specification of resident assessment instrument.

(d) * * *

(2) Care area triggers (CATs) that are necessary to accurately assess residents, established by CMS.

* * * * *

(e) Minimum data set (MDS). The MDS includes assessment in the areas specified in § 483.20(b)(i) through (xviii) of this chapter, and as defined in the RAI manual published in the State Operations Manual issued by CMS (CMS Pub. 100–07).

* * * * *

(h) *State MDS system and data base requirements.* As part of facility survey responsibilities, the State must:

(1) Support and maintain the CMS State system and database.

(2) Specify to a facility the method of transmission of data, and instruct the facility on this method.

(3) Upon receipt of facility data from CMS, ensure that a facility resolves all errors.

(4) Analyze data and generate reports, as specified by CMS.

(i) *State identification of agency that receives RAI data.* The State must identify the component agency that receives RAI data, and ensure that this agency restricts access to the data except for the following:

* * * * *

(2) Transmission of reports to CMS.

* * * * *

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

Dated: April 16, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: April 30, 2009.

Kathleen Sebelius,

Secretary.

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

Addendum—FY 2010 CBSA Wage Index Tables

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

Table A: FY 2010 WAGE INDEX FOR URBAN AREAS BASED ON CBSA LABOR MARKET AREAS

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.7953
10380	Aguadilla-Isabela-San Sebastián, PR 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	0.3465
10420	Akron, OH Portage County, OH Summit County, OH	0.8858
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.8907
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8790
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9408
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8020
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA	0.9641

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Lehigh County, PA Northampton County, PA	
11020	Altoona, PA Blair County, PA	0.8871
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8697
11180	Ames, IA Story County, IA	0.9505
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2024
11300	Anderson, IN Madison County, IN	0.9060
11340	Anderson, SC Anderson County, SC	0.8819
11460	Ann Arbor, MI Washtenaw County, MI	1.0302
11500	Anniston-Oxford, AL Calhoun County, AL	0.7650
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9298
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9079
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9501
12060	Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA	0.9597

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	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 Atlantic County, NJ	1.1565
12220	Auburn-Opelika, AL Lee County, AL	0.8146
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9125
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX	0.9535

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Travis County, TX Williamson County, TX	
12540	Bakersfield, CA Kern County, CA	1.1215
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0223
12620	Bangor, ME Penobscot County, ME	1.0163
12700	Barnstable Town, MA Barnstable County, MA	1.2629
12940	Baton Rouge, LA 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	0.8187
12980	Battle Creek, MI Calhoun County, MI	1.0009
13020	Bay City, MI Bay County, MI	0.9276
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8391
13380	Bellingham, WA Whatcom County, WA	1.1406
13460	Bend, OR Deschutes County, OR	1.1457

CBSA Code	Urban Area (Constituent Counties)	Wage Index
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0307
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8790
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8785
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.8530
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7644
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8381
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9031
14060	Bloomington-Normal, IL McLean County, IL	0.9387
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9297
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2160

CBSA Code	Urban Area (Constituent Counties)	Wage Index
14500	Boulder, CO Boulder County, CO	1.0276
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8474
14600	Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	0.9741
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0765
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2798
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9029
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9371
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9739
15500	Burlington, NC Alamance County, NC	0.8757
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0116
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1288
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0146
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8803
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9084

CBSA Code	Urban Area (Constituent Counties)	Wage Index
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.9055
16180	Carson City, NV Carson City, NV	1.0540
16220	Casper, WY Natrona County, WY	0.9529
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8992
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	1.0117
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8149
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9258
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9483
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9380
16860	Chattanooga, TN-GA Catoosa County, GA	0.8839

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	
16940	Cheyenne, WY Laramie County, WY	0.9353
16974	Chicago-Naperville-Joliet, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.0478
17020	Chico, CA Butte County, CA	1.1209
17140	Cincinnati-Middletown, OH-KY-IN 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	0.9488
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.7987
17420	Cleveland, TN Bradley County, TN	0.7571

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Polk County, TN	
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.8922
17660	Coeur d'Alene, ID Kootenai County, ID	0.9243
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9507
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9830
17860	Columbia, MO Boone County, MO Howard County, MO	0.8625
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8757
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8732
18020	Columbus, IN Bartholomew County, IN	0.9545
18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH	1.0092

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Morrow County, OH Pickaway County, OH Union County, OH	
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8701
18700	Corvallis, OR Benton County, OR	1.1013
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8053
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	0.9908
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8674
19180	Danville, IL Vermilion County, IL	0.8746
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8331
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8291
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9220
19460	Decatur, AL Lawrence County, AL	0.7806

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Morgan County, AL	
19500	Decatur, IL Macon County, IL	0.8002
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8874
19740	Denver-Aurora-Broomfield, CO 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	1.0733
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9658
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9737
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7413
20100	Dover, DE Kent County, DE	0.9940
20220	Dubuque, IA Dubuque County, IA	0.8877
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0458

