AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

FEDERAL REGISTER

Vol. 76 Friday,
No. 88 May 6, 2011

Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 413, 424, and 455
Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Disclosures of Ownership and Additional Disclosable Parties Information; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 413, 424, and 455

[CMS–1351–P]

RIN 0938–AQ29

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Disclosures of Ownership and Additional Disclosable Parties Information

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

ACTION: Proposed rule.

SUMMARY: This proposed rule presents two options for updating the payment rates used under the prospective payment system for skilled nursing facilities (SNFs), for fiscal year 2012. In this context, it examines recent changes in provider behavior relating to the implementation of the Resource Utilization Groups, version 4 (RUG–IV) case-mix classification system and considers a possible recalibration of the case-mix indexes so that they more accurately reflect parity in expenditures between RUG–IV and the previous case-mix classification system. It also includes a discussion of a Non-Therapy Ancillary component and outlier research currently under development within CMS. In addition, this proposed rule discusses the impact of certain provisions of the Affordable Care Act. It proposes to require for fiscal year 2012 and subsequent fiscal years that the SNF market basket percentage change be reduced by the multi-factor productivity adjustment. It also proposes to require Medicare SNFs and Medicaid nursing facilities to disclose certain information to the Secretary of the United States Department of Health and Human Services (the Secretary) and other entities regarding the ownership and organizational structure of their facilities. Finally, it proposes certain changes relating to the payment of group therapy services and proposes new resident assessment policies.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 27, 2011.

ADDRESSES: In commenting, please refer to file code CMS–1351–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–1351–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–1351–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 and 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 and 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:

Sandra Bastinelli, (410) 786–3630 (for disclosure of ownership).

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

John Kane, (410) 786–0557 (for information related to the development of the payment rates and case-mix indexes). Kia Sidbury, (410) 786–7816 (for information related to the wage index).

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

SUPPLEMENTARY INFORMATION: *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:

ABN Advance Beneficiary Notice
AIDS Acquired Immune Deficiency Syndrome
ARD Assessment Reference Date
ASAP Assessment Submission and Processing
BBA Balanced Budget Act of 1997, Public Law 105–33
BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public Law 106–113
BIMS Brief Interview for Mental Status
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106–554
CAH Critical Access Hospital
CBSA Core-Based Statistical Area
CCR Cost-to-Charge Ratio
CFR Code of Federal Regulations
CMI Case-Mix Index
CMS Centers for Medicare & Medicaid Services
COT Change of Therapy
EOT End of Therapy
EOT–R End of Therapy—Resumption
FQHC Federally Qualified Health Center
FR Federal Register
FY Fiscal Year
GAO Government Accountability Office
HAC Hospital-Acquired Condition
HCC Hierarchical Condition Category
HCPCS Healthcare Common Procedure Coding System
HR–III Hybrid Resource Utilization Groups, Version 3
IGI IHS (Information Handling Services) Global Insight, Inc.
MDS Minimum Data Set
MFP Multifactor Productivity
MIPPA Medicare Improvements for Patients and Providers Act of 2008, Public Law 110–275
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007, Public Law 110–173
MPAF Medicare PPS Assessment Form
MSA Metropolitan Statistical Area
NTA Non-Therapy Ancillary
OMB Office of Management and Budget
OMRA Other Medicare-Required Assessment
ONTA Other Non-Therapy Ancillary
OSCAR Online Survey Certification and Reporting System
PAC–PRD Post Acute Care Payment Reform Demonstration
PECOS Medicare Provider Enrollment, Chain, and Ownership System
PPS Prospective Payment System
QIES Quality Improvement and Evaluation System
RAI Resident Assessment Instrument
RAVEN Resident Assessment Validation Entry
RFA Regulatory Flexibility Act, Public Law 96–354
RNP Routine NTA Bundled Payment
RHC Rural Health Clinic
RIA Regulatory Impact Analysis
RTM Reimbursable Therapy Minutes
RUG–III Resource Utilization Groups, Version 3
RUG–IV Resource Utilization Groups, Version 4
RUG–53 Refined 53–Group RUG–III Case-Mix Classification System
SCHIP State Children's Health Insurance Program
SNF Skilled Nursing Facility
STM Staff Time Measurement
STRIVE Staff Time and Resource Intensity Verification
TNP Tiered Non-routine NTA Payment
UMRA Unfunded Mandates Reform Act, Public Law 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, Public Law 105–33, enacted on August 5, 1997), and amended by subsequent legislation as discussed elsewhere in this preamble. Our most recent annual update occurred in an update notice with comment period (75 FR 42886, July 22, 2010) that set forth updates to the SNF PPS payment rates for fiscal year (FY) 2011. We subsequently published a correction notice (75 FR 55801, September 14, 2010) with respect to those payment rate updates. We will respond to public comments which relate to the FY 2011 update notice, along with those relating to this current proposed rule, in the FY 2012 final rule.

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 would update the

per diem payment rates for SNFs for FY 2012. Major elements of the SNF PPS include:

• *Rates.* As discussed in section I.G.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. As further discussed in section I.G.1. of this proposed rule, for FY 2012 this adjustment will utilize the Resource Utilization Groups, version 4 (RUG–IV) case-mix classification, and will use information obtained from the required resident assessments using version 3.0 of the Minimum Data Set (MDS 3.0). (The resident assessment is approved under OMB# 0938–0739.) Additionally, as noted elsewhere in this preamble, the payment rates at various times have also reflected specific legislative provisions for certain temporary adjustments.

• *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 case-mix 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. As further discussed in section II.E. of this proposed rule, in FY 2012, this approach includes an administrative presumption that utilizes a beneficiary's initial classification in one of the upper 52 RUGs of the 66-group RUG–IV case-mix classification system to assist in making certain SNF level of care determinations. In the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the case-mix classification structure (see section II.E. of this proposed rule for a more detailed discussion of the relationship between the case-mix classification system and SNF level of care determinations).

• *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 therapy, occupational therapy, and speech-language pathology services 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 discussed 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 (Pub. L. 106–113, enacted on November 29, 1999) 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 groups in the original, 44-group Resource Utilization Groups, version 3 (RUG–III) case-mix classification system. In accordance with section 101(c)(2) of the BBRA, this temporary payment adjustment expired on January 1, 2006, upon the implementation of a refined, 53-group version of the RUG–III system, RUG–53 (see section I.G.1. of this proposed rule). We included further information on BBRA provisions that affected the SNF PPS in Program Memoranda 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 (Pub. L. 106–554, enacted December 21, 2000) 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 *http://www.cms.gov/transmittals/downloads/a0109.pdf.*

• Section 311 of the BIPA revised the statutory update formula for the SNF market basket, and also directed us to conduct a study of alternative case-mix classification systems for the SNF PPS. In 2006, we submitted a report to the Congress on this study, which is available online at *http://www.cms.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 therapy, occupational therapy, and speech-language pathology services) 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 unfeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data.

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

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

The MMA (Pub. L. 108–173, enacted on December 8, 2003) included a provision that resulted 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.gov/transmittals/downloads/r160cp.pdf.* In the SNF PPS final rule for FY 2010 (74 FR 40288, August 11, 2009), we did not address the certification of the AIDS add-on in that final rule's implementation of the case-mix refinements for RUG–IV, 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 2009 data, we identified less than 3,500 SNF residents with a diagnosis code of 042 (Human Immunodeficiency Virus (HIV) Infection). For FY 2012, an urban facility with a resident with AIDS in RUG–IV group "HC2" would have a case-mix adjusted payment of $400.01 (see Table 5) 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 $912.02.

In addition, section 410 of the MMA contained a provision that excluded from consolidated billing certain 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. The Affordable Care Act

On March 23, 2010, the Patient Protection and Affordable Care Act, Public Law 111–148, was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010) amended certain provisions of Public Law 111–148 and certain sections of the Social Security Act and, in certain instances, included "freestanding" provisions (Pub. L. 111–148 and Pub. L. 111–152 are collectively referred to in this proposed rule as "the Affordable Care Act"). Section 10325 of the Affordable Care Act included a provision involving the SNF PPS. Section 10325 postponed the implementation of the RUG–IV case-mix classification system published in the FY 2010 SNF PPS final rule (74 FR 40288, August 11, 2009), requiring that the Secretary not implement the RUG–IV case-mix classification system before October 1, 2011. Notwithstanding this postponement of overall RUG–IV implementation, section 10325 further specified that the Secretary implement, effective October 1 2010, the changes related to concurrent therapy and the look-back period that were finalized as components of RUG–IV (see 74 FR 40315–19, 40322–24, August 11, 2009). As we noted in the FY 2011 SNF PPS update notice (75 FR 42889), implementing the particular combination of RUG–III and RUG–IV features specified in section 10325 of the Affordable Care Act would require developing a revised grouper, something that could not be accomplished by that provision's effective date (October 1, 2010) without risking serious disruption to providers, suppliers, and State agencies. Accordingly, in the FY 2011 update notice (75 FR 42889), we announced our intention to proceed on an interim basis with implementation of the full RUG–IV case-mix classification system as of October 1, 2010, followed by a retroactive claims adjustment, using a hybrid RUG–III (HR–III) system reflecting the Affordable Care Act configuration, once we had developed a revised grouper that could accommodate it. In that update notice, we also invited public comment specifically on our plans for implementing section 10325 of the Affordable Care Act in this manner.

However, on December 15, 2010, the President signed H.R. 4994, the "Medicare and Medicaid Extenders Act of 2010" (Pub. L. 111–309), in which section 202 repeals section 10325 of the

Affordable Care Act. We will, therefore, leave in place permanently the implementation of the full RUG–IV system as of FY 2011, as finalized in the FY 2010 SNF PPS final rule (74 FR 40288). Moreover, as the repeal of section 10325 of the Affordable Care Act has now eliminated the need for a subsequent transition to the HR–III system, this also effectively renders moot any further discussion of public comments that we had invited on our planned implementation of that transition. In addition, we note that implementation of version 3.0 of the Minimum Data Set (MDS 3.0) has proceeded as originally scheduled, with an effective date of October 1, 2010. The MDS 3.0 RAI Manual and MDS 3.0 Item Set are published on the MDS 3.0 Training Materials Web site, at *http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp*.

We note that a parity adjustment was applied to the RUG–53 nursing case-mix weights when the RUG–III system was initially refined in 2006, in order to ensure that the implementation of the refinements would not cause any change in overall payment levels (70 FR 45031, August 4, 2005). A detailed discussion of the parity adjustment in the specific context of the RUG–IV payment rates appears in the FY 2010 SNF PPS proposed rule (74 FR 22236–38, May 12, 2009) and final rule (74 FR 40338–40339, August 11, 2009), and in the FY 2011 update notice (75 FR 42892–42893).

Accordingly, as discussed above, effective October 1, 2010, we implemented and paid claims under the RUG–IV system that was finalized in the FY 2010 SNF PPS final rule. In section IV. of this proposed rule, we discuss certain ongoing Affordable Care Act initiatives that relate to SNFs, and in section V.A., we discuss proposed revisions involving section 6101 of the Affordable Care Act, regarding required disclosure of ownership and additional disclosable parties information.

G. 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 methodology uses 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 and bad debts. 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–IV classification system uses beneficiary assessment data from the MDS 3.0 completed by SNFs to assign beneficiaries to one of 66 RUG–IV groups. The original RUG–III case-mix classification system used beneficiary assessment data from the MDS, version 2.0 (MDS 2.0) completed by SNFs to assign beneficiaries to one of 44 RUG–III groups. Then, 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–III 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 RUG–53 system appeared in the proposed and final rules for FY 2006 (70 FR 29070, May 19, 2005, and 70 FR 45026, August 4, 2005), and a detailed description of the current 66-group RUG–IV system appeared in the proposed and final rules for FY 2010 (74 FR 22208, May 12, 2009, and 74 FR 40288, August 11, 2009).

Further, in accordance with sections 1888(e)(4)(E)(ii)(IV) and (e)(5) of the Act, the Federal rates in this proposed rule reflect an update to the rates that we published in the update notice for FY 2011 (75 FR 42886, July 22, 2010) and the associated correction notice (75 FR 55801, September 14, 2010), equal to the full change in the SNF market basket index, adjusted by the forecast error correction, if applicable, and the Multifactor Productivity (MFP) adjustment for FY 2012. A more detailed discussion of the SNF market basket index and related issues appears in sections I.G.2. and VI. of this proposed rule.

2. FY 2012 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, adjusted in the manner described below, 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 2012 market basket increase is 2.7 percent, which is based on IHS Global Insight, Inc. (IGI) first quarter 2011 forecast with historical data through fourth quarter 2010.

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 2010 (the most recently available FY for which there is final data), the estimated increase in the market basket index was 2.2 percentage points, while the actual increase was 2.0 percentage points, resulting in the actual increase being 0.2 percentage point lower than the estimated increase. 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 2012 do not include a forecast error adjustment. As we stated in the final rule for FY 2004 that first promulgated the forecast error adjustment (68 FR 46058, August 4, 2003), the adjustment will "* * * reflect both upward and downward adjustments, as appropriate." Table 1 shows the forecasted and actual market basket amounts for FY 2010.

TABLE 1—DIFFERENCE BETWEEN THE FORECASTED AND ACTUAL MARKET BASKET INCREASES FOR FY 2010

Index	Forecasted FY 2010 increase *	Actual FY 2010 increase **	FY 2010 difference
SNF	2.2	2.0	−0.2

* Published in **Federal Register**; based on second quarter 2009 IHS Global Insight Inc. forecast (2004-based index).
** Based on the first quarter 2011 IHS Global Insight forecast, with historical data through the fourth quarter 2010 (2004-based index).

Furthermore, effective FY 2012, as required by section 3401(b) of the Affordable Care Act, the market basket percentage is reduced by a productivity adjustment equal to "the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost-reporting period or other annual period)" (the MFP adjustment). As discussed in greater detail in section VI.C of this proposed rule, the proposed MFP adjustment for FY 2012 is 1.2 percent.

II. FY 2012 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, 2011. 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 FY 2012 rates reflect an update using the latest market basket index, reduced by the MFP adjustment. The FY 2012 market basket increase factor is 2.7 percent, which as discussed in section VI.C of this proposed rule, is reduced by a 1.2 percent MFP adjustment. 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. As explained above in section I.C of this proposed rule, under 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, 2010, and ending September 30, 2011, and the midpoint of the Federal FY beginning October 1, 2011, and ending September 30, 2012, to which the payment rates apply. In accordance with sections 1888(e)(4)(E)(ii)(IV) and (e)(5) of the Act, we update the payment rates for FY 2012 by a factor equal to the market basket index percentage increase, as discussed in sections I.G.2 and VI. of this proposed rule. As further explained in sections I.G.2 and VI. of this proposed rule, as applicable, we adjust the market basket index by the forecast error from the most recently available FY for which there is final data and apply this adjustment whenever the difference between the forecasted and actual change in the market basket exceeds a 0.5 percentage point threshold. In addition, as further explained in sections I.G.2 and VI. of this proposed rule, effective FY 2012 and each subsequent fiscal year, we are required to reduce the market basket percentage by the MFP adjustment. 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 2012, prior to adjustment for case-mix.

TABLE 2—FY 2012 UNADJUSTED FEDERAL RATE PER DIEM URBAN

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$160.20	$120.68	$15.90	$81.76

TABLE 3—FY 2012 UNADJUSTED FEDERAL RATE PER DIEM RURAL

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$153.07	$139.15	$16.97	$83.28

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 RUG–III case-mix classification system, which tied the amount of payment to resident resource use in combination with resident characteristic information. Staff time measurement (STM) studies conducted in 1990, 1995, and 1997 provided information on resource use (time spent by staff members on residents) and resident characteristics that enabled us not only to establish RUG–III, but also to create case-mix indexes (CMIs).

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 case-mix adjustment derived from a classification system based on comprehensive resident assessments using the MDS. Case-mix classification is based, in part, on the beneficiary's need for skilled nursing care and therapy. The case-mix classification system uses clinical data from the MDS, 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. Because the MDS is a payment as well as a clinical document, we have provided extensive training on proper coding and the time frames for MDS completion in our Resident Assessment Instrument (RAI) Manual. For an MDS to be considered valid for use in determining payment, the MDS assessment must be completed in compliance with the instructions in the RAI Manual in effect at the time the assessment is completed. For payment and quality monitoring purposes, the RAI Manual consists of both the Manual instructions and the interpretive guidance and policy clarifications posted on the appropriate MDS Web site at *http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp.*

The original RUG–III grouper logic was based on clinical data collected in 1990, 1995, and 1997. As discussed in the SNF PPS proposed rule for FY 2010 (74 FR 22208, May 12, 2009), we subsequently conducted a multi-year data collection and analysis under the Staff Time and Resource Intensity Verification (STRIVE) project to update the case-mix classification system for FY 2011. The resulting RUG–IV case-mix classification system reflected the data collected in 2006–2007 during the STRIVE project, and was finalized in the FY 2010 SNF PPS final rule (74 FR 40288, August 11, 2009) to take effect in FY 2011 concurrently with an updated new resident assessment instrument, the MDS 3.0, which collects the clinical data used for case-mix classification under RUG–IV.

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.G of this proposed rule, the payment rates set forth herein reflect the use of the RUG–IV case-mix classification system from October 1, 2011, through September 30, 2012.

2. Parity Adjustment

As discussed further below, we are considering two options for the CMIs that would be applied to the FY 2012 RUG–IV payment rates.

a. Option for Recalibration of the Parity Adjustment

As explained in the FY 2011 SNF PPS notice with comment period (75 FR 42886, 42892, July 22, 2010), we applied an upward adjustment of 61 percent to the RUG–IV nursing CMIs to achieve parity between the RUG–53 and RUG–IV models, based on an analysis using final FY 2009 claims data. Our calculation of the parity adjustment used the most recent data available to estimate RUG–IV utilization. As we stated in the FY 2010 SNF PPS final rule (74 FR 40339), in the absence of actual RUG–IV utilization for FY 2011, we believed the most recent data represented the best source available, by virtue of being the closest to the FY 2011 timeframe. We also stated that as actual data for RUG–IV utilization became available, we intended to assess the effectiveness of the parity adjustment in maintaining budget neutrality and, if necessary, to recalibrate the adjustment in future years (see 74 FR 40339).

Since the FY 2011 SNF PPS update notice was published, actual first quarter RUG–IV claims data became available. Our continued monitoring of recent claims data indicates that actual RUG–IV utilization patterns differ significantly from those we had projected using the FY 2009 claims data. In particular, the proportion of patients grouped in the highest-paying RUG therapy categories, such as Ultra High Rehabilitation, greatly exceeded our expectations. This is likely due to the significant reduction in the use of concurrent therapy, which first quarter 2011 RUG–IV claims data suggest has been reduced to less than 5 percent of all therapy utilization. These first quarter 2011 RUG–IV claims also suggest a significant increase in the utilization of individual and group therapy, which, given current MDS coding instructions, may also account for the high proportion of SNF residents classified in the Ultra High Rehabilitation RUG categories.

Based on this initial RUG–IV claims data, it would appear that rather than simply achieving parity, the FY 2011 parity adjustment may have inadvertently triggered a significant increase in overall payment levels. We

believe that if this preliminary assessment is confirmed as further FY 2011 RUG–IV claims data become available, a recalibration of the parity adjustment may become warranted in the FY 2012 final rule, in order to ensure that the adjustment continues to serve as intended to make the transition from RUG–53 to RUG–IV in a budget-neutral manner. As discussed in the FY 2010 SNF PPS final rule (74 FR 40296), we believe that ensuring parity (that is, ensuring that the RUG–IV classification system is implemented as intended on a budget-neutral basis) is integral to the process of providing "for an appropriate adjustment to account for case mix" that is based upon appropriate data in accordance with section 1888(e)(4)(G)(i) of the Act. Accordingly, in this proposed rule, we include the following analysis based on first quarter RUG–IV data in order to provide the public with information on the potential scope and impact of the recalibration we are considering for FY 2012.

To determine a specific parity adjustment factor that, under the initial RUG–IV claims data currently available, would be needed to reestablish budget neutrality, we used approximately 920,000 first quarter 2011 claims (the most current data available at the time) to compare the distribution of payment days by RUG category under the original RUG–53 model with the distribution of payment days observed in the first quarter of 2011 under the RUG–IV model. Using a file which linked these 920,000 claims to the corresponding MDS assessments, we determined the appropriate RUG group for the patients covered by the aforementioned set of claims under RUG–53. This permitted a more precise comparison of the same patients under both systems, to control for potential variations in case-mix or patient volume. Given the RUG assignments for this set of SNF residents under both RUG–53 and RUG–IV, we were able to determine a distribution of RUG assignments.