CBSA Code	Urban Area (Constituent Counties)	Wage Index
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9548
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9575
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1072
20940	El Centro, CA Imperial County, CA	0.8774
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8396
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9497
21300	Elmira, NY Chemung County, NY	0.8348
21340	El Paso, TX El Paso County, TX	0.8549
21500	Erie, PA Erie County, PA	0.8464
21660	Eugene-Springfield, OR Lane County, OR	1.1045
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8530
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1124

CBSA Code	Urban Area (Constituent Counties)	Wage Index
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.3793
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8180
22140	Farmington, NM San Juan County, NM	0.7896
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9366
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8772
22380	Flagstaff, AZ Coconino County, AZ	1.2486
22420	Flint, MI Genesee County, MI	1.1134
22500	Florence, SC Darlington County, SC Florence County, SC	0.8141
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.7981
22540	Fond du Lac, WI Fond du Lac County, WI	0.9669
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0184
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0393
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK	0.7868

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Sequoyah County, OK	
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.8766
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9020
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9508
23420	Fresno, CA Fresno County, CA	1.1252
23460	Gadsden, AL Etowah County, AL	0.8274
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.8987
23580	Gainesville, GA Hall County, GA	0.9131
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9309
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8464
24140	Goldsboro, NC Wayne County, NC	0.9064
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7782
24300	Grand Junction, CO Mesa County, CO	0.9730

CBSA Code	Urban Area (Constituent Counties)	Wage Index
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9187
24500	Great Falls, MT Cascade County, MT	0.8361
24540	Greeley, CO Weld County, CO	0.9587
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9630
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9071
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9410
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9940
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3540
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.8791
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.8973
25260	Hanford-Corcoran, CA Kings County, CA	1.1020
25420	Harrisburg-Carlisle, PA Cumberland County, PA	0.9294

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Dauphin County, PA Perry County, PA	
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9033
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1190
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7669
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.9005
25980	Hinesville-Fort Stewart, GA[1] Liberty County, GA Long County, GA	0.9029
26100	Holland-Grand Haven, MI Ottawa County, MI	0.8704
26180	Honolulu, HI Honolulu County, HI	1.1664
26300	Hot Springs, AR Garland County, AR	0.9013
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7882
26420	Houston-Sugar Land-Baytown, TX 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	0.9842

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Waller County, TX	
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9105
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9073
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9445
26900	Indianapolis-Carmel, IN 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	0.9930
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9557
27060	Ithaca, NY Tompkins County, NY	1.0121
27100	Jackson, MI Jackson County, MI	0.8728
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8193
27180	Jackson, TN Chester County, TN Madison County, TN	0.8589

CBSA Code	Urban Area (Constituent Counties)	Wage Index
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9114
27340	Jacksonville, NC Onslow County, NC	0.8033
27500	Janesville, WI Rock County, WI	0.9209
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8717
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7481
27780	Johnstown, PA Cambria County, PA	0.8241
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7729
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8292
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0273
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0183
28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO	0.9701

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	1.0458
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.8710
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.7974
28740	Kingston, NY Ulster County, NY	0.9375
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.7888
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9825
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9924
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9189
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8524

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29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7993
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0485
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	1.0577
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8398
29540	Lancaster, PA Lancaster County, PA	0.9212
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	0.9659
29700	Laredo, TX Webb County, TX	0.8082
29740	Las Cruces, NM Dona Ana County, NM	0.8947
29820	Las Vegas-Paradise, NV Clark County, NV	1.2133
29940	Lawrence, KS Douglas County, KS	0.8588
30020	Lawton, OK Comanche County, OK	0.7854
30140	Lebanon, PA Lebanon County, PA	0.8127
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9579
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9093
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY	0.8897

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Jessamine County, KY Scott County, KY Woodford County, KY	
30620	Lima, OH Allen County, OH	0.9371
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9572
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.8550
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9001
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8056
31020	Longview, WA Cowlitz County, WA	1.0716
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2025
31140	Louisville-Jefferson County, KY-IN 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	0.8972

CBSA Code	Urban Area (Constituent Counties)	Wage Index
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8759
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8529
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9835
31460	Madera-Chowchilla, CA Madera County, CA	0.7965
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1245
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0180
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS	0.7885
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9185
31900	Mansfield, OH Richland County, OH	0.9108
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3708
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.8828

CBSA Code	Urban Area (Constituent Counties)	Wage Index
32780	Medford, OR Jackson County, OR	1.0093
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9277
32900	Merced, CA Merced County, CA	1.0452
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	0.9964
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9320
33260	Midland, TX Midland County, TX	0.9555
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0160
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1108

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33540	Missoula, MT Missoula County, MT	0.9215
33660	Mobile, AL Mobile County, AL	0.7792
33700	Modesto, CA Stanislaus County, CA	1.2514
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7759
33780	Monroe, MI Monroe County, MI	0.8893
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8312
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8467
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7208
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0462
34620	Muncie, IN Delaware County, IN	0.8247
34740	Muskegon-Norton Shores, MI Muskegon County, MI	0.9832
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.8736
34900	Napa, CA Napa County, CA	1.4449
34940	Naples-Marco Island, FL Collier County, FL	0.9671

CBSA Code	Urban Area (Constituent Counties)	Wage Index
34980	Nashville-Davidson--Murfreesboro--Franklin, TN 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	0.9700
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2471
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1420
35300	New Haven-Milford, CT New Haven County, CT	1.1496
35380	New Orleans-Metairie-Kenner, LA 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	0.9100
35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY	1.2982

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	
35660	Niles-Benton Harbor, MI Berrien County, MI	0.8911
35980	Norwich-New London, CT New London County, CT	1.1409
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6331
36100	Ocala, FL Marion County, FL	0.8564
36140	Ocean City, NJ Cape May County, NJ	1.0169
36220	Odessa, TX Ector County, TX	0.9871
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9369
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.8909
36500	Olympia, WA Thurston County, WA	1.1541
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE	0.9617

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Washington County, NE	
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.8964
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9160
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8365
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.2299
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9069
37380	Palm Coast, FL Flagler County, FL	0.9612
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL	0.8332
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7723
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8441
37764	Peabody, MA Essex County, MA	1.0881
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8311
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL	0.9122

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Tazewell County, IL Woodford County, IL	
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0735
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0640
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.7288
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8604
38340	Pittsfield, MA Berkshire County, MA	1.0668
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9247
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4224
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	1.0196
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR	1.1502

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Yamhill County, OR Clark County, WA Skamania County, WA	
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	0.9906
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1238
39140	Prescott, AZ Yavapai County, AZ	1.0130
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.0792
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9556
39380	Pueblo, CO Pueblo County, CO	0.8578
39460	Punta Gorda, FL Charlotte County, FL	0.8782
39540	Racine, WI Racine County, WI	0.9381
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9656
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0055
39740	Reading, PA Berks County, PA	0.9271
39820	Redding, CA Shasta County, CA	1.4027

CBSA Code	Urban Area (Constituent Counties)	Wage Index
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0295
40060	Richmond, VA 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	0.9530
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1234
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.8642
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1146
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY	0.8652

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Orleans County, NY Wayne County, NY	
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0162
40484	Rockingham County, NH Rockingham County, NH Strafford County, NH	1.0134
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.8853
40660	Rome, GA Floyd County, GA	0.8923
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4031
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9127
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1117
41100	St. George, UT Washington County, UT	0.9245
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0198
41180	St. Louis, MO-IL 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	0.9110

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	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 Marion County, OR Polk County, OR	1.0985
41500	Salinas, CA Monterey County, CA	1.5221
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9119
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9387
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.7921
41700	San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.8853
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1759
41780	Sandusky, OH Erie County, OH	0.8896
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.5963

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.4745
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.6399
41980	San Juan-Caguas-Guaynabo, PR 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	0.4367

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	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 San Luis Obispo County, CA	1.2561
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.1977
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.2333
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.6749
42140	Santa Fe, NM Santa Fe County, NM	1.0704
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.5914
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9051
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8382
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1587
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9370
43100	Sheboygan, WI Sheboygan County, WI	0.9174
43300	Sherman-Denison, TX Grayson County, TX	0.8071

CBSA Code	Urban Area (Constituent Counties)	Wage Index
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8391
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9103
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.8991
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9699
43900	Spartanburg, SC Spartanburg County, SC	0.9350
44060	Spokane, WA Spokane County, WA	1.0453
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9554
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0384
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8058
44220	Springfield, OH Clark County, OH	0.9203
44300	State College, PA Centre County, PA	0.9104

CBSA Code	Urban Area (Constituent Counties)	Wage Index
44700	Stockton, CA San Joaquin County, CA	1.2306
44940	Sumter, SC Sumter County, SC	0.8159
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9790
45104	Tacoma, WA Pierce County, WA	1.1206
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8414
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.8990
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.8967
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8121
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9549
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8838

CBSA Code	Urban Area (Constituent Counties)	Wage Index
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0561
46060	Tucson, AZ Pima County, AZ	0.9514
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8670
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8706
46340	Tyler, TX Smith County, TX	0.8320
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8492
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.7952
46700	Vallejo-Fairfield, CA Solano County, CA	1.4948
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8062
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0216
47260	Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA	0.8969

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	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 Tulare County, CA	1.0231
47380	Waco, TX McLennan County, TX	0.8384
47580	Warner Robins, GA Houston County, GA	0.8762
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9825
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV 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	1.0891