To determine the appropriate parity adjustment, consistent with the methodology described in the FY 2010 SNF PPS final rule (74 FR 40296) and detailed in the FY 2006 SNF PPS proposed rule (70 FR 29077 through 29079), we determined the total number of first quarter FY 2011 RUG–IV payment days, as well as the number of first quarter FY 2011 payment days of each RUG–IV category based on the first quarter FY 2011 SNF PPS claims. By linking these FY 2011 claims with the corresponding MDS 3.0 data, we were able to determine the appropriate RUG–53 category for each FY 2011 SNF resident represented in the sample of FY 2011 claims. We multiplied the percentage of SNF residents in each RUG–IV and RUG–53 category by the total number of first quarter FY 2011 payment days of service in order to determine a distribution of RUG–IV and RUG–53 payment days, given the first quarter FY 2011 claims and linked MDS 3.0 data. We then multiplied the projected RUG–IV and RUG–53 days of service by the FY 2012 unadjusted Federal per diem payment rate components, multiplied by the unadjusted case mix indexes to establish expenditures under the RUG–53 and RUG–IV systems. The parity adjustment used to ensure that the transition between the two systems is budget-neutral and does not create, in and of itself, an increase in the amount of SNF expenditures, was determined as the percent increase necessary for the nursing CMIs to generate estimated expenditure levels under the RUG–IV system that were equal to those estimated under the RUG–53 system. Based on the first quarter FY 2011 RUG–IV claims data, we determined that the adjustment, which had originally produced an increase of 61 percent to the nursing CMIs as discussed in the FY 2011 SNF PPS update notice, would need to be decreased to 22.55 percent to achieve budget neutrality, if we were to apply the parity adjustment equally to all nursing CMIs as we have done in the past. However, given that the most notable differences between expected and actual utilization patterns occurred within the therapy RUG categories, we believe that rather than applying the new parity adjustment percentage to all the nursing CMIs, it would be more appropriate to achieve budget neutrality between the RUG–53 and RUG–IV systems by maintaining the 61 percent parity adjustment to the nursing CMIs for the RUG–IV non-therapy groups, and reducing the 61 percent parity adjustment as it applied to the nursing CMIs for the RUG–IV therapy groups. Using this recalibration methodology described above, we found that the adjustment to the nursing CMIs of the RUG–IV therapy groups necessary to achieve parity, while maintaining the 61 percent parity adjustment for RUG–IV non-therapy groups, would be an updated adjustment of 19.81 percent. An analysis of recent utilization patterns is provided in Table 4. In this proposed rule, we are including Tables 5A and 6A, which illustrate the payment rates that would be derived from nursing CMIs reflecting this recalibration methodology.

TABLE 4—FY 2011 PROJECTED VERSUS ACTUAL RUG–IV UTILIZATION DISTRIBUTION AS PERCENT OF TOTAL DAYS OF SERVICE

RUG–IV group	Projected (percent)	Actual (percent)
RUX	0.18	0.60
RUL	0.05	0.75
RVX	0.36	0.41
RVL	0.53	0.56
RHX	0.43	0.17
RHL	0.72	0.19
RMX	0.76	0.33
RML	0.79	0.28
RLX	0.00	0.01
RUC	3.56	12.68
RUB	3.26	16.19
RUA	2.12	12.80
RVC	5.49	7.82
RVB	7.17	9.67
RVA	8.61	9.13
RHC	6.34	3.77
RHB	7.09	3.54
RHA	11.41	3.54
RMC	4.95	3.06
RMB	6.84	2.42
RMA	8.74	2.41
RLB	0.21	0.07
RLA	0.23	0.06
ES3	0.52	0.14
ES2	0.17	0.14
ES1	0.35	0.29
HE2	0.04	0.10
HE1	1.40	0.32
HD2	0.32	0.09
HD1	1.30	0.42
HC2	0.78	0.06
HC1	1.33	0.33
HB2	0.78	0.07
HB1	0.61	0.31
LE2	0.05	0.12
LE1	0.70	0.65
LD2	0.28	0.12
LD1	1.31	0.78
LC2	0.26	0.07
LC1	0.60	0.57
LB2	0.02	0.04
LB1	0.34	0.23
CE2	0.15	0.04
CE1	0.21	0.21
CD2	0.58	0.07
CD1	0.70	0.46
CC2	0.36	0.07
CC1	0.67	0.53
CB2	0.65	0.05
CB1	0.53	0.44
CA2	0.32	0.07
CA1	1.41	0.66
BB2	0.07	0.02
BB1	0.27	0.22
BA2	0.01	0.01
BA1	0.26	0.17
PE2	0.03	0.02
PE1	0.07	0.17
PD2	0.00	0.03
PD1	0.38	0.38
PC2	0.01	0.05
PC1	1.26	0.51
PB2	0.02	0.01
PB1	0.59	0.25
PA2	0.05	0.01

TABLE 4—FY 2011 PROJECTED VERSUS ACTUAL RUG–IV UTILIZATION DISTRIBUTION AS PERCENT OF TOTAL DAYS OF SERVICE—Continued

RUG–IV group	Projected (percent)	Actual (percent)
PA1	0.40	0.24

Note: Projected utilization data based on STRIVE study results. Actual utilization data based on first quarter 2011 claims data.

We want to emphasize that any such recalibration would be implemented on a prospective basis only, which we believe would be the most equitable approach with regard to its potential impact on providers. For FY 2012, the aggregate impact of the recalibration described in this proposed rule would be the difference between the increase of 61 percent for all nursing CMIs (as set forth in the FY 2011 update notice), and the recalibrated increase of 19.81 percent for the nursing CMIs for the RUG–IV therapy groups (maintaining the 61 percent parity adjustment to the nursing CMIs for the RUG–IV non-therapy groups), or a negative $4.47 billion. We note that the negative $4.47 billion would be partly offset by the FY 2012 market basket adjustment factor of 1.5 percent, or $530 million, with a net result of a negative $3.94 billion update for FY 2012 (an aggregate negative impact of 11.3 percent).

We note that as an alternative to the preceding recalibration methodology, we initially considered applying a recalibration to all nursing CMIs, irrespective of RUG category. However, we found that such a recalibration most drastically affected non-therapy RUG groups, such as the Extensive Services RUG–IV group, which seemed incongruent with the perceived reasons for differences between expected and actual utilization patterns, as noted in Table 4. In addition, we considered using an analytical approach that would reflect implementing partial adjustments to the case-mix indexes over multiple years until parity is achieved. However, we believe that such an approach 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. We believe that stabilizing the baseline is a necessary first step toward properly implementing and maintaining the integrity of the RUG–IV classification methodology and the SNF PPS as a whole.

As explained above, in determining the parity adjustment in the FY 2011 update notice, we used CY 2009 data as representing the most recent final claims data available at that time. However, we believe that it is appropriate to standardize the new model for the time period in which it is used, and we believe that using actual claims data under RUG–IV would allow us to calibrate the RUG–IV model more precisely. While, in the past, we have waited for a full year of claims data before recalibrating the CMIs, under the recalibration methodology discussed above, we are considering using partial FY 2011 claims data (that is, FY 2011 RUG–IV claims data available at the time of the final rule) to recalibrate the CMIs for FY 2012 if our analysis of such data prior to the final rule confirms our initial assessment (based on first quarter FY 2011 claims data) that the parity adjustment implemented in the FY 2011 update notice has inadvertently triggered an increase in overall payments as discussed above. We believe it would be reasonable and appropriate to use actual RUG–IV claims data from FY 2011 to estimate utilization under RUG–IV, as we believe that it provides the most recent, clear evidence of utilization patterns and evolving provider behaviors under RUG–IV. Additionally, using FY 2010 claims data, we analyzed the quality of representation of the first quarter of FY 2010, in terms of both the volume of claims received and RUG distribution, for FY 2010 as a whole and found there to be no examples of seasonality which would affect predictions of SNF volume or utilization patterns. Given this analysis, we believe that using the partial FY 2011 claims data would provide a representative and reasonable sample from which to project FY 2011 utilization patterns and expenditures. We invite comments on the recalibration methodology considered above, as well as on potential alternative methodologies for recalibrating the parity adjustment in an accurate and equitable manner.

We also note that any measures taken to achieve parity for RUG–IV may happen to coincide with the introduction of various revisions under the RUG–IV system (for example, the original RUG–IV parity adjustment took effect on October 1, 2010, along with the allocation of concurrent therapy time). As noted in our discussion of the proposed allocation of group therapy time that appears later in this proposed rule in section V.C, preliminary data indicate a recent significant increase in the provision of individual and group therapy services, which have not, to date, been subject to the allocation requirement, and a corresponding decrease in the provision of concurrent therapy, which has been subject to the allocation requirement. We anticipate that imposing a similar allocation requirement for group therapy time (as discussed further in section V.C of this proposed rule) would eliminate an existing incentive to substitute such therapy for either concurrent or individual therapy.

However, even if the distribution of therapy minutes between individual, concurrent, and group therapy changes, this does not mean that a reduction in the parity adjustment for the RUG–IV therapy groups would be inappropriate. As explained previously, the purpose of the parity adjustment is simply to ensure that the transition from the RUG–53 model to the RUG–IV model does not trigger, in and of itself, an increase or decrease in overall payment levels. Because the FY 2011 first quarter RUG–IV utilization trends indicated that the most notable differences between expected and actual RUG–IV utilization patterns occurred within the therapy RUG categories, we believe that focusing any recalibration on these groups would provide for budget neutrality in an equitable manner given the RUG–IV utilization.

Moreover, even under the previous RUG–53 model, it is clear that the predominant mode of therapy that the payment rates were designed to address was individual therapy rather than concurrent or group therapy. As far back as the SNF PPS final rule for FY 2000, we specified that the minutes of group therapy received by the beneficiary may account for no more than 25 percent of the therapy (per discipline) received in a 7-day period (64 FR 41662, July 30, 1999). In addition, the SNF PPS rulemaking has on numerous occasions included discussions of concurrent therapy: In the FY 2002 proposed rule (66 FR 23991–23992, May 10, 2001) and final rule (66 FR 39567–68, July 31, 2001); in the FY 2006 proposed rule (70 FR 29082–29083, May 19, 2005) and final rule (70 FR 45036–45037, August 4, 2005); and, most recently, in the FY 2010 proposed rule (74 FR 22222–23, May 12, 2009) and final rule (74 FR 40315–19, August 11, 2009). These discussions clearly establish that we have always considered concurrent therapy as an infrequent exception rather than the norm. However, as discussed previously, the significant increase in individual and group therapy services and the reduction in concurrent therapy utilization reflected

in the first quarter RUG–IV data indicate that actual RUG–IV utilization patterns differ significantly from those we had projected using FY 2009 claims data in calculating the parity adjustment. The resulting unintended and significant increase in overall payment levels has prompted the need to reexamine the parity adjustment.

Thus, under the Medicare program, the standard of practice in the SNF setting has always been individual therapy, which is generally necessary to ensure that the services being delivered provide the high degree of individualized treatment and complex skill level required for Medicare coverage. We recognize that some SNFs may have actually used a less intensive combination of therapy modalities in the past year for some patients in response to the way in which therapy minutes were counted. However, the SNF PPS payment rates themselves have always reflected a standard of practice in which individual therapy is the predominant treatment modality. Further, because the overall payment rates under the previous RUG–III model were constructed to be sufficient to accommodate this level of resource intensity, we believe that the adequacy of those payment rates in this context would carry over to the payment rates under the current RUG–IV model, even if modified by an updated parity adjustment.

Given the apparent magnitude of the recalibration that would be needed to restore parity based on the initial RUG–IV claims data currently available (as discussed in the preceding analysis), we have provided in Tables 5A and 6A the case-mix adjusted RUG–IV payment rates which reflect the parity adjustment recalibration considered above based on our preliminary analysis using first quarter FY 2011 claims data. As further FY 2011 RUG–IV data become available, before we publish the final rule, we would review such additional data to confirm our preliminary assessment of the recalibration that would be necessary to achieve parity between the RUG–53 and RUG–IV models and would revise the parity adjustment in the final rule as necessary based on this additional data. We believe that the very magnitude of the potential recalibration, based on first quarter FY 2011 data, would make it inappropriate for us merely to consider payment rates for FY 2012 that solely reflect the standard update methodology without regard to the need for maintaining parity, as such an approach ultimately could result in continuing to make overall payments that significantly exceed their intended levels for an indefinite period.

b. Option for Application of Standard Update for FY 2012 Without Recalibration

Although our preliminary analysis of the RUG–IV data currently available suggests that recalibration of the parity adjustment would be needed to restore parity between the RUG–53 and RUG–IV models, in the circumstances discussed below, we are also considering not recalibrating the CMIs for FY 2012 and applying the standard update to the FY 2011 payment rates. As we observed in the preceding discussion of the recalibration option, it would appear from the currently available FY 2011 claims data that overall payments under the parity adjustment are significantly exceeding their intended levels. However, it is also possible that the apparent magnitude of the overpayments may itself represent a temporary aberrance resulting from the limited FY 2011 data that are available at this point in time. Moreover, we note that as with any significant programmatic change, the transition from the previous case-mix classification system to RUG–IV has been accompanied by a learning curve for providers, as they work to familiarize themselves with the requirements of the new system. As a consequence, it is possible that as additional FY 2011 claims data become available, they may indicate utilization patterns that are more consistent with our projections, and expenditures that are more in parity with those under the previous RUG–53 model. For this reason, we reserve the option to not implement in the final rule the type of recalibration discussed above, and instead to apply the standard update of the payment rates for FY 2012 if we find that the additional RUG–IV claims data collected prior to publication of the final rule are consistent with parity in expenditures between the current RUG–IV and previous RUG–53 models.

Accordingly, in this proposed rule, we are considering two separate options regarding the FY 2012 payment rates: One that incorporates the kind of recalibration discussed above which, based on the initial RUG–IV claims data currently available, may be necessary to restore overall payments under the parity adjustment to their intended levels (which recalibration may be adjusted based on further FY 2011 RUG–IV claims data that become available prior to publication of the final rule), and another that simply reflects the standard update to the FY 2011 payment rates without a recalibration of the FY 2011 parity adjustment. We solicit comments on these options as described above.

We list the case-mix adjusted RUG–IV payment rates which would exist if we choose to move forward with the recalibration of the parity adjustment described throughout this section, provided separately for urban and rural SNFs in Tables 5A and 6A, with the corresponding case-mix values which reflect the parity adjustment recalibration discussed above. Similarly, the case-mix adjusted RUG–IV rates, which would occur in the absence of such a recalibration of the parity adjustment, are listed in Tables 5B and 6B. 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 5A—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES (INCLUDING PARITY ADJUSTMENT RECALIBRATION)

[Urban]

RUG–IV category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUX	2.67	1.87	$427.73	$225.67		$81.76	$735.16
RUL	2.57	1.87	411.71	225.67		81.76	719.14
RVX	2.61	1.28	418.12	154.47		81.76	654.35
RVL	2.19	1.28	350.84	154.47		81.76	587.07
RHX	2.55	0.85	408.51	102.58		81.76	592.85
RHL	2.15	0.85	344.43	102.58		81.76	528.77
RMX	2.47	0.55	395.69	66.37		81.76	543.82
RML	2.19	0.55	350.84	66.37		81.76	498.97
RLX	2.26	0.28	362.05	33.79		81.76	477.60

TABLE 5A—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES (INCLUDING PARITY ADJUSTMENT RECALIBRATION)—Continued

[Urban]

RUG–IV category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUC	1.56	1.87	249.91	225.67		81.76	557.34
RUB	1.56	1.87	249.91	225.67		81.76	557.34
RUA	0.99	1.87	158.60	225.67		81.76	466.03
RVC	1.51	1.28	241.90	154.47		81.76	478.13
RVB	1.11	1.28	177.82	154.47		81.76	414.05
RVA	1.10	1.28	176.22	154.47		81.76	412.45
RHC	1.45	0.85	232.29	102.58		81.76	416.63
RHB	1.19	0.85	190.64	102.58		81.76	374.98
RHA	0.91	0.85	145.78	102.58		81.76	330.12
RMC	1.36	0.55	217.87	66.37		81.76	366.00
RMB	1.22	0.55	195.44	66.37		81.76	343.57
RMA	0.84	0.55	134.57	66.37		81.76	282.70
RLB	1.50	0.28	240.30	33.79		81.76	355.85
RLA	0.71	0.28	113.74	33.79		81.76	229.29
ES3	3.58		573.52		15.90	81.76	671.18
ES2	2.67		427.73		15.90	81.76	525.39
ES1	2.32		371.66		15.90	81.76	469.32
HE2	2.22		355.64		15.90	81.76	453.30
HE1	1.74		278.75		15.90	81.76	376.41
HD2	2.04		326.81		15.90	81.76	424.47
HD1	1.60		256.32		15.90	81.76	353.98
HC2	1.89		302.78		15.90	81.76	400.44
HC1	1.48		237.10		15.90	81.76	334.76
HB2	1.86		297.97		15.90	81.76	395.63
HB1	1.46		233.89		15.90	81.76	331.55
LE2	1.96		313.99		15.90	81.76	411.65
LE1	1.54		246.71		15.90	81.76	344.37
LD2	1.86		297.97		15.90	81.76	395.63
LD1	1.46		233.89		15.90	81.76	331.55
LC2	1.56		249.91		15.90	81.76	347.57
LC1	1.22		195.44		15.90	81.76	293.10
LB2	1.46		233.89		15.90	81.76	331.55
LB1	1.14		182.63		15.90	81.76	280.29
CE2	1.68		269.14		15.90	81.76	366.80
CE1	1.50		240.30		15.90	81.76	337.96
CD2	1.56		249.91		15.90	81.76	347.57
CD1	1.38		221.08		15.90	81.76	318.74
CC2	1.29		206.66		15.90	81.76	304.32
CC1	1.15		184.23		15.90	81.76	281.89
CB2	1.15		184.23		15.90	81.76	281.89
CB1	1.02		163.40		15.90	81.76	261.06
CA2	0.88		140.98		15.90	81.76	238.64
CA1	0.78		124.96		15.90	81.76	222.62
BB2	0.97		155.39		15.90	81.76	253.05
BB1	0.90		144.18		15.90	81.76	241.84
BA2	0.70		112.14		15.90	81.76	209.80
BA1	0.64		102.53		15.90	81.76	200.19
PE2	1.50		240.30		15.90	81.76	337.96
PE1	1.40		224.28		15.90	81.76	321.94
PD2	1.38		221.08		15.90	81.76	318.74
PD1	1.28		205.06		15.90	81.76	302.72
PC2	1.10		176.22		15.90	81.76	273.88
PC1	1.02		163.40		15.90	81.76	261.06
PB2	0.84		134.57		15.90	81.76	232.23
PB1	0.78		124.96		15.90	81.76	222.62
PA2	0.59		94.52		15.90	81.76	192.18
PA1	0.54		86.51		15.90	81.76	184.17

TABLE 5B—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES (WITHOUT PARITY ADJUSTMENT RECALIBRATION)

[Urban]

RUG–IV category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUX	3.59	1.87	$575.12	$225.67		$81.76	$882.55
RUL	3.45	1.87	552.69	225.67		81.76	860.12

TABLE 5B—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES (WITHOUT PARITY ADJUSTMENT RECALIBRATION)—Continued

[Urban]

RUG–IV category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RVX	3.51	1.28	562.30	154.47		81.76	798.53
RVL	2.95	1.28	472.59	154.47		81.76	708.82
RHX	3.43	0.85	549.49	102.58		81.76	733.83
RHL	2.89	0.85	462.98	102.58		81.76	647.32
RMX	3.31	0.55	530.26	66.37		81.76	678.39
RML	2.95	0.55	472.59	66.37		81.76	620.72
RLX	3.04	0.28	487.01	33.79		81.76	602.56
RUC	2.10	1.87	336.42	225.67		81.76	643.85
RUB	2.10	1.87	336.42	225.67		81.76	643.85
RUA	1.33	1.87	213.07	225.67		81.76	520.50
RVC	2.02	1.28	323.60	154.47		81.76	559.83
RVB	1.49	1.28	238.70	154.47		81.76	474.93
RVA	1.48	1.28	237.10	154.47		81.76	473.33
RHC	1.94	0.85	310.79	102.58		81.76	495.13
RHB	1.60	0.85	256.32	102.58		81.76	440.66
RHA	1.23	0.85	197.05	102.58		81.76	381.39
RMC	1.83	0.55	293.17	66.37		81.76	441.30
RMB	1.63	0.55	261.13	66.37		81.76	409.26
RMA	1.13	0.55	181.03	66.37		81.76	329.16
RLB	2.01	0.28	322.00	33.79		81.76	437.55
RLA	0.95	0.28	152.19	33.79		81.76	267.74
ES3	3.58		573.52		15.90	81.76	671.18
ES2	2.67		427.73		15.90	81.76	525.39
ES1	2.32		371.66		15.90	81.76	469.32
HE2	2.22		355.64		15.90	81.76	453.30
HE1	1.74		278.75		15.90	81.76	376.41
HD2	2.04		326.81		15.90	81.76	424.47
HD1	1.60		256.32		15.90	81.76	353.98
HC2	1.89		302.78		15.90	81.76	400.44
HC1	1.48		237.10		15.90	81.76	334.76
HB2	1.86		297.97		15.90	81.76	395.63
HB1	1.46		233.89		15.90	81.76	331.55
LE2	1.96		313.99		15.90	81.76	411.65
LE1	1.54		246.71		15.90	81.76	344.37
LD2	1.86		297.97		15.90	81.76	395.63
LD1	1.46		233.89		15.90	81.76	331.55
LC2	1.56		249.91		15.90	81.76	347.57
LC1	1.22		195.44		15.90	81.76	293.10
LB2	1.46		233.89		15.90	81.76	331.55
LB1	1.14		182.63		15.90	81.76	280.29
CE2	1.68		269.14		15.90	81.76	366.80
CE1	1.50		240.30		15.90	81.76	337.96
CD2	1.56		249.91		15.90	81.76	347.57
CD1	1.38		221.08		15.90	81.76	318.74
CC2	1.29		206.66		15.90	81.76	304.32
CC1	1.15		184.23		15.90	81.76	281.89
CB2	1.15		184.23		15.90	81.76	281.89
CB1	1.02		163.40		15.90	81.76	261.06
CA2	0.88		140.98		15.90	81.76	238.64
CA1	0.78		124.96		15.90	81.76	222.62
BB2	0.97		155.39		15.90	81.76	253.05
BB1	0.90		144.18		15.90	81.76	241.84
BA2	0.70		112.14		15.90	81.76	209.80
BA1	0.64		102.53		15.90	81.76	200.19
PE2	1.50		240.30		15.90	81.76	337.96
PE1	1.40		224.28		15.90	81.76	321.94
PD2	1.38		221.08		15.90	81.76	318.74
PD1	1.28		205.06		15.90	81.76	302.72
PC2	1.10		176.22		15.90	81.76	273.88
PC1	1.02		163.40		15.90	81.76	261.06
PB2	0.84		134.57		15.90	81.76	232.23
PB1	0.78		124.96		15.90	81.76	222.62
PA2	0.59		94.52		15.90	81.76	192.18
PA1	0.54		86.51		15.90	81.76	184.17