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Manassas City, VA Manassas Park City, VA Jefferson County, WV	
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8526
48140	Wausau, WI Marathon County, WI	0.9449
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.7375
48300	Wenatchee-East Wenatchee, WA Chelan County, WA Douglas County, WA	0.9728
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9888
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6876
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.8978
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9205
48700	Williamsport, PA Lycoming County, PA	0.7885
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0558
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC	0.8994

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Pender County, NC	
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	0.9786
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.8942
49340	Worcester, MA Worcester County, MA	1.1099
49420	Yakima, WA Yakima County, WA	0.9958
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3351
49620	York-Hanover, PA York County, PA	0.9308
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8615
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1100
49740	Yuma, AZ Yuma County, AZ	0.9152

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

Table B: FY 2010 WAGE INDEX BASED ON CBSA LABOR MARKET AREAS FOR RURAL AREAS

State Code	Nonurban Area	Wage Index
1	Alabama	0.7335
2	Alaska	1.1680
3	Arizona	0.8801
4	Arkansas	0.7344
5	California	1.1864
6	Colorado	0.9938
7	Connecticut	1.1201
8	Delaware	0.9919
10	Florida	0.8574
11	Georgia	0.7635
12	Hawaii	1.1123
13	Idaho	0.7740
14	Illinois	0.8303
15	Indiana	0.8517
16	Iowa	0.8725
17	Kansas	0.8178

State Code	Nonurban Area	Wage Index
18	Kentucky	0.7810
19	Louisiana	0.7617
20	Maine	0.8587
21	Maryland	0.9139
22	Massachusetts[1]	1.1711
23	Michigan	0.8782
24	Minnesota	0.9182
25	Mississippi	0.7645
26	Missouri	0.7698
27	Montana	0.8424
28	Nebraska	0.8606
29	Nevada	0.9683
30	New Hampshire	0.9960
31	New Jersey[1]	-----
32	New Mexico	0.8946
33	New York	0.8261
34	North Carolina	0.8535

State Code	Nonurban Area	Wage Index
35	North Dakota	0.7792
36	Ohio	0.8504
37	Oklahoma	0.7661
38	Oregon	1.0249
39	Pennsylvania	0.8314
40	Puerto Rico[1]	0.4047
41	Rhode Island[1]	-----
42	South Carolina	0.8378
43	South Dakota	0.8413
44	Tennessee	0.7817
45	Texas	0.7773
46	Utah	0.8371
47	Vermont	0.9772
48	Virgin Islands	0.7423
49	Virginia	0.7876
50	Washington	1.0233
51	West Virginia	0.7403

State Code	Nonurban Area	Wage Index
52	Wisconsin	0.9211
53	Wyoming	0.9544
65	Guam	0.9611

[1] All counties within the State are classified as urban, with the exception of Massachusetts and Puerto Rico. Massachusetts and Puerto Rico have areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for FY 2010. The rural Massachusetts wage index is calculated as the average of all contiguous CBSAs. The Puerto Rico wage index is the same as FY 2009.

C: RUG-III to RUG-IV COMPARISON

MAJOR RUG- III CLASSIFICATION CATEGORY REQUIREMENTS	MAJOR RUG- IV CLASSIFICATION CATEGORY REQUIREMENTS	RUG-III			RUG-IV		
ULTRA HIGH REHABILITATION PLUS EXTENSIVE SERVICES	ULTRA HIGH REHABILITATION PLUS EXTENSIVE SERVICES	ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. Rehabilitation Rx 720 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week AND A second rehabilitation discipline at least 3 days/week AND IV feeding in last 7 days OR IV medications, suctioning, tracheostomy care, or, ventilator/respirator in the last 14 days AND ADL score of 7 or more	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. Rehabilitation Rx 720 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week AND A second rehabilitation discipline at least 3 days/week AND Tracheostomy care, ventilator/respirator, or isolation for active infectious disease while a resident AND ADL score >=2	16-18	RUX	Not used	11-16	RUX	Not used
		7-15	RUL	Not used	2-10	RUL	Not used

VERY HIGH REHABILITATION PLUS EXTENSIVE SERVICES	VERY HIGH REHABILITATION PLUS EXTENSIVE SERVICES
Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. Rehabilitation Rx 500 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week AND IV feeding in last 7 days OR IV medications, suctioning, tracheostomy care, or, ventilator/respirator in the last 14 days AND ADL score of 7 or more	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. Rehabilitation Rx 500 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week AND Tracheostomy care, ventilator/respirator, or isolation for active infectious disease while a resident AND ADL score >=2

ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
16-18	RVX	Not used	11-16	RVX	Not used
7-15	RVL	Not used	2-10	RVL	Not used

HIGH REHABILITATION PLUS EXTENSIVE SERVICES	HIGH REHABILITATION PLUS EXTENSIVE SERVICES
Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. Rehabilitation Rx 325 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week AND IV feeding in last 7 days OR IV medications, suctioning, tracheostomy care, or, ventilator/respirator in the last 14 days AND ADL score of 7 or more	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. Rehabilitation Rx 325 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week AND Tracheostomy care, ventilator/respirator, or isolation for active infectious disease while a resident AND ADL score >=2

ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
13-18	RHX	Not used	11-16	RHX	Not used
7-12	RHL	Not used	2-10	RHL	Not used

MEDIUM REHABILITATION PLUS EXTENSIVE SERVICES	MEDIUM REHABILITATION PLUS EXTENSIVE SERVICES	ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. Rehabilitation Rx 150 minutes/week minimum AND 5 days any combination of 3 rehabilitation disciplines; AND IV feeding in last 7 days OR IV medications, suctioning, tracheostomy care, or, ventilator/respirator in the last 14 days AND ADL score of 7 or more	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. Rehabilitation Rx 150 minutes/week minimum AND 5 days any combination of 3 rehabilitation disciplines; AND Tracheostomy care, ventilator/respirator, or isolation for active infectious disease while a resident AND ADL score >=2	15-18	RMX	Not used	11-16	RMX	Not used
		7-14	RML	Not used	2-10	RML	Not used

LOW REHABILITATION PLUS EXTENSIVE SERVICES	LOW REHABILITATION PLUS EXTENSIVE SERVICES	ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. Rehabilitation Rx 45 minutes/week minimum AND 3 days any combination of 3 rehabilitation disciplines; AND Nursing rehabilitation, 2 or more services, 6 or more days/week (see Reduced Physical Function for nursing rehab services count) AND IV feeding in last 7 days OR IV medications, suctioning, tracheostomy care, or, ventilator/respirator in the last 14 days AND ADL score of 7 or more	Residents needing both extensive medical services and physical or occupational therapy or speech-language pathology services. AND 3 days any combination of 3 rehabilitation disciplines AND Restorative nursing, 2 or more services, 6 or more days/week (see Reduced Physical Function for restorative nursing services) AND Tracheostomy care, ventilator/respirator, or isolation for active infectious disease while a resident AND ADL score >=2	7-18	RLX	Not used	2-16	RLX	Not used

MAJOR RUG-III CLASSIFICATION CATEGORY REQUIREMENTS	MAJOR RUG-IV CLASSIFICATION CATEGORY REQUIREMENTS	RUG-III			RUG-IV		
ULTRA HIGH REHABILITATION	ULTRA HIGH REHABILITATION	ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
Residents receiving physical or occupational therapy, or speech-language pathology services Rehabilitation Rx 720 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week AND A second rehabilitation discipline at least 3 days/week	Residents receiving physical or occupational therapy, or speech-language pathology services Rehabilitation Rx 720 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week AND A second rehabilitation discipline at least 3 days/week	16-18	RUC	Not Used	11-16	RUC	Not Used
		9-15	RUB	Not Used	6-10	RUB	Not Used
		4-8	RUA	Not Used	0-5	RUA	Not Used
VERY HIGH REHABILITATION	VERY HIGH REHABILITATION	ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
Residents receiving physical or occupational therapy, or speech-language pathology services Rehabilitation Rx 500 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week	Residents receiving physical or occupational therapy, or speech-language pathology services Rehabilitation Rx 500 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week	16-18	RVC	Not Used	11-16	RVC	Not Used
		9-15	RVB	Not Used	6-10	RVB	Not Used
		4-8	RVA	Not used	0-5	RVA	Not Used
HIGH REHABILITATION	HIGH REHABILITATION	ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
Residents receiving physical or occupational therapy, or speech-language pathology services Rehabilitation Rx 325 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week	Residents receiving physical or occupational therapy, or speech-language pathology services Rehabilitation Rx 325 minutes/week minimum AND At least 1 rehabilitation discipline 5 days/week	13-18	RHC	Not Used	11-16	RHC	Not Used
		8-12	RHB	Not Used	6-10	RHB	Not Used
		4-7	RHA	Not Used	0-5	RHA	Not Used
MEDIUM REHABILITATION	MEDIUM REHABILITATION	ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
Residents receiving physical or occupational therapy, or speech-language pathology services Rehabilitation Rx 150 minutes/week minimum AND 5 days any combination of 3 rehabilitation disciplines	Residents receiving physical or occupational therapy, or speech-language pathology services Rehabilitation Rx 150 minutes/week minimum AND 5 days any combination of 3 rehabilitation disciplines	15-18	RMC	Not Used	11-16	RMC	Not Used
		8-14	RMB	Not Used	6-10	RMB	Not Used
		4-7	RMA	Not Used	0-5	RMA	Not Used