TABLE 6A—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES (INCLUDING PARITY ADJUSTMENT RECALIBRATION)

[Rural]

RUG–IV category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUX	2.67	1.87	$408.70	$260.21		$83.28	$752.19
RUL	2.57	1.87	393.39	260.21		83.28	736.88
RVX	2.61	1.28	399.51	178.11		83.28	660.90
RVL	2.19	1.28	335.22	178.11		83.28	596.61
RHX	2.55	0.85	390.33	118.28		83.28	591.89
RHL	2.15	0.85	329.10	118.28		83.28	530.66
RMX	2.47	0.55	378.08	76.53		83.28	537.89
RML	2.19	0.55	335.22	76.53		83.28	495.03
RLX	2.26	0.28	345.94	38.96		83.28	468.18
RUC	1.56	1.87	238.79	260.21		83.28	582.28
RUB	1.56	1.87	238.79	260.21		83.28	582.28
RUA	0.99	1.87	151.54	260.21		83.28	495.03
RVC	1.51	1.28	231.14	178.11		83.28	492.53
RVB	1.11	1.28	169.91	178.11		83.28	431.30
RVA	1.10	1.28	168.38	178.11		83.28	429.77
RHC	1.45	0.85	221.95	118.28		83.28	423.51
RHB	1.19	0.85	182.15	118.28		83.28	383.71
RHA	0.91	0.85	139.29	118.28		83.28	340.85
RMC	1.36	0.55	208.18	76.53		83.28	367.99
RMB	1.22	0.55	186.75	76.53		83.28	346.56
RMA	0.84	0.55	128.58	76.53		83.28	288.39
RLB	1.50	0.28	229.61	38.96		83.28	351.85
RLA	0.71	0.28	108.68	38.96		83.28	230.92
ES3	3.58		547.99		16.97	83.28	648.24
ES2	2.67		408.70		16.97	83.28	508.95
ES1	2.32		355.12		16.97	83.28	455.37
HE2	2.22		339.82		16.97	83.28	440.07
HE1	1.74		266.34		16.97	83.28	366.59
HD2	2.04		312.26		16.97	83.28	412.51
HD1	1.60		244.91		16.97	83.28	345.16
HC2	1.89		289.30		16.97	83.28	389.55
HC1	1.48		226.54		16.97	83.28	326.79
HB2	1.86		284.71		16.97	83.28	384.96
HB1	1.46		223.48		16.97	83.28	323.73
LE2	1.96		300.02		16.97	83.28	400.27
LE1	1.54		235.73		16.97	83.28	335.98
LD2	1.86		284.71		16.97	83.28	384.96
LD1	1.46		223.48		16.97	83.28	323.73
LC2	1.56		238.79		16.97	83.28	339.04
LC1	1.22		186.75		16.97	83.28	287.00
LB2	1.46		223.48		16.97	83.28	323.73
LB1	1.14		174.50		16.97	83.28	274.75
CE2	1.68		257.16		16.97	83.28	357.41
CE1	1.50		229.61		16.97	83.28	329.86
CD2	1.56		238.79		16.97	83.28	339.04
CD1	1.38		211.24		16.97	83.28	311.49
CC2	1.29		197.46		16.97	83.28	297.71
CC1	1.15		176.03		16.97	83.28	276.28
CB2	1.15		176.03		16.97	83.28	276.28
CB1	1.02		156.13		16.97	83.28	256.38
CA2	0.88		134.70		16.97	83.28	234.95
CA1	0.78		119.39		16.97	83.28	219.64
BB2	0.97		148.48		16.97	83.28	248.73
BB1	0.90		137.76		16.97	83.28	238.01
BA2	0.70		107.15		16.97	83.28	207.40
BA1	0.64		97.96		16.97	83.28	198.21
PE2	1.50		229.61		16.97	83.28	329.86
PE1	1.40		214.30		16.97	83.28	314.55
PD2	1.38		211.24		16.97	83.28	311.49
PD1	1.28		195.93		16.97	83.28	296.18
PC2	1.10		168.38		16.97	83.28	268.63
PC1	1.02		156.13		16.97	83.28	256.38
PB2	0.84		128.58		16.97	83.28	228.83
PB1	0.78		119.39		16.97	83.28	219.64
PA2	0.59		90.31		16.97	83.28	190.56
PA1	0.54		82.66		16.97	83.28	182.91

TABLE 6B—RUG–IV CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDEXES: WITHOUT PARITY ADJUSTMENT RECALIBRATION)

[Rural]

RUG–IV category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
RUX	3.59	1.87	$549.52	$260.21		$83.28	$893.01
RUL	3.45	1.87	528.09	260.21		83.28	871.58
RVX	3.51	1.28	537.28	178.11		83.28	798.67
RVL	2.95	1.28	451.56	178.11		83.28	712.95
RHX	3.43	0.85	525.03	118.28		83.28	726.59
RHL	2.89	0.85	442.37	118.28		83.28	643.93
RMX	3.31	0.55	506.66	76.53		83.28	666.47
RML	2.95	0.55	451.56	76.53		83.28	611.37
RLX	3.04	0.28	465.33	38.96		83.28	587.57
RUC	2.10	1.87	321.45	260.21		83.28	664.94
RUB	2.10	1.87	321.45	260.21		83.28	664.94
RUA	1.33	1.87	203.58	260.21		83.28	547.07
RVC	2.02	1.28	309.20	178.11		83.28	570.59
RVB	1.49	1.28	228.07	178.11		83.28	489.46
RVA	1.48	1.28	226.54	178.11		83.28	487.93
RHC	1.94	0.85	296.96	118.28		83.28	498.52
RHB	1.60	0.85	244.91	118.28		83.28	446.47
RHA	1.23	0.85	188.28	118.28		83.28	389.84
RMC	1.83	0.55	280.12	76.53		83.28	439.93
RMB	1.63	0.55	249.50	76.53		83.28	409.31
RMA	1.13	0.55	172.97	76.53		83.28	332.78
RLB	2.01	0.28	307.67	38.96		83.28	429.91
RLA	0.95	0.28	145.42	38.96		83.28	267.66
ES3	3.58		547.99		$16.97	83.28	648.24
ES2	2.67		408.70		16.97	83.28	508.95
ES1	2.32		355.12		16.97	83.28	455.37
HE2	2.22		339.82		16.97	83.28	440.07
HE1	1.74		266.34		16.97	83.28	366.59
HD2	2.04		312.26		16.97	83.28	412.51
HD1	1.60		244.91		16.97	83.28	345.16
HC2	1.89		289.30		16.97	83.28	389.55
HC1	1.48		226.54		16.97	83.28	326.79
HB2	1.86		284.71		16.97	83.28	384.96
HB1	1.46		223.48		16.97	83.28	323.73
LE2	1.96		300.02		16.97	83.28	400.27
LE1	1.54		235.73		16.97	83.28	335.98
LD2	1.86		284.71		16.97	83.28	384.96
LD1	1.46		223.48		16.97	83.28	323.73
LC2	1.56		238.79		16.97	83.28	339.04
LC1	1.22		186.75		16.97	83.28	287.00
LB2	1.46		223.48		16.97	83.28	323.73
LB1	1.14		174.50		16.97	83.28	274.75
CE2	1.68		257.16		16.97	83.28	357.41
CE1	1.50		229.61		16.97	83.28	329.86
CD2	1.56		238.79		16.97	83.28	339.04
CD1	1.38		211.24		16.97	83.28	311.49
CC2	1.29		197.46		16.97	83.28	297.71
CC1	1.15		176.03		16.97	83.28	276.28
CB2	1.15		176.03		16.97	83.28	276.28
CB1	1.02		156.13		16.97	83.28	256.38
CA2	0.88		134.70		16.97	83.28	234.95
CA1	0.78		119.39		16.97	83.28	219.64
BB2	0.97		148.48		16.97	83.28	248.73
BB1	0.90		137.76		16.97	83.28	238.01
BA2	0.70		107.15		16.97	83.28	207.40
BA1	0.64		97.96		16.97	83.28	198.21
PE2	1.50		229.61		16.97	83.28	329.86
PE1	1.40		214.30		16.97	83.28	314.55
PD2	1.38		211.24		16.97	83.28	311.49
PD1	1.28		195.93		16.97	83.28	296.18
PC2	1.10		168.38		16.97	83.28	268.63
PC1	1.02		156.13		16.97	83.28	256.38
PB2	0.84		128.58		16.97	83.28	228.83
PB1	0.78		119.39		16.97	83.28	219.64
PA2	0.59		90.31		16.97	83.28	190.56
PA1	0.54		82.66		16.97	83.28	182.91

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 are maintaining that practice for FY 2012, 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 continue to use 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 2012 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 use the average wage index from all contiguous Core-Based Statistical Areas (CBSAs) as a reasonable proxy. This methodology was used to construct the wage index for rural Massachusetts for FY 2011. However, there is now a rural hospital with wage data upon which to base an area wage index for rural Massachusetts. Therefore, it is not necessary to apply this methodology to rural Massachusetts for FY 2012. For rural Puerto Rico, we do not apply this methodology due to the distinct economic circumstances that exist there, but instead continue using the most recent wage index previously available for that area. For urban areas without specific hospital wage index data, we use the average wage indexes of all of the urban areas within the State to serve as a reasonable proxy for the wage index of that urban CBSA. For FY 2012, there is an additional urban area without hospital wage index data. Therefore, for FY 2012, the two urban areas without wage index data available are CBSA 25980, Hinesville-Fort Stewart, GA, and CBSA 49700, Yuba City, CA.

To calculate the SNF PPS wage index adjustment, we apply the wage index adjustment to the labor-related portion of the Federal rate, which is 68.805 percent of the total rate. This percentage reflects the labor-related relative importance for FY 2012, using the revised and rebased FY 2004-based market basket. The labor-related relative importance for FY 2011 was 69.311, as shown in Table 11. We calculate the labor-related relative importance from the SNF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2012. 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 2012 than the base year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2012 in four steps. First, we compute the FY 2012 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 2012 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2012 relative importance for each cost category by multiplying this ratio by the base year (FY 2004) weight. Finally, we add the FY 2012 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 2012 labor-related relative importance. Tables 7A and 8A show the case-mix adjusted RUG–IV Federal rates by labor-related and non-labor-related components that would exist if we choose to move forward with the parity adjustment recalibration described in section II.B.2. Similarly, Tables 7B and 8B show the case-mix adjusted RUG–IV Federal rates by labor-related and non-labor related components in the absence of such a parity adjustment recalibration.

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

[Including parity adjustment recalibration]

RUG–IV category	Total rate	Labor portion	Non-labor portion
RUX	$735.16	$505.83	$229.33
RUL	719.14	494.80	224.34
RVX	654.35	450.23	204.12
RVL	587.07	403.93	183.14
RHX	592.85	407.91	184.94
RHL	528.77	363.82	164.95
RMX	543.82	374.18	169.64
RML	498.97	343.32	155.65
RLX	477.60	328.61	148.99
RUC	557.34	383.48	173.86
RUB	557.34	383.48	173.86
RUA	466.03	320.65	145.38
RVC	478.13	328.98	149.15
RVB	414.05	284.89	129.16
RVA	412.45	283.79	128.66
RHC	416.63	286.66	129.97
RHB	374.98	258.00	116.98
RHA	330.12	227.14	102.98
RMC	366.00	251.83	114.17
RMB	343.57	236.39	107.18
RMA	282.70	194.51	88.19
RLB	355.85	244.84	111.01
RLA	229.29	157.76	71.53
ES3	671.18	461.81	209.37
ES2	525.39	361.49	163.90
ES1	469.32	322.92	146.40
HE2	453.30	311.89	141.41
HE1	376.41	258.99	117.42
HD2	424.47	292.06	132.41
HD1	353.98	243.56	110.42
HC2	400.44	275.52	124.92
HC1	334.76	230.33	104.43
HB2	395.63	272.21	123.42
HB1	331.55	228.12	103.43
LE2	411.65	283.24	128.41
LE1	344.37	236.94	107.43
LD2	395.63	272.21	123.42
LD1	331.55	228.12	103.43
LC2	347.57	239.15	108.42
LC1	293.10	201.67	91.43
LB2	331.55	228.12	103.43
LB1	280.29	192.85	87.44
CE2	366.80	252.38	114.42
CE1	337.96	232.53	105.43
CD2	347.57	239.15	108.42
CD1	318.74	219.31	99.43
CC2	304.32	209.39	94.93
CC1	281.89	193.95	87.94
CB2	281.89	193.95	87.94
CB1	261.06	179.62	81.44
CA2	238.64	164.20	74.44
CA1	222.62	153.17	69.45
BB2	253.05	174.11	78.94
BB1	241.84	166.40	75.44
BA2	209.80	144.35	65.45
BA1	200.19	137.74	62.45
PE2	337.96	232.53	105.43
PE1	321.94	221.51	100.43
PD2	318.74	219.31	99.43
PD1	302.72	208.29	94.43
PC2	273.88	188.44	85.44
PC1	261.06	179.62	81.44
PB2	232.23	159.79	72.44
PB1	222.62	153.17	69.45
PA2	192.18	132.23	59.95
PA1	184.17	126.72	57.45

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

[Without parity adjustment recalibration]

RUG–IV category	Total rate	Labor portion	Non-labor portion
RUX	$882.55	$607.24	$275.31
RUL	860.12	591.81	268.31
RVX	798.53	549.43	249.10
RVL	708.82	487.70	221.12
RHX	733.83	504.91	228.92
RHL	647.32	445.39	201.93
RMX	678.39	466.77	211.62
RML	620.72	427.09	193.63
RLX	602.56	414.59	187.97
RUC	643.85	443.00	200.85
RUB	643.85	443.00	200.85
RUA	520.50	358.13	162.37
RVC	559.83	385.19	174.64
RVB	474.93	326.78	148.15
RVA	473.33	325.67	147.66
RHC	495.13	340.67	154.46
RHB	440.66	303.20	137.46
RHA	381.39	262.42	118.97
RMC	441.30	303.64	137.66
RMB	409.26	281.59	127.67
RMA	329.16	226.48	102.68
RLB	437.55	301.06	136.49
RLA	267.74	184.22	83.52
ES3	671.18	461.81	209.37
ES2	525.39	361.49	163.90
ES1	469.32	322.92	146.40
HE2	453.30	311.89	141.41
HE1	376.41	258.99	117.42
HD2	424.47	292.06	132.41
HD1	353.98	243.56	110.42
HC2	400.44	275.52	124.92
HC1	334.76	230.33	104.43
HB2	395.63	272.21	123.42
HB1	331.55	228.12	103.43
LE2	411.65	283.24	128.41
LE1	344.37	236.94	107.43
LD2	395.63	272.21	123.42
LD1	331.55	228.12	103.43
LC2	347.57	239.15	108.42
LC1	293.10	201.67	91.43
LB2	331.55	228.12	103.43
LB1	280.29	192.85	87.44
CE2	366.80	252.38	114.42
CE1	337.96	232.53	105.43
CD2	347.57	239.15	108.42
CD1	318.74	219.31	99.43
CC2	304.32	209.39	94.93
CC1	281.89	193.95	87.94
CB2	281.89	193.95	87.94
CB1	261.06	179.62	81.44
CA2	238.64	164.20	74.44
CA1	222.62	153.17	69.45
BB2	253.05	174.11	78.94
BB1	241.84	166.40	75.44
BA2	209.80	144.35	65.45
BA1	200.19	137.74	62.45
PE2	337.96	232.53	105.43
PE1	321.94	221.51	100.43
PD2	318.74	219.31	99.43
PD1	302.72	208.29	94.43
PC2	273.88	188.44	85.44
PC1	261.06	179.62	81.44
PB2	232.23	159.79	72.44
PB1	222.62	153.17	69.45
PA2	192.18	132.23	59.95
PA1	184.17	126.72	57.45

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

[Including parity adjustment recalibration]

RUG–IV category	Total rate	Labor portion	Non-labor portion
RUX	$752.19	$517.54	$234.65
RUL	736.88	507.01	229.87
RVX	660.90	454.73	206.17
RVL	596.61	410.50	186.11
RHX	591.89	407.25	184.64
RHL	530.66	365.12	165.54
RMX	537.89	370.10	167.79
RML	495.03	340.61	154.42
RLX	468.18	322.13	146.05
RUC	582.28	400.64	181.64
RUB	582.28	400.64	181.64
RUA	495.03	340.61	154.42
RVC	492.53	338.89	153.64
RVB	431.30	296.76	134.54
RVA	429.77	295.70	134.07
RHC	423.51	291.40	132.11
RHB	383.71	264.01	119.70
RHA	340.85	234.52	106.33
RMC	367.99	253.20	114.79
RMB	346.56	238.45	108.11
RMA	288.39	198.43	89.96
RLB	351.85	242.09	109.76
RLA	230.92	158.88	72.04
ES3	648.24	446.02	202.22
ES2	508.95	350.18	158.77
ES1	455.37	313.32	142.05
HE2	440.07	302.79	137.28
HE1	366.59	252.23	114.36
HD2	412.51	283.83	128.68
HD1	345.16	237.49	107.67
HC2	389.55	268.03	121.52
HC1	326.79	224.85	101.94
HB2	384.96	264.87	120.09
HB1	323.73	222.74	100.99
LE2	400.27	275.41	124.86
LE1	335.98	231.17	104.81
LD2	384.96	264.87	120.09
LD1	323.73	222.74	100.99
LC2	339.04	233.28	105.76
LC1	287.00	197.47	89.53
LB2	323.73	222.74	100.99
LB1	274.75	189.04	85.71
CE2	357.41	245.92	111.49
CE1	329.86	226.96	102.90
CD2	339.04	233.28	105.76
CD1	311.49	214.32	97.17
CC2	297.71	204.84	92.87
CC1	276.28	190.09	86.19
CB2	276.28	190.09	86.19
CB1	256.38	176.40	79.98
CA2	234.95	161.66	73.29
CA1	219.64	151.12	68.52
BB2	248.73	171.14	77.59
BB1	238.01	163.76	74.25
BA2	207.40	142.70	64.70
BA1	198.21	136.38	61.83
PE2	329.86	226.96	102.90
PE1	314.55	216.43	98.12
PD2	311.49	214.32	97.17
PD1	296.18	203.79	92.39
PC2	268.63	184.83	83.80
PC1	256.38	176.40	79.98
PB2	228.83	157.45	71.38
PB1	219.64	151.12	68.52
PA2	190.56	131.11	59.45
PA1	182.91	125.85	57.06

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

[Without parity adjustment recalibration]

RUG–IV category	Total rate	Labor portion	Non-Labor portion
RUX	893.01	$614.44	$278.57
RUL	871.58	599.69	271.89
RVX	798.67	549.52	249.15
RVL	712.95	490.55	222.40
RHX	726.59	499.93	226.66
RHL	643.93	443.06	200.87
RMX	666.47	458.56	207.91
RML	611.37	420.65	190.72
RLX	587.57	404.28	183.29
RUC	664.94	457.51	207.43
RUB	664.94	457.51	207.43
RUA	547.07	376.41	170.66
RVC	570.59	392.59	178.00
RVB	489.46	336.77	152.69
RVA	487.93	335.72	152.21
RHC	498.52	343.01	155.51
RHB	446.47	307.19	139.28
RHA	389.84	268.23	121.61
RMC	439.93	302.69	137.24
RMB	409.31	281.63	127.68
RMA	332.78	228.97	103.81
RLB	429.91	295.80	134.11
RLA	267.66	184.16	83.50
ES3	648.24	446.02	202.22
ES2	508.95	350.18	158.77
ES1	455.37	313.32	142.05
HE2	440.07	302.79	137.28
HE1	366.59	252.23	114.36
HD2	412.51	283.83	128.68
HD1	345.16	237.49	107.67
HC2	389.55	268.03	121.52
HC1	326.79	224.85	101.94
HB2	384.96	264.87	120.09
HB1	323.73	222.74	100.99
LE2	400.27	275.41	124.86
LE1	335.98	231.17	104.81
LD2	384.96	264.87	120.09
LD1	323.73	222.74	100.99
LC2	339.04	233.28	105.76
LC1	287.00	197.47	89.53
LB2	323.73	222.74	100.99
LB1	274.75	189.04	85.71
CE2	357.41	245.92	111.49
CE1	329.86	226.96	102.90
CD2	339.04	233.28	105.76
CD1	311.49	214.32	97.17
CC2	297.71	204.84	92.87
CC1	276.28	190.09	86.19
CB2	276.28	190.09	86.19
CB1	256.38	176.40	79.98
CA2	234.95	161.66	73.29
CA1	219.64	151.12	68.52
BB2	248.73	171.14	77.59
BB1	238.01	163.76	74.25
BA2	207.40	142.70	64.70
BA1	198.21	136.38	61.83
PE2	329.86	226.96	102.90
PE1	314.55	216.43	98.12
PD2	311.49	214.32	97.17
PD1	296.18	203.79	92.39
PC2	268.63	184.83	83.80
PC1	256.38	176.40	79.98
PB2	228.83	157.45	71.38
PB1	219.64	151.12	68.52
PA2	190.56	131.11	59.45
PA1	182.91	125.85	57.06

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 2012 (Federal rates effective October 1, 2011), we apply an adjustment to fulfill the budget neutrality requirement. We meet this requirement by multiplying each of the components of the unadjusted Federal rates by a budget neutrality factor equal to the ratio of the weighted average wage adjustment factor for FY 2011 to the weighted average wage adjustment factor for FY 2012. For this calculation, we use the same 2010 claims utilization data for both the numerator and denominator of this ratio. We define the wage adjustment factor used in this calculation as the labor share of the rate component multiplied by the wage index plus the non-labor share of the rate component. The budget neutrality factor for this year is 1.0001. The wage index applicable to FY 2012 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 are available online at *http://www.whitehouse.gov/omb/bulletins/index.html.*

In adopting the OMB CBSA geographic designations, we provided for a 1-year transition with a blended wage index for all providers. For FY 2006, the wage index for each provider consisted of a blend of 50 percent of the FY 2006 MSA-based wage index and 50 percent of the FY 2006 CBSA-based wage index (both using FY 2002 hospital data). We referred to the blended wage index as the FY 2006 SNF PPS transition wage index. As discussed in the SNF PPS final rule for FY 2006 (70 FR 45041), subsequent to the expiration of this 1-year transition on September 30, 2006, we used the full CBSA-based wage index values, as now presented in Tables 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, and section 1888(e)(5)(B) of the Act as amended by section 3401(b) of the Affordable Care Act, the payment rates in this proposed rule reflect an update equal to the full SNF market basket, estimated at 2.7 percentage points, reduced by the MFP adjustment. As discussed in sections I.G.2 and VI.C of this proposed rule, the annual update includes a 1.2 percentage point reduction to account for the MFP adjustment described in the latter section, for a net update of 1.5 percent for FY 2012. We continue to disseminate the rates, wage index, and case-mix classification methodology through the **Federal Register** before the August 1 that precedes the start of each succeeding FY.