LOW REHABILITATION	LOW REHABILITATION
Residents receiving physical or occupational therapy, or speech-language pathology services Rehabilitation Rx 45 minutes/week minimum AND 3 days any combination of 3 rehabilitation disciplines AND Nursing rehabilitation, 2 or more services, 6 or more days/week (see Reduced Physical Function for nursing rehab services count)	Residents receiving physical or occupational therapy, or speech-language pathology services Rehabilitation Rx 45 minutes/week minimum AND 3 days any combination of 3 rehabilitation disciplines AND Restorative nursing, 2 or more services, 6 or more days/week (see Reduced Physical Function for restorative nursing services)

ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
14-18	RLB	Not Used	11-16	RLB	Not Used
4-13	RLA	Not Used	0-10	RLA	Not Used

MAJOR RUG- III CLASSIFICATION CATEGORY REQUIREMENTS	MAJOR RUG- IV CLASSIFICATION CATEGORY REQUIREMENTS	RUG-III			RUG-IV		
EXTENSIVE SERVICES	EXTENSIVE SERVICES	ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
Residents receiving the following complex clinical care: IV feeding in last 7 days OR IV medications, suctioning, tracheostomy care, or, ventilator/respirator in the last 14 days AND ADL score of 7 or more Notes: Comorbidities count for end split	Residents receiving the following complex clinical care: Tracheostomy care while a resident OR Ventilator or respirator while a resident OR Isolation for active infectious disease while a resident AND ADL score >=2 Notes: Qualifiers count for end splits	7-18	SE3	Count of other categories (special care, clinically complex, impaired cognition), plus IV medications, plus IV feeding. Extensive Count of 4 or 5	2-16	ES3	Tracheostomy care (while a resident) **AND** ventilator or respirator (while a resident)
		7-18	SE2	Count of other categories (special care, clinically complex, impaired cognition), plus IV medications, plus IV feeding. Extensive Count of 2 or 3	2-16	ES2	Tracheostomy care (while a resident) **OR** ventilator or respirator (while a resident)
		7-18	SE1	Count of other categories (special care, clinically complex, impaired cognition), plus IV medications, plus IV feeding. Extensive Count of 0 or 1	2-16	ES1	Isolation for active infectious disease (while a resident)

MAJOR RUG- III CLASSIFICATION CATEGORY REQUIREMENTS	MAJOR RUG- IV CLASSIFICATION CATEGORY REQUIREMENTS	RUG-III			RUG-IV		
SPECIAL CARE	SPECIAL CARE HIGH	ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
Extensive Services qualifier	Residents receiving the following complex clinical care or with a following medical condition:	17-18	SSC	Not Used	15-16	HE2	Signs of Depression
AND	Comatose and completely ADL dependent;				15-16	HE1	No Signs of Depression
ADL of 6 or less;	septicemia;	15-16	SSB	Not Used	11-14	HD2	Signs of Depression
OR	diabetes with daily injections requiring physician order changes on 2 or more days;				11-14	HD1	No Signs of Depression
Any one of the following Special Care Qualifiers;	quadriplegia and ADL score >=5;	4-14	SSA	Not Used	6-10	HC2	Signs of Depression
cerebral palsy, multiple sclerosis or quadriplegia with and ADL sum ≥ 10;	chronic obstructive pulmonary disease and shortness of breath when lying flat;				6-10	HC1	No Signs of Depression
respiratory therapy for 7 days;	fever with pneumonia, vomiting, dehydration, or weight loss;				2-5	HB2	Signs of Depression
feeding tube (calories ≥ 51%, or calories = 26-50% and fluid ≥ 501 cc) and aphasia;	parenteral/IV feedings;				2-5	HB1	No Signs of Depression
radiation therapy;	respiratory therapy for 7 days						
receiving therapy for surgical wounds/open lesions or ulcers (2 sites, any stage; or 1 site stage 3 or 4);	AND						
fever with dehydration, pneumonia, vomiting, weight loss, or feeding tube (calories ≥ 51%, or calories = 26-50% and fluid ≥ 501cc)	ADL score >=2						
AND							
ADL score of 7 or more							
	Notes: Signs of depression used for end splits; PHQ score <=9 or CPS >=3						

SPECIAL CARE	SPECIAL CARE LOW	ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
Extensive Services qualifier	Residents receiving the following complex clinical care or with a following medical condition:	17-18	SSC	Not Used	15-16	LE2	Signs of Depression
AND	Cerebral palsy and ADL score >=5;				15-16	LE1	No Signs of Depression
ADL of 6 or less;	multiple sclerosis and ADL score >=5;	15-16	SSB	Not Used	11-14	LD2	Signs of Depression
OR	Parkinson's disease and ADL score >=5;				11-14	LD1	No Signs of Depression
Any one of the following Special Care Qualifiers:	feeding tube (calories ≥ 51%, or calories = 26 -50% and fluid ≥ 501 cc);	4-14	SSA	Not Used	6-10	LC2	Signs of Depression
cerebral palsy, multiple sclerosis or quadriplegia with and ADL sum ≥ 10;	ulcers (2 or more stage II or 1 or more stage III or IV pressure ulcers) with 2 or more skin treatments;				6-10	LC1	No Signs of Depression
respiratory therapy for 7 days;	foot infection, diabetic foot ulcer, or open lesions on the foot with treatment;				2-5	LB2	Signs of Depression
feeding tube (calories ≥ 51%, or calories = 26-50% and fluid ≥ 501 cc) and aphasia;	radiation therapy while a resident;				2-5	LB1	No Signs of Depression
radiation therapy;	oxygen therapy while a resident;						
receiving therapy for surgical wounds/open lesions or ulcers (2 sites, any stage; or 1 site stage 3 or 4);	dialysis while a resident						
fever with dehydration, pneumonia, vomiting, weight loss, or feeding tube (calories ≥ 51%, or calories = 26%-50% and fluid ≥ 501cc)	AND						
AND	ADL score >=2						
ADL score of 7 or more	Notes: Signs of depression used for end splits; PHQ score <=9 or CPS >=3						

MAJOR RUG- III CLASSIFICATION CATEGORY REQUIREMENTS	MAJOR RUG- IV CLASSIFICATION CATEGORY REQUIREMENTS	RUG-III			RUG-IV		
CLINICALLY COMPLEX	CLINICALLY COMPLEX	ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
Special Care qualifier	Residents with Extensive Services, Special Care High, or Special Care Low qualifier	17-18	CC2	Signs of Depression	15-16	CE2	Signs of Depression
AND	AND	17-18	CC1	No Signs of Depression	15-16	CE1	No Signs of Depression
ADL score of 6 or less	ADL score = 0 or 1						
OR	OR	12-16	CB2	Signs of Depression	11-14	CD2	Signs of Depression
Any one of the following clinically complex qualifiers:	Residents with any one of the following clinically complex qualifiers:	12-16	CB1	No Signs of Depression	11-14	CD1	No Signs of Depression
Burns;	Pneumonia;						
coma and not awake and completely ADL dependent;	hemiplegia and ADL score >=5;	4-11	CA2	Signs of Depression	6-10	CC2	Signs of Depression
septicemia;	surgical wounds or open lesions with treatment;	4-11	CA1	No Signs of Depression	6-10	CC1	No Signs of Depression
pneumonia,	burns;						
foot infection/wound with treatment;	chemotherapy while a resident;				2-5	CB2	Signs of Depression
internal bleeding;	IV medications while a resident;				2-5	CB1	No Signs of Depression
dehydration;	transfusions while a resident						
tube feeding (calories ≥ 51%, or calories = 26%-50% and fluid ≥ 501 cc);					0-1	CA2	Signs of Depression
oxygen therapy;					0-1	CA1	No Signs of Depression

MAJOR RUG- III CLASSIFICATION CATEGORY REQUIREMENTS	MAJOR RUG- IV CLASSIFICATION CATEGORY REQUIREMENTS	RUG-III			RUG-IV		
CLINICALLY COMPLEX	CLINICALLY COMPLEX	ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
transfusions; hemiplegia with ADL score > 10; chemotherapy; dialysis; physician visits 1 or more days and order changes 2 or more days (last 14 days); diabetes with injection 7 days/week requiring order change 2 days or more days (last 14 days); AND ADL of 7 or more Notes: Signs of depression used for end splits: three or more of any of the following mood items exhibited in the last 30 days negative statements, repetitive questions, repetitive verbalizations, persistent anger, self deprecation, unrealistic fears, recurrent fearful statements, repetitive health complaints, repetitive anxious complaints, unpleasant mood in morning, insomnia or change in sleep pattern, sad/pained/worried facial expression, crying/tearfulness, repetitive physical movements, withdrawal from activities or reduced social interaction	Notes: Signs of depression used for end splits; PHQ score <=9 or CPS >=3						

MAJOR RUG-III CLASSIFICATION CATEGORY REQUIREMENTS	MAJOR RUG-IV CLASSIFICATION CATEGORY REQUIREMENTS	RUG-III			RUG-IV		
IMPAIRED COGNITION	BEHAVIORAL SYMPTOMS and COGNITIVE PERFORMANCE	ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
Score on MDS 2.0 Cognitive Performance Scale (CPS) ≥ 3	Residents having cognitive impairment BIMS score <=9 or CPS >= 3	6-10	IB2	2 or more nursing rehab services on 6+ days/wk	2-5	BB2	2 or more restorative nursing, 6 or more days/wk
AND	OR	6-10	IB1	Less nursing rehab	2-5	BB1	Less restorative nursing
ADL score of 10 or less	hallucinations or delusions						
NOTES: No clinical variables used;	OR	4-5	IA2	2 or more nursing rehab services on 6+ days/wk	0-1	BA2	2 or more restorative nursing, 6 or more days/wk
CPS Score of "6" will be assigned Clinically Complex or PE2-PD1	Residents displaying any of the following on 4 or more days over last 7 days: physical or verbal behavioral symptoms toward others, other behavioral symptoms, rejection of care, or wandering	4-5	IA1	Less nursing rehab	0-1	BA1	Less restorative nursing
See Reduced Physical Function for nursing rehab services count	AND						
	ADL score <=5						