E. Relationship of Case-Mix 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. As set forth in the FY 2011 SNF PPS update notice (75 FR 42910, July 22, 2010), this designation reflects an administrative presumption under the 66-group RUG–IV system that beneficiaries who are correctly assigned to one of the upper 52 RUG–IV groups on the initial 5-day, Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date on the 5-day Medicare-required assessment.

A beneficiary assigned to any of the lower 14 RUG–IV groups is not automatically classified as either meeting or not meeting the definition, but instead receives an individual level of care determination using the existing administrative criteria. This presumption recognizes the strong likelihood that beneficiaries assigned to one of the upper 52 RUG–IV groups during the immediate post-hospital period require a covered level of care, which would be less likely for those beneficiaries assigned to one of the lower 14 RUG–IV groups.

In this proposed rule, we once again propose to designate the upper 52 RUG–IV groups for purposes of this administrative presumption, consisting of all groups encompassed by the following RUG–IV categories:

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

However, we note that this administrative presumption policy does not supersede the SNF's responsibility to ensure that its decisions relating to level of care are appropriate and timely, including a review to confirm that the services prompting the beneficiary's assignment to one of the upper 52 RUG–IV groups (which, in turn, serves to trigger the administrative presumption) are themselves medically necessary. As we explained in the FY 2000 SNF PPS final rule (64 FR 41667, July 30, 1999), the administrative presumption

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

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

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

Using the hypothetical SNF XYZ described below, Tables 9A and 9B show the adjustments made to the Federal per diem rates to compute the provider's actual per diem PPS payment under each of the described scenarios (that is, with a parity adjustment recalibration and without a parity adjustment recalibration). SNF XYZ's 12-month cost reporting period begins October 1, 2011. As illustrated in Table 9A, SNF XYZ's total PPS payment would equal $40,021.02 with the application of a parity adjustment recalibration (calculated using first quarter FY 2011 data), as described in section II.B.2 above. SNF XYZ's total PPS payment would equal $42,636.62

without the application of the parity adjustment recalibration considered in section II.B.2, as illustrated in Table 9B. We derive the Labor and Non-labor columns from Tables 7A and 7B.

TABLE 9A—RUG–IV—INCLUDING PARITY ADJUSTMENT RECALIBRATION SNF XYZ: LOCATED IN CEDAR RAPIDS, IA

[(Urban CBSA 16300) Wage Index: 0.8857]

RUG–IV group	Labor	Wage index	Adjusted labor	Non-labor	Adjusted rate	Percent adjustment	Medicare days	Payment
RVX	$450.23	0.8857	$398.77	$204.12	$602.89	$602.89	14	$8,440.46
ES2	361.49	0.8857	320.17	163.90	484.07	484.07	30	14,522.10
RHA	227.14	0.8857	201.18	102.98	304.16	304.16	16	4,866.56
CC2 *	209.39	0.8857	185.46	94.93	280.39	639.29	10	6,392.90
BA2	144.35	0.8857	127.85	65.45	193.30	193.30	30	5,799.00
							100	40,021.02

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

TABLE 9B—RUG–IV—WITHOUT PARITY ADJUSTMENT RECALIBRATION SNF XYZ: LOCATED IN CEDAR RAPIDS, IA

[(Urban CBSA 16300) Wage Index: 0.8857]

RUG–IV group	Labor	Wage index	Adjusted labor	Non-labor	Adjusted rate	Percent adjustment	Medicare days	Payment
RVX	$549.43	0.8857	$486.63	$249.10	$735.73	$735.73	14	$10,300.22
ES2	361.49	0.8857	320.17	163.90	484.07	484.07	30	14,522.10
RHA	262.42	0.8857	232.43	118.97	351.40	351.40	16	5,622.40
CC2*	209.39	0.8857	185.46	94.93	280.39	639.29	10	6,392.90
BA2	144.35	0.8857	127.85	65.45	193.30	193.30	30	5,799.00
							100	42,636.62

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

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

A. Prospective Payment for SNF Non-therapy Ancillary Costs

1. Previous Research

We have conducted several studies since 1999 to refine the reimbursement methodology for non-therapy ancillary (NTA) services covered by the SNF PPS. 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 was only a weak correlation between NTA services costs and the RUG–III classification group. As the current RUG–IV system, similar to the RUG–III system, has maintained NTA costs coverage as part of the nursing CMIs, we believe that the present methodology for case-mix adjusting the NTA payment amount may not be the most 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, which could lead to restricted access to care for those patients.

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 RUG groups (65 FR 19193–19194, 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 of patients who qualify solely for a Rehabilitation RUG.

As noted in the 2006 Report to Congress on case-mix refinements (available online at *http://www.cms.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 costs, 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 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 essentially implemented a variation of the 58-group RUG proposal developed by Abt Associates discussed above. 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 intended to enable the original RUG–III payment model 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 used to measure independent variables in the data base led to potential improvements over the earlier model. 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 assessments 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.medpac.gov/documents/Jun08_SNF_PPS_CONTRACTOR_CC.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.

In a June 2010 memo to MedPAC (available online at *http://www.medpac.gov/documents/Oct10_SNF_NonTherapyAncillary_CONTRACTOR_CC.pdf*), the Urban Institute described a series of refinements to MedPAC's 2008 proposed model. Most importantly, with their 2010 model, the Urban Institute sought to reduce the number of indicators from nearly 70 and ensure that all indicators are derived from information based on available administrative data. Additionally, when the Urban Institute used 2007 SNF data files (as compared to the 2003 data files used to support the previous model), they found that the predictive ability of the model was reduced slightly from 23 percent to 21 percent.

After completing a revised statistical analysis and eliminating indicators for conditions that were either relatively rare or had little impact on NTA costs, the Urban Institute advanced a 20-variable "streamlined" model that maintained almost equivalent predictive accuracy to MedPAC's 2008 proposed model described above. The streamlined model included many of the "high-impact" variables contained in the 69-variable model, such as IV medication use and respiratory services. Additionally, the streamlined model included variables suggested by CMS, such as the nursing case-mix index and the MDS diabetes diagnosis, which were also found to be strong indicators of anticipated NTA costs.

2. Conceptual Analysis

Based on our initial research, we continue to believe that an administratively feasible and equitable approach to prospective payments for NTA costs would incorporate the following criteria:

- Uses information from available administrative data (data available on claims or on the MDS assessment);
- Uses predictor variables that represent meaningful correlates of NTA services that are highly predictive, clinically sensible, sensitive to patient NTA variation, and do not promote undesirable incentives for providers;
- Is developed by using the best and most recently available data sources, in order to assure that it reflects current care practices and resource utilization;
- Results in a separate NTA component and index that uses a minimal number of payment groups, or tiers, to limit the complexity of the SNF PPS as a whole; and
- Uses payment groups and predictor variables that are readily understandable and clinically intuitive.

These criteria and our initial research intent were discussed in the FY 2010 SNF PPS proposed rule (74 FR 22238 through 22241, May 12, 2009), and responses to comments on this initial research proposal were part of the FY 2010 SNF PPS final rule (74 FR 40341 through 40342, August 11, 2009). These comments helped to guide our initial research to develop the conceptual model discussed in this proposed rule.

In addition to the criteria specified above, our research is also guided by the results of multiple recent studies, such as those conducted by the Urban Institute, regarding the relationship between NTA utilization and resident condition. Most relevant to our work in this area, these studies suggest that the highest-cost ancillary services (such as respiratory services, enteral and parenteral feeding, and treatment of chronic conditions, such as AIDS) are used by a small subset of the SNF population, and that the high and varied cost of individual services or drugs by these populations—rather than the volume of NTA utilization—can at least partially explain the wide variance in NTA costs.

To continue our analytic work for developing a payment methodology for NTA costs, we have utilized a large analytic data file that combines Medicare SNF claims, cost reports, and MDS assessments from FY 2007. The file has been used to study relationships between reported claims charges for NTA-related revenue centers and predictor variables defined from items on the MDS. We augmented the analytic file with diagnosis information from the patient's qualifying hospital stay as a way of compensating for potentially incomplete diagnosis reporting on MDS and on SNF claims. (As noted earlier, it is not our intention to use hospital-assigned diagnoses directly in any tiered system we may propose.) Because three-quarters of the NTA costs are pharmacy-related, we have summarized the patient's recent diagnoses using the diagnosis classification system CMS developed for Medicare Part D risk adjustment. This is known as the RxHCC system. The RxHCC system was developed from the Hierarchical Condition Categories (HCCs) used for risk-adjustment in Medicare Part C. We also continue to examine the performance of the diagnosis flags from Section I of the MDS.

Now that more recent data are available, we are developing a similar

file using FY 2009 data, which may be used to test our initial model formulas and monitor any recent changes to NTA utilization patterns. We solicit comment on the criteria specified above and the conceptual model discussed in the following sections.

3. Analytic Sample

To develop the analytic sample, we linked FY 2007 SNF cost reports with SNF Medicare Part A claims covering services delivered during the SNF's cost reporting period. The actual cost of the NTA services is determined by adjusting claims charges for NTA services in accordance with cost-to-charge ratios (CCRs) from the cost report. The NTA costs are then used as the dependent variable in all subsequent analyses, while MDS items and claims diagnoses act as the independent variables. We collected all claims, and used only those claims submitted within the reporting period for the cost reports available. Requiring a matched cost report eliminated some SNFs represented in the 2007 National Claims History. The SNFs that do not meet this threshold tend to be smaller SNFs, though this requirement does not adversely affect the representativeness of the analytic sample.

We have studied the same three general categories of NTAs as previous research has suggested: Respiratory-related costs (for example, ventilator services), drug-related costs, and other non-therapy ancillary (ONTA) costs (for example, wound dressings). We derive category-specific CCRs for each facility's cost report remaining in the sample. An additional requirement for an SNF to be in the sample is that it reports some drug and ONTA charges on the claims; otherwise, the facility's data may not be accurate enough to be used in the sample. Positive respiratory charges are not necessary, as these types of charges are not always reported. One reason is that some respiratory charges, such as oxygen-related supplies, are reported as ONTAs, based on certain reporting standards.

We trimmed the sample to eliminate facilities with extreme values for CCRs, as outlying CCRs could skew the results of our analysis. Finally, we compared the drug and ONTA charges on the claims to the SNF's cost report drug and ONTA charges, since wide differences could be the result of incomplete or inaccurate reporting. Facilities that were found to exhibit such wide differences were dropped from the sample. For our analysis, accurate charge reporting is critical for the measurement of our dependent-variable, CCR-adjusted NTA charges.

4. Approach to Analysis

The dependent variable in our analysis is the NTA charges, adjusted by CCRs. The independent variables are diagnosis groupings and variables selected from the matched MDS assessments. With the recent implementation of the MDS 3.0, we will monitor any changes in our selected set of variables and, based on research conducted as part of the Post Acute Care Payment Reform Demonstration (PAC–PRD), we may explore changes to the MDS assessment which would allow us to collect more detailed information on NTA costs and utilization. However, as our current analytic database is based on FY 2007 and FY 2009 data, our analysis still utilizes the MDS 2.0. The following sections of the MDS 2.0 contribute variables to be tested for their predictive value:

E: Mood and Behavior Problems
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 particular MDS items and diagnosis groupings to predict NTA costs builds on previous research discussed above and adheres to the criteria outlined earlier in this section. Now that we have completed the initial phase of this research, we are in a better position to understand the relationship between NTA costs and certain classes of illness. Understanding these relationships has led us to explore potential groupings of conditions, distinct from the RUG classification or qualifying hospital condition, which could suggest a feasible system for NTA payment tiers.

5. Payment Methodology

The payments associated with a new NTA component of the SNF PPS would be financed by reallocating that portion of the current nursing component which has been previously considered to account for NTA costs. Our intent in adding a separate NTA component, distinct from the nursing component, would be to provide greater predictive ability, promote more equitable NTA reimbursement, and achieve a more cost-effective payment structure for SNFs.

The NTA payment would be broken into two parts: A routine NTA bundled payment (RNP) and a tiered non-routine NTA payment (TNP).

a. Routine Non-Therapy Ancillary Payment

The RNP would constitute a base payment for every patient day, distinct from the tiered NTA payment described below and separate from the nursing component, to cover the cost of routine NTA services (drugs, laboratory services, *etc.*) that are commonly given to a wide range of SNF patients. CMS is currently analyzing SNF claims data linked to specially collected data from Medicare research projects, such as the STRIVE study and the PAC–PRD project, to help determine the specific drugs and services that would be included in the RNP and an appropriate per diem amount to cover their purchase and administration. Examples of such routine NTAs could include high blood pressure medication, common analgesics, anti-infective agents, sleep aids, laxatives, and standard blood tests, among others. The RNP would help capture the daily cost of administering these types of routine NTAs, thereby allowing for a more clearly defined and appropriate tiered NTA bundled payment to cover non-routine NTA services, as well as a more transparent payment for such routine costs incurred by providers. We also believe that, in conjunction with a possible NTA outlier policy (discussed below), having an RNP component would limit the administrative burdens associated with reporting that might be required to administer outlier payments.

As with the other components of the SNF PPS, the RNP piece of the NTA component would be updated annually to account for changes in the market basket and other relevant adjustments. It would operate in much the same way as the non-therapy non-case mix adjusted component of the current SNF PPS, in that it would constitute a flat amount added to the payment for all applicable SNF claims.

b. Tiered Non-Routine NTA Bundled Payment

The TNP would operate as a variation of the model previously discussed in the FY 2001 SNF PPS proposed rule (65 FR 19188, April 10, 2000). Specifically, we are in the process of developing a tiered NTA bundled payment, where payment tiers track relative variations in NTA costs and utilization. The June 2008 Urban Institute report referenced above (Garrett and Wissoker, June 2008) suggested that average wage-adjusted per diem NTA costs were approximately $68, with a standard deviation of $94, which would support the use of multiple case-mix-adjusted tiers.

The TNP is designed to capture the average cost of the drugs and services, given the patient's clinical characteristics, excluding the drugs and services covered by the RNP or those already excluded from the SNF PPS altogether under the consolidated billing requirements. Such a cost schedule and tier structure is currently under development, using recent Medicare Part A claims data and data from the PAC–PRD.

We have focused on developing an index model in which predictions are arrayed and then subdivided into fixed ranges of cost values to form distinct payment groups, or tiers, as we believe this type of approach is better equipped to handle the number of explanatory variables needed to predict NTA costs reasonably well. The tiers which constitute the TNP will be based on average NTA costs as measured from available administrative data. Generally, based on the resident's case mix and the variables selected for predicting NTA costs, if the resident's expected NTA costs exceed a particular threshold, then the facility would be paid a prospective amount, which would be added to the base RNP amount.

c. Non-Routine NTA Outlier Payment

Though we currently lack explicit statutory authority to establish an SNF outlier policy, we are continuing to explore how such a policy could be implemented in the event that we receive statutory authority. Results of the STRIVE study suggest that it is the cost of individual high-cost pharmaceuticals and other NTAs, rather than a particular patient's use of a high volume of NTA services, which creates high NTA costs. Given the effect of specific high-cost items like prescription drugs or respiratory services, it is clear that any type of averaging system (such as the conceptual NTA model discussed here) will not in all cases account for the cost of such items. It will be insufficiently sensitive to high NTA costs deriving from variations among costs of individual medications and ONTAs.

Accordingly, we are currently reviewing the available data to determine how an outlier approach could be designed to address patient-specific expenditures that exceed the routine and non-routine NTA payments that we would make, while allowing for an outlier threshold. While we have not yet fully simulated a potential SNF outlier payment policy, we believe it is appropriate to conduct analysis at the stay level, because NTA utilization can fluctuate significantly during a given SNF stay. Using a stay-level analysis of potential NTA cost outliers would help us to predict NTA costs more accurately over the course of a given SNF stay. Any further developments in this area will be discussed in future rulemaking.

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

As discussed 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 for 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. * * *" We know, as a result of the STRIVE study and a review of SNF cost data, that SNF residents with AIDS require much greater and more costly care than those without AIDS and that much of this additional cost is the result of NTAs, specifically high-cost medications.

Accordingly, as we have not yet completed work on the NTA component or an SNF outlier policy, we cannot yet determine whether such policy changes would be sufficient to compensate facilities for the costs associated with the treatment of residents with AIDS, in accordance with section 511 of the MMA. We will continue to study the relationship between NTA costs and resource use as they pertain to this population in order to develop an "appropriate adjustment" to account for such costs, as envisioned in the MMA.

IV. Ongoing Initiatives Under the Affordable Care Act

The Affordable Care Act contains a number of provisions that involve ongoing initiatives relating to SNFs. Here, we highlight several of these initiatives.

A. Value-Based Purchasing (Section 3006)

Section 3006(a) of the Affordable Care Act directs the Secretary to develop a plan to implement a value-based purchasing program for SNFs, with a report to Congress due by October 1, 2011. As we discussed previously in the SNF PPS proposed rule (73 FR 25932, May 7, 2008) and final rule (73 FR 46431–32, August 8, 2008) for FY 2009, value-based purchasing programs are intended to tie payment to performance in such a way as to reduce inappropriate or poorly provided care and identify and reward those who provide effective and efficient patient care.

We are in the process of developing the SNF value-based purchasing implementation plan and report. In accordance with section 3006(a) of the Affordable Care Act, we will be consulting with stakeholders in developing the implementation plan, as well as considering the outcomes of any recent demonstration projects related to value-based purchasing which we believe might be relevant to the SNF setting. We anticipate being able to provide further information on the progress of our efforts in future rulemaking.

B. Payment Adjustment for Hospital-Acquired Conditions (Section 3008)

As we discussed previously in the SNF PPS proposed rule for FY 2009 (73 FR 25932, May 7, 2008), "The preventable hospital-acquired conditions (HAC) payment provision for IPPS hospitals is another of CMS' value-based purchasing initiatives. The principal behind the HAC payment provision (Medicare not paying more for healthcare-associated conditions) could be applied to the Medicare payment systems for other settings of care." Section 3008 of the Affordable Care Act amends section 1886 of the Act by adding a new subsection (p) to establish a payment adjustment beginning in FY 2015 for subsection (d) hospitals that fall in the top quartile of national, risk-adjusted HAC rates. For such hospitals, the payment amount under section 1886, section 1814(b)(3), or section 1814(l)(4) of the Act for all discharges would be reduced by 1 percent. Section 3008(b) of the Affordable Care Act goes on to direct the Secretary to conduct a study on expanding the already-existing HAC policy found in section 1886(d)(4)(D) of the Act to payments made in various post-acute settings, including SNFs. In developing this study, the Secretary is directed to include the impact of expanding the HAC policy on patient care, safety, and overall payments.

In accordance with section 3008 of the Affordable Care Act, we are in the process of developing such a study, the outcomes of which are to be reported to Congress no later than January 1, 2012. As with the value-based purchasing program described above, we plan to consult with stakeholders in developing this study, and anticipate being able to provide information on our progress in future rulemaking.

C. Nursing Home Transparency and Improvement (Section 6104)

This provision of the Affordable Care Act requires SNFs to report expenditures separately for direct care staff wages and benefits on the Medicare cost report, for cost reporting periods beginning on or after 2 years after its enactment. Not later than 1 year after enactment of this section of the Affordable Care Act, the Secretary must redesign the cost report after consultation with private sector accountants experienced with Medicare and Medicaid nursing facility home cost reports. Within 30 months of its enactment, the provision requires the Secretary, in consultation with the Medicare Payment Advisory Commission (MedPAC), the Medicaid and CHIP Payment and Access Commission, the Inspector General of the United States Department of Health and Human Services, and other expert parties the Secretary determines appropriate, to categorize expenditures for each SNF into specific functional accounts on an annual basis. The provision also requires the Secretary to establish procedures to make information on the expenditures available to interested parties upon request, subject to the requirements the Secretary may specify under such procedures. A discussion of the information collection requirements currently being proposed in connection with this provision appears in a notice that was published in the March 11, 2011 **Federal Register** (76 FR 13415 through 13418).