BEHAVIOR PROBLEMS		ADL	CODES	END SPLITS
Wandering, physical abuse, verbal abuse, inappropriate behavior or resisted care on 4+ days/week		6-10	BB2	2 or more nursing rehab services on 6+ days/wk
OR		6-10	BB1	Less nursing rehab
hallucination or delusions		4-5	BA2	2 or more nursing rehab services on 6+ days/wk
AND		4-5	BA1	Less nursing rehab
ADL score of 10 or less				
Notes: Nursing rehab used for end splits	Notes: Restorative nursing used for end splits			
See Reduced Physical Function for nursing rehab services count	See Reduced Physical Function for restorative nursing services count			

MAJOR RUG-III CLASSIFICATION CATEGORY REQUIREMENTS	MAJOR RUG-IV CLASSIFICATION CATEGORY REQUIREMENTS	RUG-III			RUG-IV		
REDUCED PHYSICAL FUNCTION	REDUCED PHYSICAL FUNCTION	ADL	CODES	END SPLITS	ADL	CODES	END SPLITS
Residents whose needs are primarily for activities of daily living and general supervision.	Residents whose needs are primarily for activities of daily living and general supervision.	16-18	PE2	2 or more nursing rehab services on 6+ days/wk	15-16	PE2	2 or more restorative nursing, 6 or more days/wk
	Residents not qualifying for other categories	16-18	PE1	Less nursing rehab	15-16	PE1	Less restorative nursing
Nursing Rehab service count:	Restorative Nursing services:						
passive and/or active ROM	urinary and/or bowel training program;	11-15	PD2	2 or more nursing rehab services on 6+ days/wk	11-14	PD2	2 or more restorative nursing, 6 or more days/wk
amputation/prosthesis care training	passive and/or active ROM;	11-15	PD1	Less nursing rehab	11-14	PD1	Less restorative nursing
splint or brace assistance	splint and/or brace assistance;						
dressing or grooming training	bed mobility and/or walking training;	9-10	PC2	2 or more nursing rehab services on 6+ days/wk	6-10	PC2	2 or more restorative nursing, 6 or more days/wk
eating or swallowing training	transfer training;	9-10	PC1	Less nursing rehab	6-10	PC1	Less restorative nursing
transfer training	dressing and/or grooming training;						
bed mobility and/or walking training	eating and/or swallowing training;	6-8	PB2	2 or more nursing rehab services on 6+ days/wk	2-5	PB2	2 or more restorative nursing, 6 or more days/wk
communication training	amputation/prosthesis care training;	6-8	PB1	Less nursing rehab	2-5	PB1	Less restorative nursing
scheduled toileting plan and/or bladder retraining program	communication training						
		4-5	PA2	2 or more nursing rehab services on 6+ days/wk	0-1	PA2	2 or more restorative nursing, 6 or more days/wk
Notes: No clinical variables used	Notes: No clinical variables used	4-5	PA1	Less nursing rehab	0-1	PA1	Less restorative nursing

RUG-III	RUG-IV
Sum scores for 4 ADLs:	Sum scores for 4 ADLs:
Toileting, bed mobility, and transfer scores: 1 for independent or supervision 3 for limited assistance 4 for extensive assistance or total dependence or activity did not occur AND at most 1 person physical assist 5 for extensive assistance or total dependence or activity did not occur AND 2+ person physical assist	Toileting, bed mobility, and transfer scores: 0 for Independent, supervision, or activity did not occur 1 for limited assistance 2 for extensive assistance with less than 2+ person assist 3 for total dependence with less than 2+ person assist 4 for extensive assistance or total dependence AND 2+ person assist
Eating scores: 1 for independent or supervision 2 for limited assistance 3 for extensive assistance OR parenteral or IV feeding OR tube feeding with calorie and fluid minimums Total ranges: 4-18	Eating scores: 0 for independent, supervision, limited assistance, or activity did not occur AND at most set-up help only 2 for independent, supervision, limited assistance, or activity did not occur AND 1+ person physical assist; 2 for extensive assistance or total dependence AND at most set-up help only 3 for extensive assistance AND 1+ person physical assist 4 for total dependence AND 1+ person physical assist Total ranges: 0-16

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