V. Other Issues

A. Required Disclosure of Ownership and Additional Disclosable Parties Information (Section 6101)

Section 6101 of the Affordable Care Act was enacted in March 2010 to improve transparency of information in all Medicare SNFs and Medicaid nursing facilities. Specifically, it requires these facilities to make available on request by the Secretary and others certain information on ownership, including a description of the governing body and organizational structure of the relevant Medicare SNF or Medicaid nursing facility, and information regarding additional disclosable parties. Thus, we are proposing additional information that must be disclosed by Medicare SNFs and Medicaid nursing facilities in order for them to maintain their enrollment in Medicare and/or Medicaid.

According to nursing home quality data collected by CMS in 2008, about 1.5 million Americans reside in the Nation's 16,000 nursing homes on any given day. More than 3 million Americans rely on services provided by a nursing home at some point during the year. Those individuals, and an even larger number of their family members, friends, and relatives, must be able to count on nursing homes to provide reliable care of consistently high quality.

In 2007, the *New York Times* analyzed trends at nursing homes purchased by private investment groups. It subsequently reported that upon ownership by these private investment firms, the facilities' managers quickly cut costs by significantly decreasing the number of registered nurses, budgets for nursing supplies, resident activities, and other services. CMS's data revealed that of those homes bought by large private investment groups from 2000 to 2006, in 60 percent of those acquisitions, managers cut the number of clinical registered nurses far below levels required by the Medicare long-term care facility participation requirements under 42 CFR 483.30. Nursing homes owned by large private investment firms provided one clinical registered nurse for every 20 residents, which was 35 percent below the national average.

In its 2010 report to Congress entitled "Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data" (GAO–10–710, available online at *http://www.gao.gov/new.items/d10710.pdf*), the GAO reported similar findings. The GAO found that, although certain information on ownership was available to the public upon request, that information was not transparent because it did not establish the relationship of each owner to the nursing home and to one another. Also, it was found that the information was not being utilized by the State agencies for review purposes.

Hearings were conducted in November and December of 2007 by the House Committee on Ways and Means, the United States Senate Special Committee on Aging, and the United States Senate Committee on Finance, seeking information on investor-owned nursing homes. Congress found through several hearings that legal schemes were being used by investment firms to shield themselves from liability and, in effect, to deny residents and their families legal remedy against the nursing home. Congress believed that these complex legal structures can also result in a lack of transparency regarding who is responsible for resident care and the operation of investor-owned nursing homes.

We currently collect ownership information on nursing homes using the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). In addition, we currently capture ownership information on Medicaid nursing facilities using the Online Survey Certification and Reporting System (OSCAR). Nursing home providers, along with any other provider or supplier, must report information about any individual or entity with a 5 percent ownership interest. As discussed in section IX. of this proposed rule, we are hereby proposing to revise the reporting requirements that Medicare SNFs and Medicaid nursing facilities must disclose at the time of enrollment and when any change in ownership occurs, in order to implement section 6101 of the Affordable Care Act.

B. Therapy Student Supervision

In this proposed rule, we are proposing to revise a policy that originally appeared in the SNF PPS final rule for FY 2000 (64 FR 41644, July 30, 1999). The preamble in that final rule had indicated (at 64 FR 41661) that a therapy student in the SNF setting must "* * * be under the 'line-of-sight' level of supervision of the professional therapist." We note that the corresponding standards for the other inpatient settings under Part A (such as acute care hospitals and inpatient rehabilitation facilities) are silent on the issue of therapy student supervision and currently do not impose this type of restriction, so that each provider is free to determine for itself the most appropriate manner of supervision in this context, consistent with applicable State and local laws and practice standards. Because we consider it inequitable for SNFs to be subject to a more restrictive set of standards in this regard than the other inpatient settings, we believe that line-of-sight supervision should no longer be required in the SNF setting. Instead, as with other inpatient settings, each SNF would determine for itself the appropriate manner of supervision of therapy students, consistent with applicable State and local laws and practice standards. Accordingly, we are proposing to revise our current policy regarding supervision of therapy students, such that a therapy student working in an SNF would no longer be required to be in the supervising therapist's line of sight. We invite comments on our proposed revision to the supervision requirements for therapy students working in SNFs, and note that we plan to continue

monitoring the provision of therapy services in the SNF setting. We also note that we may revisit this issue in the future; however, consistent with the aim of promoting greater uniformity across inpatient settings on this point, we believe that such an analysis would most appropriately take place in the broader context of therapy standards that pertain to inpatient settings generally.

C. Group Therapy and Therapy Documentation

When the original RUG–III model was developed, most therapy services were furnished on a one-to-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, the results of our multi-year STRIVE project showed that provider practice patterns had changed and that a significant amount of therapy was provided on a concurrent basis, which at that time was defined as simultaneous treatment of multiple patients who were receiving different types of therapy services. In the FY 2010 final rule (74 FR 40315), we stated that as Medicare and Medicaid patients are among the frailest and most vulnerable populations in nursing homes, we believed the most appropriate mode of providing therapy would usually be individual therapy, not concurrent therapy. Further, we expressed concern that the method for reporting concurrent therapy on the MDS under RUG–III created an inappropriate payment incentive to perform concurrent therapy in place of individual therapy, because the method of reporting under RUG–III permitted concurrent therapy time to be counted in the same manner as individual therapy time. As we stated in the SNF PPS final rule for FY 2010 (74 FR 40315), the SNF PPS is based on resource allocation and costs. When a therapist treats two patients concurrently for an hour, it does not cost the SNF twice the amount (or 2 hours of the therapist's salary) to provide those services. As a result, with the introduction of RUG–IV, we modified the way providers report and are reimbursed for concurrent therapy services such that allocated concurrent therapy minutes are used to assign patients to RUG–IV groups. Providers can no longer be reimbursed for one hour's therapy time for each of the two Medicare beneficiaries treated concurrently for one hour. Effective October 1, 2010, providers are required to report on the MDS 3.0 for each patient the total unallocated minutes of concurrent therapy and specify the mode as concurrent. We then divide the total concurrent therapy time (60 minutes in this case) between the two patients in determining each patient's RUG–IV payment level (74 FR 40315–19). As we stated in the FY 2010 final rule (74 FR 40318), allocating concurrent therapy time reflects resource utilization more accurately for this type of therapy, and allows for more accurate RUG classification as well as the application of more appropriate CMIs. We note that in the FY 2010 final rule (74 FR 40317), we limited the number of concurrent therapy participants to two.

In comparison, we also considered the treatment of group therapy in the FY 2010 final rule (74 FR 40318); that is, simultaneous treatment of no more than four individuals (regardless of payer source) doing similar activities directed by a single therapist. Our STRIVE data showed that group therapy was used sparingly, and that utilization had not changed significantly since the inception of the SNF PPS in 1998. Further, in the FY 2010 proposed rule (74 FR 22223), we noted the difference between group and concurrent therapy. In group therapy, patients are performing similar activities, and by interacting with one another, group therapy patients observe and learn from each other and apply this new information to their own therapy program to progress and benefit from the group therapy setting. By contrast, in concurrent therapy, patients are not performing similar activities and often do not interact with each other. Because we had not proposed in the FY 2010 proposed rule to change the method in which group therapy minutes are used in RUG–IV classification, and the amount of group therapy being provided was low, in the FY 2010 final rule (74 FR 40318), we retained the original SNF PPS policy for payment of group therapy services, that is, group therapy minutes were not allocated but were limited to no more than 25 percent of the total weekly minutes per discipline for a particular patient. However, in the FY 2010 final rule (74 FR 40318), we discussed our intent "* * * to monitor therapy provided in the group setting, analyze data associated with group therapy, and, if needed, address any issues at a later time" in order to update these reporting requirements as necessary to maintain the accuracy and integrity of the RUG–IV payment system.

Using our STRIVE data as a baseline, we have identified two very significant changes in provider behavior related to the provision of therapy services to Medicare beneficiaries in SNFs under RUG–IV. First, we saw a major decrease in the amount of concurrent therapy performed in SNFs. At the same time, we found a significant increase in the amount of group therapy services which are not subject to the allocation requirement. Given this increase in group therapy services, we are concerned that the current method for reporting group therapy on the MDS creates an inappropriate payment incentive to perform the less intensive group therapy in place of individual therapy, because the current method of reporting group therapy time does not require allocation among patients. In addition, the allocation of concurrent therapy minutes effective FY 2011 may have created an incentive to perform group therapy in place of concurrent therapy in situations where concurrent therapy may have otherwise been appropriate. After further reviewing data associated with group therapy, we are proposing to change our policies relating to group therapy as further discussed below.

As noted above, we believe there are unique benefits to group therapy. In group therapy, patients are performing similar activities. Thus, in contrast to concurrent therapy, group therapy gives patients the opportunity to benefit from each other's therapy regimen by observing and interacting with one another, and applying the lessons learned from others to one's own therapy program in order to progress. Large groups, such as those of five or more participants, can make it difficult for the participants to engage with one another over the course of the session. In addition, we have long believed that therapists could not adequately supervise large groups, and, since the inception of the SNF PPS in July 1998, we have capped the number of residents at four.

Furthermore, we believe that groups of fewer than four participants do not maximize the group therapy benefit for the participants. As discussed above, and in the FY 2010 proposed rule (74 FR 22223), the unique benefit of group therapy comes from the interaction between multiple patients, which permits them to observe and learn from one another and apply the new information to their own program to progress and benefit from the group therapy setting. We believe that in groups of 2 or 3 participants, the opportunities for patients in the group to interact and learn from each other are significantly diminished given the small size of the group. Thus, we believe that groups of two or three participants, given their small size, significantly limit the ability of patients to derive the unique benefits associated with group

therapy. In such small groups, these limitations become even more accentuated whenever one or two patients are absent from the therapy session (in fact, with groups of two participants, if one patient is absent from the session, there are no longer any patients with whom the remaining participant can interact, thereby eliminating any benefit that could be derived from participation in a group). Thus, for the reasons discussed above, we believe that the most appropriate group therapy size for the SNF setting is four, which we believe is the size that permits the therapy participants to derive the maximum benefit from the group therapy setting.

As discussed in the FY 2010 final rule, we are responsible for determining Medicare coverage and payment policy, that is, "the scope of services that will be paid for by the Medicare program under the SNF PPS and the manner in which those services will be reported and paid" (74 FR 40316). Thus, for purposes of payment under the Medicare SNF PPS, for the reasons discussed above, we are proposing to establish a standard that defines group therapy as therapy provided simultaneously to four patients who are performing similar therapy activities.

Furthermore, as we have stated previously, the SNF PPS is based on resource utilization and costs. We believe that when a therapist treats four patients in a group for an hour, it does not cost the SNF four times the amount (or four hours of a therapist's salary) to provide those services. The therapist would appropriately receive one hour's salary for the hour of therapy provided. Accordingly, we believe that allocating group therapy minutes among the four group therapy participants best captures the resource utilization associated with providing a maximally beneficial group therapy intervention. For therapists treating patients in a group setting, the full time spent by the therapist with these patients would be divided by 4 (the number of patients that comprise a group). For example, if a therapist spends 1 hour with four residents in a group therapy session, regardless of payer source, then the time used to determine the appropriate RUG–IV classification for each Medicare beneficiary receiving SNF care benefits as part of a qualified Part A stay will be 15 minutes, or 60 minutes of total therapist time divided by four. These 15 minutes, which may be referred to as the therapist's "reimbursable therapy minutes" (RTM), are those minutes used to classify a patient for therapy purposes. For each of the RUG–IV categories, it is the number of reimbursable therapy minutes that is used to classify a given patient into a therapy RUG–IV group. For example, if a therapist provides 400 minutes of individual therapy, 200 minutes of concurrent therapy, and 120 minutes of group therapy (given the proposed policy change to group therapy discussed here), then the therapist's total RTM would be 530, or 400 RTM for individual therapy, 100 RTM for concurrent therapy, and 30 RTM for group therapy. The total of 530 RTM is what would be used to determine the patient's appropriate RUG–IV classification. We hope that defining this concept of a reimbursable therapy minute will help clarify the number of minutes necessary to reach certain RUG–IV categories, given the allocation policies discussed here and in the FY 2010 proposed and final rules.

As is currently the procedure, the SNF would report the total unallocated group therapy minutes on the MDS 3.0 (60 minutes in the scenario above) for each patient. In terms of RUG–IV classification, this total time would be allocated (that is, divided) among the four group therapy participants to determine the appropriate number of RTM and, therefore, the appropriate RUG–IV therapy group and payment level, for each participant. The 25 percent cap on group therapy minutes, as defined in the July 30, 1999 final rule (64 FR 41662) will remain in effect, as we continue to believe that group therapy should serve only as an adjunct to individual therapy. The 25 percent cap would be applied to the patient's reimbursable group therapy minutes. In addition, consistent with our current policy (64 FR 41662), the supervising therapist may not be supervising any individuals other than the four individuals who are in the group at the time of the therapy session. We invite comments on our proposals to revise our group therapy policies as discussed above, including the proposal to establish a standard that defines group therapy as a service provided to four patients, and the proposal to allocate group therapy minutes.

While we believe that group therapy can play an important role in SNF patient care, we note that group therapy is not appropriate for either all patients or for all conditions, and is primarily effective as a supplement to individual therapy, which we maintain should be considered the primary therapy mode and standard of care in therapy services provided to SNF residents. As evidenced by the application of a cap on the amount of group therapy services that may be provided to SNF residents, we do not believe that a SNF providing the preponderance of therapy in the form of group therapy would be demonstrating the intensity of therapy appropriate to this most frail and vulnerable nursing home population. Accordingly, we believe it is important to clarify our expectations regarding the clinical documentation needed to support each patient's plan of care, including the patient's prescribed group therapy interventions, as further discussed below. Additionally, we specifically solicit comments on the types of patients for which group therapy may be appropriate, and the specific amounts of group therapy that may be beneficial for these types of patients. We anticipate using this information to assess the appropriate use of group therapy in SNFs and may revise standards of group therapy care in SNFs accordingly.

SNFs are currently required to prescribe the type, amount, frequency, and duration of physical therapy, occupational therapy, and speech-language pathology services in a patient's plan of care. Under § 409.23(c), Medicare pays for therapy services if they are furnished, among other things, in accordance with a plan that meets the requirements of § 409.17(b) through (d). Section 409.17(c)(1) states that the plan must prescribe "the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual." As evidenced by the discussion of care planning and the qualifications for skilled therapy services in Chapter 3, Section O of the RAI manual in relation to item O0400, SNFs are expected to include supporting documentation in each patient's medical record on an ongoing basis. We further believe that such medical record documentation is needed so that SNFs can verify that the plan of care is being followed. In addition, we believe that such clinical documentation has always been necessary so that SNFs can identify when significant changes in a patient's medical condition occur requiring an unscheduled assessment, such as a Significant Change in Status assessment. In fact, even when the clinical change is unrelated to the therapy program, these unscheduled assessments require completion of Section O, which reports therapy minutes by individual, concurrent, and group modes. Finally, we believe that such documentation has always been required so that contractors can verify medical necessity when they review SNF claims.

Additionally, under § 409.17(c)(2), SNFs must indicate "the diagnosis and anticipated goals" associated with the

therapy services prescribed in accordance with § 409.17(c)(1), as described above. It is incumbent upon providers to ensure that skilled therapy services provided to a given SNF resident are appropriate to the goals of the patient's individualized plan of care. Thus, it should be clear, based on the patient's medical record, therapy notes, and/or other related documentation, how the prescribed skilled therapy services contribute to the patient's anticipated progression toward the prescribed goals. Because group therapy is not appropriate for either all patients or all conditions, and in order to verify that group therapy is medically necessary and appropriate to the needs of each beneficiary, SNFs should include in the patient's plan of care an explicit justification for the use of group, rather than individual or concurrent, therapy. This description should include, but need not be limited to, the specific benefits to that particular patient of including the documented type and amount of group therapy; that is, how the prescribed type and amount of group therapy will meet the patient's needs and assist the patient in reaching the documented goals. In addition, we believe that the above documentation is necessary to demonstrate that the SNF is providing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with section 1819(b)(2) of the Act.

Should the actual utilization of therapy services deviate significantly from the patient's plan of care, we expect the facility to update the plan of care to prescribe the new type, amount, frequency, and duration of physical therapy, occupational therapy, and speech-language pathology services. Furthermore, we believe that such changes to the mode and/or intensity of therapy must be justified by changes in the beneficiary's underlying health condition; thus, in order to demonstrate that such changes are medically necessary, the provider should clearly describe in the plan of care the reasons for deviating from the original care plan. Consistent with § 409.17(c), the revised care plan must outline the updated goals and the revised type (that is, mode), amount, frequency, and duration of physical therapy, occupational therapy, and speech-language pathology services to be furnished to the patient.

In addition, with approximately 90 percent of the beneficiaries in Medicare stays receiving therapy, changes in the mode, amount, frequency, and/or duration of therapy services can have significant payment implications when such changes also result in a reclassification of the beneficiary's case-mix group. Under § 413.343(b), SNFs are required to perform assessments on the 5th, 14th, 30th, 60th, and 90th days of posthospital SNF care, "and such other assessments that are necessary to account for changes in patient care needs." The unscheduled assessments exist to capture changes in a resident's skilled nursing or therapy needs outside the observation window used for the scheduled PPS assessments. We expect that the data reported in these required assessments, both scheduled and unscheduled, provide an accurate representation of the skilled therapy and nursing needs of the patient. Thus, if providers find changes in clinical and therapy status which would affect the accuracy of a resident's most recent assessment, then we would expect (as discussed above) that these changes would be recorded in the patient's plan of care and medical record, as well as through the use of unscheduled assessments, to determine if a subsequent change in payment is necessary. However, based on the available data, we believe that changes in resident status outside the observation window do not always generate an unscheduled assessment, as the changes, while significant for payment, do not always rise to the level of a significant change in clinical status. Additionally, in some cases, changes in therapy utilization levels may even be unrelated to the patient's clinical condition but may be caused by staffing constraints or facility practices. For these reasons, we are proposing alternative solutions which would help capture perceived changes in resident status, as discussed in section V.D below.

D. Proposed Changes to the MDS 3.0 Assessment Schedule and Other Medicare-Required Assessments

Under section 1888(e)(6) of the Act, SNFs are required to provide the Secretary, in a manner and within the timeframes prescribed by the Secretary, the resident assessment data necessary to develop and implement the payment rates. In order to receive proper payment for services provided during Part A Medicare SNF stays, SNFs must perform patient assessments in accordance with the assessment schedule outlined in the May 12, 1998 interim final rule (63 FR 26265–26268) and, under the discussion in that interim final rule, in accordance with the guidelines found in the RAI Manual, version 3.0. As discussed previously, the RAI Manual also includes the clarifications to the RAI Manual posted on the MDS Web site at *http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp.* Following this schedule, SNFs must currently "perform patient assessments by the 5th day (although there is a grace period that allows performance by the 8th day) of the SNF stay, again by the 14th day, by the 30th day, and every 30 days thereafter as long as the patient is in a Medicare Part A stay" (63 FR 26265) (though there is a 5-day grace period for each of the 14-, 30-, 60-, and 90-day assessments as reflected in sections 2.8 and 2.9 of the RAI Manual, version 3.0). The current assessment schedule is also described at § 413.343(b). As set forth in sections 2.8 and 2.9 of the RAI Manual, version 3.0, these Medicare-required assessments must be performed based on an Assessment Reference Date (ARD) within the specified window, which is the end-point of the observation period for the relevant MDS assessment.

After further review of the MDS 3.0 assessment schedule, we believe that the combination of the current grace period allowance and observation period could cause MDS assessments to be performed in such a way that some of the information coded on a subsequent assessment is duplicative of the previous assessment. For example, if a 5-day assessment is completed with an ARD of day 8 of the Part A stay, and the ARD for the 14-day assessment is set for day 11, then the patient's status for four days of the stay will be coded twice for some items, that is, on the 5-day Medicare-required assessment and the 14-day Medicare-required assessment (because, given the 7-day lookback period for some items, days 5 through 8 would overlap between the two assessments). The intended purpose of the Medicare assessment schedule was to capture the changes in the patient's status, especially during the first few weeks of the Medicare stay. However, because the observation periods overlap so closely, changes in the patient's status are not reflected as originally intended. In addition, the ARD of the 30-day Medicare-required assessment may be set as early as day 21 of the Medicare Part A stay, in which case, for some items the first day of the observation period may be as early as day 15 (for items with a 7-day look back). For example, the patient may have the Brief Interview for Mental Status (BIMS) conducted on day 15 and thus coded on the 30-day Medicare-required assessment, which determines the RUG–IV group for payment days 31–60. Thus, the payment based on the assessment would not reflect the

patient's cognitive status near the 30th day of the stay, but instead would actually reflect that status at the 15th day of the stay.

Given the implications of these scenarios for both care quality and payment accuracy, we propose to modify the current Medicare-required assessment schedule (Table 10A) to incorporate new assessment windows and grace days, as indicated in Table 10B, with appropriate changes to be made in the RAI Manual.

TABLE 10A—CURRENT MDS 3.0 ASSESSMENT SCHEDULE

Medicare MDS assessment type	Reason for assessment (A0310B code)	Assessment reference date window	Assessment reference date grace days	Applicable medicare payment days
5 day	01	Days 1–5	6–8	1 through 14.
14 day	02	Days 11–14	15–19	15 through 30.
30 day	03	Days 21–29	30–34	31 through 60.
60 day	04	Days 50–59	60–64	61 through 90.
90 day	05	Days 80–89	90–94	91 through 100.

TABLE 10B—PROPOSED MDS 3.0 ASSESSMENT SCHEDULE

Medicare MDS assessment type	Reason for assessment (A0310B code)	Assessment reference date window	Assessment reference date grace days	Applicable medicare payment days
5 day *	01	Days 1–5	6–8	1 through 14.
14 day	02	Days 13–14	15–18	15 through 30.
30 day	03	Days 27–29	30–33	31 through 60.
60 day	04	Days 57–59	60–63	61 through 90.
90 day	05	Days 87–89	90–93	91 through 100.

* Changes would also apply to Readmission/Return Assessment (A0310B code = 06).

We believe that these proposed changes to the Medicare-required assessment schedule will result in less duplication of information coded on subsequent assessments, and will better capture the patient's change in status, as well as the change in services/treatments, over the course of the stay without creating undue burden on providers. We also believe that ensuring the passage of a greater amount of time between assessments would improve patient and provider satisfaction and care quality, as it would not be necessary to repeat interview questions and assessment items required on the MDS assessments within such a short period of time. We solicit comments regarding these proposed changes to the current MDS 3.0 assessment schedule.

In addition, with regard to the completion of unscheduled PPS assessments, we wish to clarify a policy which first appeared in the FY 2010 final rule (74 FR 40347 through 40348). In the FY 2010 final rule (74 FR 40347 through 40348), we finalized the policy that the ARD for an End-of-Therapy (EOT) OMRA must be set 1 to 3 days after the discontinuation of all therapies (speech-language pathology services and occupational and physical therapies). Based on this policy, the EOT OMRA must be completed, at the latest, when a patient has not received therapy for three consecutive days (although we note that, as finalized in the FY 2010 final rule (74 FR 40348), in determining the ARD, days currently are counted differently for facilities that provide therapy services 5 days per week as compared to facilities that provide therapy services 7 days per week, as further discussed below). Further, in the FY 2010 final rule (74 FR 40348), we cite the "daily basis" criteria at § 409.34(b) in order to clarify that a break in therapy of 1 or 2 days (such as may result from a brief illness or extreme fatigue), would not necessarily result in a provider having to complete an EOT OMRA. Thus, we are clarifying that, consistent with this policy and our policy regarding setting the ARD for the completion of an EOT OMRA, an EOT OMRA must be completed once such therapy services cease for three consecutive days, regardless of the reason.

We note that some SNFs have expressed concern over the use of the phrase "discontinuation of therapy services." Therefore, we wish to clarify what is meant by the phrase "discontinuation of therapy services" as it applies to our policies governing completion of PPS assessments. We recognize that there may be two types of "discontinuation of therapy services." A discontinuation in therapy services may be temporary; for example, in cases of illness, patient refusal, or visits to a doctor's office. Such breaks in therapy generally cannot be predicted in the plan of care and they may be characterized as an "unplanned" discontinuation of therapy services. These types of discontinuations usually reflect an expectation that therapy will resume at some point. Alternatively, a discontinuation of therapy services may be characterized as a "planned" discontinuation, that is, the discontinuation is consistent with the patient's plan of care such as when the patient has reached the prescribed therapy goals. In the FY 2010 final rule, in finalizing our policy related to setting the ARD for an EOT OMRA at 1 to 3 days after discontinuation of therapy services, we did not distinguish between planned and temporary unplanned discontinuation of therapy. Thus, the ARD for the EOT OMRA must be set for Day 1 to 3 after the discontinuation, planned or unplanned, of all therapy services. Accordingly, we are clarifying that providers must complete an EOT OMRA for a patient classified in a RUG–IV therapy group if that patient goes three consecutive days without being furnished any therapy services, regardless of the reason for the discontinuation of therapy. We believe this clarification of the policy related to setting the ARD for the EOT OMRA, is consistent with the intent of this policy as expressed in the FY 2010 proposed and final rules (that is, to allow for more accurate classification of patients based on services needed and provided to the patient) (74 FR 22246, 74 FR 40347–48), the discussion of this policy found in section 2.9.07 of the MDS 3.0 RAI

Manual and MDS 3.0 training materials, which may be found at *http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp,* as well as with the criteria set forth in 42 CFR 409.34(b), as discussed above.

Accordingly, providers are required to complete an EOT OMRA in cases where a resident who is currently assigned to a therapy RUG–IV group has not received any therapy services for three consecutive days. By completing the EOT OMRA, SNFs will be paid at the appropriate non-therapy RUG–IV rate (starting the day following the last day that therapy services were furnished to the patient), depending on other relevant characteristics of the patient's condition. If therapy resumes, the SNF may complete the optional Start-of-Therapy (SOT) OMRA, which can be used to reclassify the patient into a therapy RUG–IV group at any point during a resident's Part A SNF stay until completion of the next regularly scheduled PPS assessment.

Following publication of the FY 2010 final rule, some SNFs have expressed concern regarding the difficulty in determining if a given facility should be considered a 5-day or 7-day facility, for the purposes of setting the ARD for the EOT OMRA (that is, whether a facility should be considered as providing therapy services 5 days per week or 7 days per week). In the FY 2010 final rule, we discussed the days to be counted toward the establishment of the ARD for the EOT OMRA. In that rule (74 FR 40348), we stated "when a facility only provides therapy 5 days a week * * * the weekend days would not be counted toward the establishment of the ARD for the end-of-therapy OMRA." This policy has since caused significant confusion for providers who might use weekends to make up for therapy that was not provided during the week or who might only provide therapy on weekend days when a holiday falls on a weekday, as it is unclear to such providers whether they would be considered a 5-day facility or a 7-day facility. As such, to alleviate this confusion and add greater clarity and consistency to our policy regarding setting the ARD for the EOT OMRA as discussed above, we propose to eliminate the distinction between 5-day and 7-day facilities for purposes of setting the ARD for the EOT OMRA. Accordingly, we propose that, effective October 1, 2011, an EOT OMRA for a patient classified in a RUG–IV therapy group would be required if that patient goes three consecutive calendar days without being furnished any therapy services, regardless of whether the facility is a 5-day or 7-day facility or the reason for the discontinuation in therapy services. However, while the ARD for the EOT OMRA would be required to be set by the third consecutive calendar day after discontinuation of therapy services, as we discuss above and in the FY 2010 final rule, the SNF also has the option of setting the ARD for the EOT OMRA on day 1 or day 2 after therapy services have been discontinued. Thus, if a facility (regardless of whether it is a 5-day or 7-day facility) discontinues therapy on a Friday, the ARD for the EOT OMRA would be required to be set for the immediately following Saturday, Sunday, or Monday, if the patient has not been provided therapy services in the interim. We believe that this proposed policy of requiring all SNFs to set the ARD for the EOT OMRA by the third consecutive calendar day after a patient's therapy services have been discontinued, appropriately reflects that the frail and vulnerable populations within SNFs require consistent therapy without significant breaks in services. In addition, this policy is consistent with our discussion of 42 CFR 409.34(b) in the FY 2010 final rule, in which a break of 1 or 2 days would not necessarily result in a provider having to complete an EOT OMRA. We invite comments on this proposed change to our policy related to setting the assessment ARD for the EOT OMRA.

In addition, some providers have suggested that the completion of an EOT OMRA and subsequent SOT OMRA may not be necessary for all patients, particularly in cases where therapy services resume at the same mode and intensity as the patient was receiving before the discontinuation of therapy service. We have considered this issue and we believe that, in some cases where an EOT OMRA has been completed and therapy resumes shortly thereafter, an SOT OMRA may not be necessary to establish the patient's clinical condition, specifically where the RUG–IV classification level has not changed (as further discussed below).

For the reasons discussed below, we propose that, effective for services provided on or after October 1, 2011, when an EOT OMRA has been completed and therapy subsequently resumes, SNFs may complete an End-of-Therapy Resumption (EOT–R) OMRA, rather than an SOT OMRA, in cases where therapy services have ceased for a period of no more than 5 consecutive calendar days, and have resumed at the same RUG–IV classification level that had been in effect prior to the EOT OMRA. In the situation where therapy services have resumed within such a short period of time at the same RUG–IV classification level, we do not believe that a new therapy evaluation and SOT OMRA would be necessary to reclassify the patient back into a RUG–IV therapy group because, given that the therapy resumed at the same RUG–IV classification level, it is likely that the patient's clinical condition has not changed. Instead, the EOT–R OMRA may be used if the resumption date is no more than 5 consecutive calendar days after the date of the last therapy service furnished prior to the temporary discontinuation of therapy service reported on the EOT OMRA. To allow resumption of therapy reporting, two new items, O0450A and O0450B (Resumption of Therapy), would be added to the EOT OMRA item set so that it may be used as an EOT–R OMRA to report a resumption of therapy. These two new items would only be completed on an EOT OMRA (A0310C = 2 or 3) when therapy has resumed in the circumstances discussed above, for purposes of reporting the resumption of therapy services. As discussed above, we propose that the resumption of therapy must occur no more than 5 calendar days after the date that all therapy ends in order for completion of an EOT–R ORMA to be appropriate. For example, if therapy services are discontinued on Day 35 of a stay, then therapy services must resume for that patient (at the same level as the patient's RUG–IV classification prior to the discontinuation) by Day 39 of the stay in order for SNFs to have the option to complete an EOT–R OMRA for that patient. If therapy does not resume until Day 40 or later, then the SNF may not choose to complete an EOT–R OMRA under these circumstances. The resumption of therapy date is reported on the EOT OMRA if that EOT OMRA has not been submitted and accepted in the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. If the EOT OMRA has already been accepted in the ASAP system without a resumption of therapy date, then the prior EOT OMRA record should be modified to add the resumption of therapy date. No other changes should be made with this modification.

In cases where therapy resumes more than five consecutive calendar days from the discontinuation of therapy service, we believe it is likely that the patient's clinical condition needs to be evaluated to identify changes in clinical and/or therapy needs. Thus, in this case, the SNF could either perform an optional SOT OMRA to classify the

patient into a RUG–IV therapy group, or wait until the completion of the next regularly scheduled PPS assessment to classify the patient into a RUG–IV therapy group, if such a classification is clinically appropriate. In these situations, the therapist would be required to conduct a therapy evaluation and establish a new therapy care plan for the patient.

As discussed above, SNFs would set the ARD for the EOT OMRA 1 to 3 calendar days after the discontinuation of all therapies (speech-language pathology services and occupational and physical therapies). The EOT–R OMRA would include the same items as the EOT OMRA with the addition of O0450A and O0450B as described above. We note that the EOT–R OMRA would be an optional assessment. If therapy resumes after completion of an EOT OMRA and the criteria are met for performance of an EOT–R OMRA (as discussed above), the SNF would have the option of performing the EOT–R OMRA, an SOT OMRA, or waiting until the next regularly scheduled PPS assessment to assess the patient's clinical condition. We solicit comments on our proposal to allow providers the option to complete an EOT–R OMRA in the circumstances described above.

In accordance with section 2.9.07 of the RAI Manual, Version 3.0 (available online at *https://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp*), completion of an EOT OMRA is required "* * * when the resident was classified in a RUG–IV Rehabilitation Plus Extensive Services or Rehabilitation group *and continues to need Part A SNF-level services after the discontinuation of all rehabilitation therapies*" (emphasis added). Accordingly, we note that a SNF's completion of an EOT OMRA does not automatically result in the immediate termination of Part A coverage. Typically, a resident in this situation will have ongoing medical conditions that are clearly of sufficient intensity to justify continued coverage under one of the non-therapy RUGs, based on the need for daily skilled nursing services. Even when it may not be readily apparent that this is, in fact, the case (for example, when a resident is assigned to one of the less intensive RUGs, such as one that would result in receiving an individual level of care determination under the administrative presumption described in section II.E of this proposed rule), there may still be a need for continued skilled services, as when skilled observation is indicated for a resident whose overall medical condition is precluding the resident from undergoing further therapy.

Moreover, even in situations where skilled rehabilitation is the sole reason for the SNF stay, the temporary discontinuation of therapy may not in itself necessarily have the effect of terminating coverage, if it is followed shortly thereafter by a resumption of therapy. For example, in discussing the effect of a brief absence from the facility on a resident's continued ability to meet the SNF level of care criterion of "daily" skilled rehabilitation, we noted in the FY 2000 final rule (64 FR 41670, July 30, 1999) that "* * * the requirement for daily skilled services should not be applied so strictly that it would not be met merely because there is a brief, isolated absence from the facility in a situation where discharge from the facility would not be practical." Similarly, a resident who does not leave the facility at all may nonetheless experience a temporary inability to undergo therapy for such a brief period that discharge from the facility would not be practical, as described in 42 CFR 409.34(b). However, as discussed above, an EOT OMRA would need to be completed if the patient goes three consecutive calendar days without therapy services, regardless of the reason for the discontinuation of therapy services.

A related point on which we have recently received inquiries is the manner in which these policies relate to the requirements for providing an Advance Beneficiary Notice of Noncoverage (ABN). As explained in § 50.2.1 of the Medicare Claims Processing Manual, chapter 30 (available online at *http://www.cms.gov/manuals/downloads/clm104c30.pdf*), an ABN serves to notify a beneficiary of the provider's belief "* * * that an otherwise covered item or service may be denied either as not reasonable and necessary under § 1862(a)(1) of the Act or because the item or service constitutes custodial care under § 1862(a)(9) of the Act." Section 70.2.3.1 describes the triggering events for issuance of an SNF ABN.

In this context, it has been suggested by some providers that when a facility furnishes therapy only on weekdays, it should routinely issue an ABN every Friday afternoon in order to anticipate the possibility that a given resident might be unable or unwilling to undergo therapy on the following Monday, thereby triggering an EOT OMRA and potentially causing the patient to drop below a covered level of care in the SNF.

We would note at the outset that under the current policy set forth in the FY 2010 final rule (74 FR 40348), a facility that provides therapy services 5 days per week would not count the weekend days in determining the ARD for the EOT OMRA and, thus, an EOT OMRA would not necessarily be triggered if the patient were to be unwilling or unable to undergo therapy on the following Monday. Nevertheless, we note that, as discussed above, we are proposing in this rule to eliminate the distinction between 5 and 7-day facilities for purposes of setting the ARD for the EOT OMRA. Even so, it is still important to bear in mind that, in this situation, the decision to issue an ABN is an individualized action, and should not be applied across the board to all patients. The ABN should not be provided merely because of the possibility that the patient might be unwilling or unable to participate in therapy the next day. There must be an actual discontinuation of therapy before the SNF can anticipate that the patient may enter into custodial care. In addition, it may not be the case for every patient that the continued SNF stay would become noncovered custodial care as a result of the cessation of therapy. Thus, it is not until that point has actually been reached that the issuance of an ABN would become appropriate. The ABN should inform the beneficiary of the provider's belief that Medicare will no longer pay for the SNF stay because the patient is unwilling or unable to continue therapy and that therapy was the only reason the SNF stay was covered by Medicare. This information will help the patient make an informed decision about the potential consequences of failing to undergo the therapy session.

However, we expect that these unplanned discontinuations in service will be relatively rare. If such unplanned discontinuations in service occur on a repeated basis, the provider should carefully evaluate whether or not the patient continues to meet Medicare coverage criteria.

Finally, as noted in section V.C above, we have found some cases where therapy services recorded on a given PPS assessment did not provide an accurate account of the therapy provided to a given resident outside the observation window used for the most recent assessment. We believe that when service levels change, whether inside or outside the observation period, such changes should be based on medical evidence. However, we have found that the current range of PPS assessments may not permit SNFs adequate flexibility to report such changes in therapy services outside the observation window. As discussed

above, based on the available data, we believe that changes in resident status outside the observation window do not always generate an unscheduled assessment, because the changes, while significant for payment, do not always rise to the level of a significant change in clinical status under § 483.20(b)(2)(ii). Additionally, in some cases, changes in therapy utilization levels may even be unrelated to the patient's clinical condition but may be caused by staffing constraints or facility practices.

Accordingly, we propose that, effective for services provided on or after October 1, 2011, SNFs would be required to complete a Change of Therapy (COT) OMRA, for patients classified into a RUG–IV therapy group, whenever the intensity of therapy (that is, the total RTM delivered) changes to such a degree that it would no longer reflect the RUG–IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment. The COT OMRA would be a new type of required PPS assessment, which would use the same item set as the current EOT OMRA. The ARD for the COT OMRA would be set for Day 7 of a COT observation period, which is a rolling 7-day window beginning on the day following the ARD set for the most recent scheduled or unscheduled PPS assessment (or beginning the day therapy resumes in cases where an EOT–R OMRA is completed, as further discussed below), and ending every 7 calendar days thereafter. For example, if a facility sets the ARD for its 14-day assessment to Day 14, then Day 1 for the purposes of the COT observation period would be Day 15 of the SNF stay, and the facility would be required to review its therapy minutes for the week consisting of Days 15 through 21. The ARD for the COT OMRA would then be set for Day 21, if the facility were to determine that the total RTM has changed such that the RUG classification found on the 14-day assessment (assuming no intervening assessments) is no longer accurate. If the SNF were to determine that the total RTM has not changed to such an extent that the RUG classification on the 14-day assessment is no longer accurate (assuming no intervening assessments), then the COT OMRA would not be completed and the next evaluation of the patient's total RTM, for the purposes of completing a COT OMRA, would occur on Day 28. We want to stress that SNFs would be required to complete a COT OMRA only if a patient's total RTM changes to such an extent that the patient's RUG classification, based on their last PPS assessment, is no longer an accurate representation of their current clinical condition. However, an evaluation of the necessity for a COT OMRA (that is, an evaluation of the patient's total RTM) must be completed every seven calendar days starting from the day following the ARD set for the most recent scheduled or unscheduled PPS assessment (or in the case of an EOT–R OMRA, starting the day that therapy resumes, as discussed below).

In cases when an unscheduled assessment must be completed within a COT observation period, then Day 1, for the purposes of setting the ARD for the COT OMRA would be the day after the ARD set for the intervening assessment or, in a case where the intervening assessment is an EOT–R OMRA, Day 1 would be the day that therapy resumed. For example, consider a patient for whom the ARD of the 30-day PPS assessment is set to Day 30 and is classified into a RUG–IV therapy group. The patient receives therapy on Days 31 through 35, does not receive therapy on Days 36 through 39, but is expected to resume therapy on Day 40. In this case, the SNF would have evaluated the patient's total RTM on Day 37. Assuming that the patient's total RTM is consistent with the patient's RUG classification on the 30-day assessment (most recent scheduled or unscheduled PPS assessment), then the next assessment that the SNF must complete, given the above scenario, would be an EOT OMRA with an ARD set for Day 36, Day 37, or Day 38 (given that therapy is expected to resume on Day 40, we would advise the SNF to hold off on submitting the EOT OMRA until after therapy has resumed, so that the EOT OMRA may be modified into an EOT–R OMRA with an accurate resumption date). Assuming therapy resumes on Day 40 at the same RUG classification level and an EOT–R OMRA is completed, the COT observation period for this patient would then begin on Day 40, and the next evaluation of the patient's total RTM would be necessary on Day 46. In terms of payment for this patient, the SNF would be paid beginning Day 31 at the rate for the RUG–IV therapy group determined on the basis of the patient's clinical condition reported on the 30-day assessment, paid for Days 36 through 39 at the corresponding non-therapy rate, based on the patient's clinical condition reported on the 30-day assessment (because therapy services were discontinued on Day 36 and an EOT OMRA was completed) and, beginning Day 40, would resume payment at the previous therapy rate (because therapy services resumed at the same RUG classification level and an EOT–R OMRA was completed). Given this scenario, the next evaluation of the patient's total RTM should occur on Day 46.

It should be noted that this proposed policy regarding the COT observation period and setting the ARD for completion of the COT OMRA would be independent of the policy for setting the ARD for the EOT OMRA as described previously. That is, if a patient classified in a RUG–IV therapy group does not receive any therapy services for three consecutive calendar days, then the provider would be required to complete an EOT OMRA with an ARD not later than the third calendar day (in accordance with the proposed policy discussed previously for setting the ARD for an EOT OMRA), even if the provider completed a COT OMRA during the temporary discontinuation of therapy service. For example, in contrast to the previous scenario, if the evaluation of the patient's total RTM on Day 37 reveals that the intensity of therapy provided to the patient has changed to such a degree that it no longer reflects the patient's RUG–IV classification as reported on the 30-day assessment, then the SNF would be required to complete a COT OMRA, with an ARD set for Day 37, which is the last day of that patient's COT observation period. Assuming the patient is still classified into a RUG–IV therapy group after completion of the COT OMRA, and all other conditions of the above scenario remain the same, then the SNF would be paid at the revised therapy RUG–IV rate beginning Day 31, the corresponding non-therapy rate for Days 36 through 39, and would resume payment at the revised RUG–IV therapy group rate beginning Day 40 (assuming therapy resumes at the same RUG classification level as determined on the COT OMRA). As in the above scenario, the next evaluation of the patient's total RTM would occur on Day 46. Thus, the new RUG–IV group resulting from the COT OMRA would be billed starting the first day of the COT observation period for which the COT OMRA was completed, and would remain at this level until a new assessment is completed which changes the patient's RUG–IV classification.

We believe that the COT OMRA would allow us to track changes in the patient's condition and in the provision of therapy services more accurately, resulting in improving the accuracy of reimbursement for therapy services and enhancing the SNF's ability to provide quality care to SNF residents. We invite

comments on this proposal to require a COT OMRA when the total RTM changes to such a degree as to affect RUG–IV classification and payment.

E. Discussion of Possible Future Initiatives

We are considering a number of possible future initiatives that may help to ensure the long-term stability of the SNF PPS and further improve the accuracy of the rate-setting process. Along with our broad, ongoing objectives of ensuring stability and promoting accuracy of the SNF PPS, this analysis has been prompted in particular by our recent experience of needing to recalibrate the CMIs in 2 of the last 3 years. Accordingly, we have begun to consider a number of possible future modifications to certain aspects of the SNF PPS. We note that we are not proposing new Medicare policy in this discussion of possible future modifications, as we recognize that depending on how such modifications are ultimately formulated, their actual implementation may require new statutory authority.

We note that previous research by the Urban Institute, as cited in Chapter 8 of MedPAC's June 2007 Report to Congress entitled "Promoting Greater Efficiency in Medicare" (available online at *http://www.medpac.gov/documents/jun07_entirereport.pdf*), has recommended an approach to therapy reimbursement based on actual patient need. This approach would consider patient diagnosis and service needs to predict and reimburse prospectively for an appropriate level of therapy. While this methodology would eliminate reliance on the actual minutes of therapy provided, we are evaluating ways to verify utilization to prevent underutilization or overutilization of therapy services.

We are also more closely examining certain methodologies that could make at least partial payment prospectively for therapy services based on anticipated patient need, rather than solely on actual service utilization. This could resemble the methodology already in use under the home health PPS, in which the projected number of therapy visits on the assessment completed at the start of the episode serves as the initial basis for payment, but that projection is subsequently verified against the actual visit information submitted in line-item detail on the claim (please refer to § 10.1.19.1 in Chapter 10 of the Medicare Claims Processing Manual, which is available online at *http://www.cms.gov/manuals/downloads/clm104c10.pdf*). The advantage of this type of approach is that it could target therapy payments and the intensity of therapy provided to patients with those diagnoses and conditions that are most likely to require such services.

A third possible approach would be to consider recalibrating the CMIs every year in order to account for significant fluctuations and changes in provider practices. Such a practice would be consistent with findings in a December 2010 OIG report entitled "Questionable Billing by Skilled Nursing Facilities" (report no. OEI–02–09–00202, available online at *http://oig.hhs.gov/oei/reports/oei-02-09-00202.pdf*), in which OIG noted a recent increase in questionable billings for higher-paying RUGs. In addition, we note that MedPAC recently cited plans to examine changes in SNF care costs and practice patterns as a possible prelude to considering the desirability of totally rebasing the system (please refer to page 10 of "Assessing Payment Adequacy: Skilled Nursing Facilities," January 13, 2011, available online at *http://www.medpac.gov/transcripts/SNF%20Jan%202011%20public.pdf*). Such an approach, while not a change in the payment methodology per se, would reestablish baseline expenditure levels using more recent data than the 1995 cost reports.

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 11 summarizes the updated labor-related share for FY 2012.

TABLE 11—LABOR-RELATED RELATIVE IMPORTANCE, FY 2011 AND FY 2012

	Relative importance, labor-related, FY 2011 10:2 forecast*	Relative importance, labor-related, FY 2012 11:1 forecast**
Wages and salaries	50.654	50.231
Employee benefits	11.511	11.514
Nonmedical professional fees	1.320	1.308
Labor-intensive services	3.427	3.390
Capital-related (.391)	2.399	2.362
Total	69.311	68.805

* Published in **Federal Register**; based on second quarter 2010 IHS Global Insight Inc. forecast.
** Based on the first quarter 2011 IHS Global Insight forecast, with historical data through the fourth quarter 2010.

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 2012. This is based on the IGI (formerly DRI–WEFA) first quarter 2011 forecast (with historical data through the fourth quarter 2010) of the FY 2012 percentage increase in the FY 2004-based SNF market basket index for routine,

ancillary, and capital-related expenses, which is used to compute the update factor in this proposed rule. As discussed in section VI.C of this proposed rule, this market basket percentage change is reduced by the MFP adjustment as required by section 1888(e)(5)(B)(ii) of the Act. 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 3-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 46057 through 46059), 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, resulting in an increase of 3.26 percent. 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.G.2 of this proposed rule, as the difference between the estimated and actual amounts of increase in the market basket index for FY 2010 (the most recently available FY for which there is final data) does not exceed the 0.5 percentage point threshold, the payment rates for FY 2012 do not include a forecast error adjustment.

C. Multifactor Productivity Adjustment

Section 3401(b) of the Affordable Care Act requires that, in FY 2012 (and in subsequent FYs), the market basket percentage under the SNF payment system as described in section 1888(e)(5)(B)(i) is to be reduced annually by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. As explained in the Senate Finance Committee report that accompanied S.1796 ("America's Healthy Future Act of 2009," the Senate's initial version of the health reform legislation), the purpose of this type of productivity adjustment is to help ensure that the market basket update, in accounting for changes in the costs of goods and services used to provide patient care, also reflects "* * * increases in provider productivity that could reduce the actual cost of providing services (such as through new technology, fewer inputs, *etc.*)" (S. Rep. No. 111–89 at 261). Specifically, section 3401(a) of the Affordable Care Act amends section 1886(b)(3)(B) of the Act to add clause (xi)(II), which sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period) (the "MFP adjustment"). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business MFP. Please see *http://www.bls.gov/mfp* to obtain the BLS historical published MFP data.

The projection of MFP is currently produced by IGI, an economic forecasting firm. In order to generate a forecast of MFP, IGI replicated the MFP measure calculated by the BLS, using a series of proxy variables derived from IGI's U.S. macroeconomic models. These models take into account a very broad range of factors that influence the total U.S. economy. IGI forecasts the underlying proxy components, such as Gross Domestic Product (GDP), capital, and labor inputs required to estimate MFP, and then combines those projections according to the BLS methodology. In Table 12, we identify each of the major MFP component series employed by the BLS to measure MFP. We also provide the corresponding concepts forecasted by IGI and determined to be the best available proxies for the BLS series.

TABLE 12—MULTIFACTOR PRODUCTIVITY COMPONENT SERIES EMPLOYED BY THE BUREAU OF LABOR STATISTICS AND IHS GLOBAL INSIGHT

BLS series	IGI series
Real value-added output, constant 2005 dollars	Non-housing non-government non-farm real GDP, Billions of chained 2005 dollars—annual rate.
Private non-farm business sector labor input; 2005 = 100.00	Hours of all persons in private nonfarm establishments, 2005 = 100.00, adjusted for labor composition effects.
Aggregate capital inputs; 2005 = 100.00	Real effective capital stock used for full employment GDP, Billions of chained 2005 dollars.

IGI found that the historical growth rates of the BLS components used to calculate MFP and the IGI components identified are consistent across all series and, therefore, suitable proxies for calculating MFP. We have included below a more detailed description of the methodology used by IGI to construct a forecast of MFP, which is aligned closely with the methodology employed by the BLS. For more information regarding the BLS method for estimating productivity, please see the following link: *http://www.bls.gov/mfp/mprtech.pdf.*

At the time of this proposed rule, the BLS has published a historical time series of private nonfarm business MFP for 1987 through 2009, with 2009 being a preliminary value. Using this historical MFP series and the IGI forecasted series, IGI has developed a forecast of MFP for 2010 through 2021, as described below.

To create a forecast of BLS' MFP index, the forecasted annual growth rates of the "non-housing, nongovernment, non-farm, real GDP," "hours of all persons in private nonfarm establishments adjusted for labor composition," and "real effective capital stock" series (ranging from 2010 to 2021) are used to "grow" the levels of the "real value-added output," "private non-farm business sector labor input," and "aggregate capital input" series published by the BLS. Projections of the "hours of all persons" measure are calculated using the difference between

the projected growth rates of real output per hour and real GDP. This difference is then adjusted to account for changes in labor composition in the forecast interval. Using these three key concepts, MFP is derived by subtracting the contribution of labor and capital inputs from output growth. However, in order to estimate MFP, we need to understand the relative contributions of labor and capital to total output growth. Therefore, two additional measures are needed to operationalize the estimation of the IGI MFP projection: Labor compensation and capital income. The sum of labor compensation and capital income represents total income. The BLS calculates labor compensation and capital income (in current dollar terms) to derive the nominal values of labor and capital inputs. IGI uses the "nongovernment total compensation" and "flow of capital services from the total private non-residential capital stock" series as proxies for the BLS's income measures. These two proxy measures for income are divided by total income to obtain the shares of labor compensation and capital income to total income. In order to estimate labor's contribution and capital's contribution to the growth in total output, the growth rates of the proxy variables for labor and capital inputs are multiplied by their respective shares of total income. These contributions of labor and capital to output growth are subtracted from total output growth to calculate the "change in the growth rates of multifactor productivity" using the following formula:

MFP = Total output growth — ((labor input growth * labor compensation share) + (capital input growth * capital income share))

The change in the growth rates (also referred to as the compound growth rates) of the IGI MFP are multiplied by 100 in order to calculate the percent change in growth rates (the percent change in growth rates is published by the BLS for its historical MFP measure). Finally, the growth rates of the IGI MFP are converted to index levels based to 2005 to be consistent with the BLS' methodology. For benchmarking purposes, the historical growth rates of IGI's proxy variables were used to estimate a historical measure of MFP, which was compared to the historical MFP estimate published by the BLS. The comparison revealed that the growth rates of the components were consistent across all series and, therefore, validated the use of the proxy variables in generating the IGI MFP projections. The resulting MFP index was then interpolated to a quarterly frequency using the Bassie method for temporal disaggregation. The Bassie technique utilizes an indicator (pattern) series for its calculations. IGI uses the index of output per hour (published by the BLS) as an indicator when interpolating the MFP index.

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

According to section 1888(e)(5)(A) of the Act, the Secretary "shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services." As described in section I.G.2 of this proposed rule, we are proposing to estimate the SNF PPS market basket percentage for FY 2012 under section 1888(e)(5)(B)(i) of the Act based on the FY 2004-based SNF market basket. Section 3401(b) of the Affordable Care Act amends section 1888(e)(5)(B) of the Act, in part, by adding a new clause (ii), which requires that for FY 2012 and each subsequent FY, after determining the market basket percentage described in section 1888(e)(5)(B)(i) of the Act, "the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)" (which we refer to as the MFP adjustment). Section 1888(e)(5)(B)(ii) of the Act further states that the reduction of the market basket percentage by the MFP adjustment may result in the market basket percentage being less than zero for a FY, and may result in payment rates under section 1888(e) of the Act for a FY being less than such payment rates for the preceding FY. Thus, if the application of the MFP adjustment to the market basket percentage calculated under section 1888(e)(5)(B)(i) results in an MFP-adjusted market basket percentage that is less than zero, then the annual update to the unadjusted Federal per diem rates under section 1888(e)(4)(E)(ii) would be negative, and such rates would decrease relative to the prior FY.

To calculate the MFP-adjusted update for the SNF PPS, we propose that the MFP percentage adjustment will be subtracted from the FY 2012 market basket percentage calculated using the FY 2004-based SNF market basket. We propose that the end of the 10-year moving average of changes in the MFP should coincide with the end of the appropriate FY update period. Since the market basket percentage is reduced by the MFP adjustment to determine the annual update for the SNF PPS, we believe it is appropriate for the numbers associated with both components of the calculation (the market basket percentage and the productivity adjustment) to be projected as of the same end date so that changes in market conditions are aligned. Therefore, for the FY 2012 update, the MFP adjustment would be calculated as the 10-year moving average of changes in MFP for the period ending September 30, 2012. We propose to round the final annual adjustment to the one-tenth of one percentage point level up or down as applicable according to conventional rounding rules (that is, if the number we are rounding is followed by 5, 6, 7, 8, or 9, we will round the number up; if the number we are rounding is followed by 0, 1, 2, 3, or 4, we will round the number down).

In accordance with section 1888(e)(5)(B)(i) of the Act, the market basket percentage for FY 2012 for the SNF PPS is based on the 1st quarter 2011 forecast of the FY 2004-based SNF market basket update, which is estimated to be 2.7 percent. In accordance with section 1888(e)(5)(B)(ii) of the Act (as added by section 3401(b) of the Affordable Care Act), this market basket percentage would then be reduced by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2012) of 1.2 percent, which is calculated as described above and based on IGI's 1st quarter 2011 forecast. The resulting MFP-adjusted market basket update would be equal to 1.5 percent, or 2.7 percent less 1.2 percentage points.

Furthermore, in fiscal years where a forecast error adjustment is applicable, we would first apply the forecast error adjustment to the market basket percentage, before applying the MFP adjustment. As discussed previously, in determining whether a forecast error adjustment should be applied, CMS compares the forecasted market basket percentage computed under section 1888(e)(5)(B)(i) of the Act for the most recently available fiscal year for which there is final data to the actual market basket percentage for that fiscal year. Because the forecast error adjustment is intended to address errors in the forecast of the market basket percentage, we believe that this adjustment is part of the establishment of the appropriate market basket percentage under section 1888(e)(5)(B)(i) of the Act. Section 1888(e)(5)(B)(ii) of the Act (as added by section 3401(b) of the Affordable Care Act) requires the MFP adjustment to be applied "after determining the percentage described in clause (i)." Thus, we would apply the forecast error adjustment (when applicable) to the market basket percentage prior to

applying the MFP adjustment, to determine the update to the unadjusted Federal per diem rates for a fiscal year.

Accordingly, we propose to revise § 413.337 by adding a new paragraph (d)(3) to require, for FY 2012 and each subsequent FY, that the market basket index percentage change (as modified by any applicable forecast error adjustment) be reduced by the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act in determining the annual update of the unadjusted Federal per diem rates. Consistent with section 1888(e)(5)(B)(ii) of the Act (as added by section 3401(b) of the Affordable Care Act), § 413.337(d)(3) would also state that the reduction of the market basket percentage change by the MFP adjustment may result in the market basket percentage change being less than zero for a fiscal year, and may result in the unadjusted Federal payment rates for a fiscal year being less than such payment rates for the preceding fiscal year.

In addition, we propose to revise existing paragraphs (d)(1) and (d)(2) of § 413.337, as discussed below. First, we are proposing to revise § 413.337(d)(1) so that the text more accurately tracks the corresponding statutory requirements at section 1888(e)(4)(E) of the Act. Currently, § 413.337(d)(1) does not reflect the amendments made to section 1888(e)(4)(E)(ii) by section 311 of the BIPA (see section I.D of this proposed rule). While we have always updated the unadjusted Federal per diem rates in accordance with the requirements set forth in section 1888(e)(4)(E)(ii) of the Act as amended by section 311 of the BIPA, we have inadvertently failed to update the regulation text to conform with the BIPA requirements. Therefore, we now propose to revise § 413.337(d)(1) to conform with the current statutory language in section 1888(e)(4)(E) as amended by section 311 of the BIPA. Second, we propose to revise § 413.337(d)(2) to specify the existing thresholds we employ in determining whether a forecast error adjustment is applicable.

D. Federal Rate Update Factor

Section 1888(e)(4)(E)(ii)(IV) of the Act requires that the update factor used to establish the FY 2011 unadjusted Federal rates be at a level equal to the 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, 2010 through September 30, 2011 to the average market basket level for the period of October 1, 2011 through September 30, 2012. Using this process, the market basket update factor for FY 2012 SNF PPS unadjusted Federal rates would be 2.7 percent. As required by section 1888(e)(5)(B) of the Act, this market basket percentage is then reduced by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2012) of 1.2 percent as described in section VI.C. The resulting MFP-adjusted market basket update would be equal to 1.5 percent, or 2.7 percent less 1.2 percentage points. We used this MFP-adjusted market basket update factor to compute 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 through 19232, April 10, 2000, and 65 FR 46790 through 46795, July 31, 2000), as well as in Program Memorandum AB–00–18 (Change Request #1070), issued March 2000, which is available online at *http://www.cms.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 therapy, occupational therapy, and speech-language pathology services 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 through 24021, May 10, 2001, and 66 FR 39587 through 39588, July 31, 2001).

In addition, section 410 of the MMA amended this provision by excluding certain practitioner and other services furnished to SNF residents by RHCs and FQHCs. We discuss this MMA amendment in greater detail in the update notice for FY 2005 (69 FR 45818 through 45819, July 30, 2004), as well as in Medicare Learning Network (MLN) Matters article #MM3575, which is available online at *http://www.cms.gov/MLNMattersArticles/downloads/MM3575.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 a telecommunications system, services of 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 Physician Fee Schedule final rule (73 FR 69726), 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 MLN Matters article #MM6215, which is available online at *http://www.cms.gov/MLNMattersArticles/downloads/MM6215.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, 2011). 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

In accordance with section 1888(e)(7) of the Act, as amended by section 203 of the BIPA, Part A pays critical access hospitals (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) and in the final rule for FY 2010 (74 FR 40288, August 11, 2009). As finalized in the FY 2010 SNF PPS final rule (74 FR 40356–57), effective October 1, 2010, non-CAH swing-bed rural hospitals are required to complete an MDS 3.0 swing-bed assessment which is limited to the required demographic, payment, and quality items. The latest changes in the MDS for swing-bed rural hospitals appear on the SNF PPS Web site, *http://www.cms.gov/snfpps.*

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 to the regulation text:

As discussed previously in section VI.C of this proposed rule, we are proposing to implement section 3401(b) of the Affordable Care Act by revising § 413.337. We would add a new paragraph (d)(3) to that section to require that, for FY 2012 and each subsequent FY, the market basket percentage change (as modified by any applicable forecast error adjustment) be reduced by the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act in determining the annual update of the unadjusted Federal per diem rates. In addition, consistent with section 1888(e)(5)(B)(ii) of the Act (as added by section 3401(b) of the Affordable Care Act), § 413.337(d)(3) would also state that the reduction of the market basket percentage change by the MFP adjustment may result in the market basket percentage change being less than zero for a fiscal year, and may result in the unadjusted Federal payment rates for a fiscal year being less than such payment rates for the preceding fiscal year.

Further, as discussed in section VI.C., we propose to revise existing paragraphs (d)(1) and (d)(2) of § 413.337 so that the text more accurately tracks the corresponding statutory requirements at section 1888(e)(4)(E) of the Act (§ 413.337(d)(1)), and to specify the existing thresholds we apply in determining whether a forecast error adjustment is appropriate (§ 413.337(d)(2)).

In addition, to implement section 6101 of the Affordable Care Act as discussed previously in section V.A. of this proposed rule, we are proposing to revise the reporting requirements that Medicare SNFs and Medicaid nursing facilities must disclose at the time of enrollment and when any change in ownership occurs. These reporting requirements will occur in PECOS for Medicare SNFs, which will be revised to capture the additional requirements. We are proposing to add a definition for "additional disclosable party" and "organizational structure." We also plan to require that these additional reporting requirements be included among the changes that must be reported in accordance with § 424.516(e) and § 455.104. Consistent with the requirements set forth in section 6101 of the Affordable Care Act, we propose to define an "additional disclosable party" to mean, with respect to a Medicare SNF or Medicaid nursing facility, any person or entity (such as a contractor, full- and part-time employee or consultant) that exercises financial, operational, or managerial control over the facility (or a part thereof); provides policies or procedures for any of the operations of the facility, including policies or procedures that establish clinical decision making capabilities directly related to resident care; provides financial or cash management services to the facility; leases or subleases real property to the facility or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility. Broadly defined, this proposed definition mirrors the statutory definition of "additional disclosable party," which is set forth at section 1124(c)(5)(A) of the Act. Given the potentially broad nature of the term "additional disclosable parties," we understand that it may be difficult for SNFs and Medicaid nursing facilities, under certain circumstances, to reasonably know without explicit guidance which parties and individuals associated with their facility are subject to the disclosure requirements discussed in this section. Therefore, we specifically solicit comment on how best to narrow the scope of the definition of this term to ensure that the additional reporting requirements described in this section apply only to those parties and individuals that are capable of exercising actual operational, financial, or managerial control over the given facility or performing any of the other functions specified in section 6101 of the Affordable Care Act.

In addition, our proposed definition for "organizational structure" mirrors the statutory definition for that term, which is set forth at section 1124(c)(5)(D) of the Act. With respect to the additional reporting requirements at § 424.516(e) addressed by this proposed rule, for a Medicare SNF defined at section 1819(a) of the Act, we propose to define a "managing employee" to include consultants and any individual who directly or indirectly manages, advises or supervises any element of the practices, finances, or operations of the facility.

In § 424.516, we are proposing to add new paragraphs (e)(4) and (e)(5). Paragraph (e)(4) includes the requirement that a Medicare SNF or Medicaid nursing facility must report the name, title, and period of service for each disclosable party. It observes that each Medicare SNF or Medicaid nursing facility must also report the organizational structure of each additional disclosable party of the facility and a description of each additional disclosable party's relationship to the facility and to one another. Proposed paragraph (e)(5) states that Medicare SNFs (as defined in section 1819(a) of the Act) must certify as a condition of participation and payment under the program under Title XVIII of the Act that the information reported by the facility in accordance with these regulations is, to the best of the facility's knowledge, accurate and correct.

While we propose (as discussed in the preceding paragraph) to collect the required information consistent with the requirements set forth in § 424.516, we also seek comment on a potential alternative approach in which we would collect this information only upon revalidation consistent with the requirements set forth in § 424.515. In accordance with § 424.515, Medicare SNFs generally would be subject to revalidation requirements every 5 years. Paragraph (d) of § 424.515, however, provides for off-cycle revalidations. We believe that an approach that requires a Medicare SNF to report the additional requirements covered by this rule at the same time CMS requires the Medicare SNF to revalidate with the Medicare program may not only allow us to satisfy the legislative intent of collecting the required additional information, but also may generally represent a decreased burden on Medicare SNFs. Thus, we seek comment on this approach.

We also propose to amend the definition of "managing employee" at § 455.101, with respect to a Medicaid nursing facility as defined by section 1919(a) of the Act, to include a consultant who directly or indirectly manages, advises or supervises any element of the practices, finances, or operations of the facility. In addition, we propose to include at § 455.101 definitions of "additional disclosable party" and "organizational structure." Finally, we propose to add a requirement to § 455.104 regarding these new disclosure requirements by Medicaid nursing facilities, which includes a certification as a condition of participation and payment under the program under Title XIX of the Act that the information reported by the facility in accordance with these regulations is, to the best of the facility's knowledge, accurate and correct.

X. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide a 60-day notice in the **Federal Register** and solicit public comments before a collection of information requirement is submitted to OMB for review and approval. In order to evaluate fairly whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comments on the following issues:

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

The information collection requirements referenced in this proposed rule with regard to resident assessment information used to determine facility payments are currently approved under OMB #0938–0739, which relates to the Medicare PPS Assessment Form (MPAF) information collection, and OMB #0938–0872, which relates to the Minimum Data Set for Swing-Bed Hospitals. We note that this proposed rule will not affect the burden associated with either of those collections.

With regard to the disclosure of information requirements included in section V.A of this rule, we currently require nursing home providers, including Medicare SNFs and Medicaid nursing facilities, to report information about any individual or entity with a 5 percent or greater ownership interest. As discussed in section IX. of this proposed rule, we are proposing to revise existing regulations to require that Medicare SNFs and Medicaid nursing facilities report the following at the time of enrollment and when any change in ownership occurs:

- Each member of the governing body of the facility, including the name, title, and period of service of each such member;
- Each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity; and
- Each person or entity who is an additional disclosable party of the facility.

We are also requiring information on the organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

In connection with the proposed implementation of the disclosure of ownership provisions set forth in section 6101 of the Affordable Care Act, we note that if a provider wants to enroll in Medicare or maintain its Medicare enrollment status, then the provider must complete the application for enrollment (Form CMS–855A) and submit it to the appropriate Medicare Administrative Contractor or Fiscal Intermediary. Form CMS–855A will be revised so that it collects the additional information required by this proposed rule from Medicare providers. (We are seeking OMB approval for the revisions under notice and comment periods separate from those associated with this proposed rule.) The burden associated with this requirement is the time and effort necessary to complete and submit the Form CMS–855A. While this requirement is subject to the PRA, the associated burden has been approved under OMB control number 0938–0685 with an expiration date of 1/31/2012.

Section V.D. of this proposed rule also contains a discussion of information collections related to a new required resident assessment, the COT OMRA. The following is a discussion of this new required PPS assessment.

As discussed previously in section V.D of this proposed rule, we are proposing to make certain modifications in the existing requirements for completing OMRAs. We propose to introduce a new COT OMRA, to be completed whenever the intensity of therapy (that is, the total RTM) changes to such an extent that it would no longer reflect the RUG–IV classification and payment assigned for a given SNF resident, based on the resident's most recent assessment used for Medicare payment. This will help to ensure that the SNF's payments accurately reflect the amount of therapy actually being provided. We have submitted a copy of this proposed rule to OMB for its review and approval of the information collection requirements discussed herein.

SNFs would be required to complete a COT OMRA only when the intensity of therapy actually being furnished changes to such a degree that it would no longer reflect the RUG–IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment. The burden associated with this requirement is the time and effort necessary to complete the COT OMRA, coding the appropriate responses, and data reporting timeframes. Because providers currently are not required to report RTM that occur outside the observation window of a given PPS assessment, we do not have the relevant data to predict with certainty the number of COT OMRAs that may be required per year. However, we have attempted to use the administrative data currently available as a reasonable proxy to determine estimates of provider burden. We estimate that, based on average burden associated with the EOT OMRA, which uses the same basic item set as the proposed COT OMRA, it will take 50 minutes (0.83 hours) to collect the information necessary for coding a COT OMRA, 10 minutes (0.17 hours) to code the responses, and 2 minutes (0.03 hours) to transmit the results, or a total of 62 minutes (1.03 hours) to complete a single COT OMRA. The estimated cost per COT OMRA is $33.84, as discussed below.

Based on information from the Bureau of Labor Statistics of May, 2009 and a 30 percent benefits rate, we estimated hourly wage rates for a Registered Nurse (RN), and for a data operator. MDS preparation costs were estimated using RN hourly wage rates based on $56,060 per year, which amounts to $0.45 per minute without consideration of employee benefits, and $0.58 per minute after increasing the rate by 30 percent to account for employee benefit compensation. For coding functions, we used a blended rate of $41,090; this was the average for RNs ($56,060/year) and data operators ($26,120/year). The blended rate calculates to $0.33 per minute without consideration of employee benefits, and $0.43 per minute after increasing the rate by 30 percent to account for employee benefit compensation. The blended rate of RN and data operator wages reflects that SNF providers historically have used both RN and support staff for the data entry function. For transmission personnel, we used data operator wages of $26,120 per year, or $0.21 per minute without consideration of employee benefits, and $0.27 per minute after increasing the rate by 30 percent to account for employee benefit compensation. The total amount of time for a single COT OMRA is 62 minutes (1.03 hours), consisting of 50 minutes (0.8333 hours) of RN time for preparation, 10 minutes (0.1667 hours) of blended RN/data operator time for coding, and 2 minutes (0.0333 hours) for data operator time for transmission. This results in an average estimated cost per COT OMRA of $33.84.

The number of stays for 2009 was approximately 2.26 million. Based on a 30-day average length of stay for RUG–IV, we believe the average number of times that a COT OMRA would need to be completed due to a decrease in therapy is once per stay. Based on our review of FY 2011 first quarter data, we found that approximately 40 percent of the claims resulted in assignment to a higher-than-projected Rehabilitation RUG. A possible reason for the difference between projected and actual FY 2011 RUG–IV case-mix utilization could involve instances where the intensity of therapy actually being furnished changed (that is, decreased) within the payment period to such a degree that it no longer reflected the RUG–IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment. As discussed previously, if such changes or decreases in therapy utilization occur outside the observation window of a given PPS assessment, such changes currently are not captured on a resident assessment, and the provider would continue to be reimbursed under a higher-paying Rehabilitation RUG until the next PPS assessment.

For FY 2012, providers would be required to complete a COT OMRA in these situations. Although we believe that only some of the 40 percent difference is likely attributable to these instances, the 40 percent would provide a quantifiable maximum burden estimate for these cases. At this time, we are unable to determine other quantifiable estimates for decreases in therapy utilization necessitating a COT OMRA. Using the percentage of claims resulting in a higher-than-projected Rehabilitation RUG as a way to estimate the maximum number of times that a therapy decrease could result in the need for a COT OMRA, 40 percent or 813,074 stays could be affected. The total number of estimated COT OMRAs per SNF for FY 2011 would be 57.

In addition, the COT OMRA can be used when providers increase the amount of therapy provided. The Start-of-Therapy (SOT) OMRA represents situations where therapy has increased to a level significant enough to change the RUG to a therapy RUG. The estimate for the possible number of times that a COT OMRA would be required due to an increase in therapy uses the number of SOT OMRAs as a proxy. Using the number of SOT OMRAs completed in the first quarter of FY 2011 projected for the entire year, we estimate that the total COT OMRAs required due to an increase in therapy would be 142,660, or 10 times per facility per year. Therefore, the estimated total number of COT OMRAs per facility per year is 67. The total annual hour burden for completing COT OMRAs is estimated to be 796,414 hours for reporting, 159,320 hours for coding, and 31,826 hours for transmission for a total burden of 987,560 hours for all 14,266 SNFs. Based on an average estimated cost per COT OMRA of $33.84, we estimate that the additional annual cost across all SNFs would be approximately $32.34 million, or $2,267.02 per facility. Further, we note that the completion of an EOT–R OMRA, as proposed in section V.D, would be entirely voluntary on the part of the facility and, thus, would not represent the imposition of a mandatory burden.

If you comment on these information collection and recordkeeping requirements, please do either of the following: Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or Mail copies to the address specified in the **ADDRESSES** section of this proposed rule and to the Office of Information and Regulatory Affairs, Room 10235, New Executive Office Building, Washington, DC 20503.

ATTN: CMS Desk Officer (CMS–1351–P).

Fax: (202) 395–6974.

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. Economic Analyses

A. Regulatory Impact Analysis

1. Introduction

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

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated an economically significant rule, under section 3(f)(1) of Executive Order 12866. Accordingly, we have prepared a regulatory impact analysis (RIA) as further discussed below. Also, the rule has been reviewed by the Office of Management and Budget.

2. Statement of Need

This proposed rule would update the SNF prospective payment rates for fiscal year 2012 as required under section 1888(e)(4)(E) of the Act. It also responds to section 1888(e)(4)(H) of the Act, which requires the Secretary to "provide for publication in the **Federal Register**" before the August 1 that precedes the start of each fiscal year, the unadjusted Federal per diem rates, the case-mix classification system, and the wage index values used in computing the prospective payment rates for that fiscal year. As these statutory provisions prescribe a detailed methodology for calculating and disseminating payment rates under the SNF PPS, we do not have the discretion to adopt an alternative approach.

3. Overall Impacts

If we implement the recalibration option in FY 2012, as described above in section II.B.2, we estimate the aggregate impact would be a net decrease of $3.94 billion in payments to SNFs, resulting from a $530 million increase from the update to the payment rates and a $4.47 billion reduction from the recalibration of the case-mix adjustment. However, if we implement the option of applying the standard update without a recalibration for FY 2012, as described above in section II.B.2, we estimate the aggregate impact would be a net increase of $530 million in payments to SNFs, resulting from the update to the payment rates. Accordingly, we have prepared a RIA that, to the best of our ability, presents the costs and benefits of the rulemaking, with respect to the two options presented in section II.B.2. of this proposed rule

The update set forth in this proposed rule applies to payments in FY 2012. Accordingly, the analysis that follows

only describes the impact of this single year. In accordance with the requirements of the Act, we will publish a notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis.

The two options being considered regarding the recalibration of the case-mix indexes are presented in section II.B.2. A detailed economic impact analysis of these two options appears below.

4. Detailed Economic Analysis

This proposed rule sets forth updates of the SNF PPS rates contained in the update notice for FY 2011 (75 FR 42886, July 22, 2010) and the associated correction notice (75 FR 55801, September 14, 2010). Based on the above, if we implement the recalibration option for FY 2012, we estimate that the aggregate impact would be a net decrease of $3.94 billion in payments to SNFs, resulting from a $530 million increase from the update to the payment rates and a $4.47 billion reduction from the recalibration of the case-mix adjustment. If we do not recalibrate the CMIs for FY 2012, as discussed in section II.B.2, we estimate that the aggregate impact would be a net increase of $530 million in payments to SNFs, resulting primarily 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 2011 to FY 2012 for each of these two possible options. We assess the effects by estimating payments under each of the two options while holding all other payment-related variables constant. Although the best data available are utilized, there is no attempt to predict behavioral responses to these changes, or to make adjustments for future changes in such variables as days or case-mix.

Certain events may occur to limit the scope or accuracy of our impact analysis, as this analysis is future-oriented and, thus, very susceptible to forecasting errors due to certain events that may occur within the assessed impact time period. Some examples of possible events may include 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) and (e)(5) of the Act, we update the payment rates for FY 2011 by a factor equal to the market basket index percentage increase adjusted by the FY 2010 forecast error adjustment (if applicable) and the MFP adjustment to determine the payment rates for FY 2012. As discussed previously, for FY 2012 and each subsequent FY, as required by section 1888(e)(5)(B) of the Act as amended by section 3401(b) of the Affordable Care Act, the market basket percentage is reduced by the MFP adjustment. The special AIDS add-on established by section 511 of the MMA remains in effect until "* * * such date as the Secretary certifies that there is an appropriate adjustment in the case mix * * *." We have not provided a separate impact analysis for the MMA provision. Our latest estimates indicate that there are less than 3,500 beneficiaries who qualify for the AIDS add-on payment. The impact to Medicare is included in the "total" column of Tables 13A and 13B. In updating the rates for FY 2012, 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).

We estimate that if we were to implement the recalibration option for FY 2012, the aggregate impact would be a net decrease of $3.94 billion in payments to SNFs, resulting from a $530 million increase from the update to the payment rates and a $4.47 billion reduction from the recalibration of the case-mix adjustment. If we do not implement the recalibration option for FY 2012, we estimate that the aggregate impact would be a net increase of $530 million in payments to SNFs, resulting from the update to the payment rates. The FY 2012 impacts that would result from implementing the recalibration option in FY 2012 are presented in Table 13A. The FY 2012 impacts that would result from not implementing the recalibration of the case-mix indexes in FY 2012 are presented in Table 13B.

a. Impacts of Implementing the Recalibration Option for FY 2012

The breakdown of the various categories of data in Table 13A is as follows.

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

The "total" row shows 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 19 rows show the effects on urban versus rural status by census region. The last 3 rows show the effects on ownership by government, profit and non-profit status.

The second column in Table 13A shows the number of facilities in the impact database.

The third column in Table 13A shows the effects of recalibrating the nursing CMIs of the RUG–IV therapy groups. As explained previously in section II.B.2 of this proposed rule, we are considering this recalibration so that the CMIs more accurately reflect parity in expenditures under the RUG–IV system introduced in FY 2011 relative to payments under the previous RUG–53 system, based on our review of initial FY 2011 claims data. The total impact of this change is a decrease of 12.6 percent. We note that some individual providers may experience larger decreases in payment than others due to case-mix utilization.

The fourth column of Table 13A 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 fifth column of Table 13A shows the effect of all of the changes on the FY 2012 payments. The update of 1.5 percent, consisting of the market basket increase of 2.7 percentage points, reduced by the 1.2 percentage point MFP adjustment is constant for all providers and, though not shown individually, is included in the total column. It is projected that aggregate payments will decrease by 11.3 percent, assuming that facilities do not change their care delivery and billing practices in response.

As shown in Table 13A, the combined effects of all of the changes vary by specific types of providers and by location.

TABLE 13A—RUG–IV PROJECTED IMPACT TO THE SNF PPS FOR FY 2012

[Includes recalibration of the case-mix indexes]

	Number of facilities FY 2012	Revised CMIs (percent)	Update wage data (percent)	Total FY 2012 change (percent)
Group:				
Total	14,266	−12.6	0.0	−11.3
Urban	10,049	−12.8	0.0	−11.5
Rural	4,217	−11.9	0.1	−10.5
Hospital based urban	421	−12.4	0.1	−11.1
Freestanding urban	9,628	−12.8	0.0	−11.5
Hospital based rural	310	−11.4	0.0	−10.2
Freestanding rural	3,907	−11.9	0.1	−10.5
Urban by region:				
New England	792	−12.6	0.0	−11.3
Middle Atlantic	1,391	−12.9	0.2	−11.5
South Atlantic	1,682	−12.8	−0.3	−11.7
East North Central	1,962	−12.9	−0.4	−11.9
East South Central	482	−12.7	−0.4	−11.8
West North Central	819	−12.8	0.3	−11.2
West South Central	1,134	−12.7	0.5	−10.9
Mountain	459	−12.8	0.2	−11.3
Pacific	1,325	−12.8	0.2	−11.3
Outlying	3	−3.7	1.1	−1.1
Rural by region:				
New England	137	−11.7	1.1	−9.4
Middle Atlantic	233	−12.4	−0.1	−11.1
South Atlantic	546	−11.8	−0.1	−10.6
East North Central	867	−12.1	−0.1	−10.9
East South Central	455	−11.8	−0.5	−10.9
West North Central	984	−12.1	0.4	−10.4
West South Central	679	−11.7	0.9	−9.6
Mountain	204	−11.8	0.4	−10.2
Pacific	112	−11.8	−0.5	−11.0
Ownership:				
Government	710	−12.5	−0.1	−11.3
Profit	9,959	−12.6	0.0	−11.3
Non-profit	3,597	−12.7	0.0	−11.4

Note: The Total column includes the 2.7 percent market basket increase, reduced by the 1.2 percentage point MFP adjustment. Additionally, we found no SNFs in rural outlying areas.

b. Impacts of Not Implementing the Recalibration Option for FY 2012

The first column of Table 13B shows the breakdown of all SNFs by urban or rural status, hospital-based or freestanding status, and census region.

The "total" row of Table 13B 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 19 rows show the effects on urban versus rural status by census region. The last 3 rows show the effects on ownership by government, profit and non-profit status.

The second column in Table 13B shows the number of facilities in the impact database.

The third column in Table 13B 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 of Table 13B shows the effect of all of the changes on the FY 2012 payments. The update of 1.5 percent, consisting of the market basket increase of 2.7 percentage points, reduced by the 1.2 percentage point MFP adjustment is constant for all providers and, though not shown individually, is included in the total column. It is projected that aggregate payments will increase by 1.5 percent, assuming that facilities do not change their care delivery and billing practices in response.

As shown in Table 13B, the combined effects of all of the changes vary by specific types of providers and by location.

TABLE 13B—RUG–IV PROJECTED IMPACT TO THE SNF PPS FOR FY 2012

[Does not include recalibration of the case-mix indexes]

	Number of facilities	Wage index (percent)	Total impact (percent)
Group:			
Total	14,266	0.0	1.5
Urban	10,049	0.0	1.5
Rural	4,217	0.1	1.6
Hospital based urban	421	0.1	1.6
Freestanding urban	9,628	0.0	1.5
Hospital based rural	310	0.0	1.5

TABLE 13B—RUG–IV PROJECTED IMPACT TO THE SNF PPS FOR FY 2012—Continued

[Does not include recalibration of the case-mix indexes]

	Number of facilities	Wage index (percent)	Total impact (percent)
Freestanding rural	3,907	0.1	1.6
Urban by region:			
New England	792	0.0	1.5
Middle Atlantic	1,391	0.2	1.7
South Atlantic	1,682	−0.3	1.2
East North Central	1,962	−0.4	1.1
East South Central	482	−0.4	1.1
West North Central	819	0.3	1.8
West South Central	1,134	0.5	2.1
Mountain	459	0.2	1.7
Pacific	1,325	0.2	1.7
Outlying	3	1.1	2.7
Rural by region:			
New England	137	1.1	2.6
Middle Atlantic	233	−0.1	1.4
South Atlantic	546	−0.1	1.4
East North Central	867	−0.1	1.4
East South Central	455	−0.5	1.0
West North Central	984	0.4	1.9
West South Central	679	0.9	2.4
Mountain	204	0.4	1.9
Pacific	112	−0.5	1.0
Ownership:			
Government	710	−0.1	1.4
Profit	9,959	0.0	1.5
Non-profit	3,597	0.0	1.5

The proposed implementation of the disclosure of ownership requirements set forth in section 6101 of the Affordable Care Act (as discussed previously in section V.A. of this proposed rule) will affect all Medicaid nursing facilities and Medicare SNFs providing care to a Medicare and/or Medicaid beneficiary. Currently, these facilities are required to disclose information and maintain up-to-date information in PECOS and/or OSCAR. Thus, these new requirements are an extension of requirements to which the facility should already be accustomed to maintain compliance. Also, the proposed new disclosure requirements do not appear to impose any labor- or system-intensive burden on the facilities.

We solicit comment on the economic impact analysis of the two options presented in section II.B.2 (that is, recalibration and no recalibration for FY 2012).

5. Alternatives Considered

As described above, if we implement the recalibration option for FY 2012, the aggregate impact would be a net decrease of $3.94 billion in payments to SNFs, resulting from a $530 million increase from the update to the payment rates and a $4.47 billion reduction from the recalibration of the case-mix adjustment. If we move forward with the option of applying the standard update without a recalibration for FY 2012, we estimate that the aggregate impact would be a net increase of $530 million in payments to SNFs, resulting from the update to the payment rates. 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). Further, section 1888(e)(4)(H) of the Act specifically requires us to disseminate the payment rates for each new FY through the **Federal Register**, and to do so before the August 1 that precedes the start of the new FY. Accordingly, we are not pursuing alternatives with respect to the payment methodology as discussed above.

Using our authority to establish an appropriate adjustment for case mix under section 1888(e)(4)(G)(i) of the Act, this proposed rule considers a recalibration of the adjustment to the nursing case-mix indexes based on actual FY 2011 data. In the FY 2010 SNF PPS final rule (74 FR 40339), we committed to monitoring the accuracy and effectiveness of the parity adjustment to maintain budget neutrality. We believe that using actual FY 2011 claims data to perform the recalibration analysis may result in case-mix weights that better reflect the resources used, produce more accurate payment, and represent an appropriate case-mix adjustment. Using FY 2011 data would be consistent with our intent to make the change from the RUG–53 model to the RUG–IV model in a budget neutral manner, as described in the SNF PPS final rule for FY 2010 (74 FR 40339).

In reviewing our initial projections, we found that the disparity which formed the basis for our considering a recalibration of the nursing case-mix indexes was at least partially the result of a shift in the mode of therapy provided to beneficiaries in a Part A stay under RUG–IV. The amount of concurrent therapy decreased significantly from historical levels, with a portion of the SNFs reporting 0

minutes of concurrent therapy for all MDS 3.0s submitted during the FY 2011 sampling period. Many of these facilities reported large increases in the amount of group therapy provided during the same time period. During the period before we publish the final rule for FY 2012, we plan to continue to collect and analyze MDS 3.0 and SNF PPS claims data to confirm our preliminary assessment of the parity adjustment considered in this rule. Then, in the final rule, we would use the expanded FY 2011 MDS 3.0 data and SNF PPS claims data to decide whether or not to pursue the considered FY 2012 recalibration of the SNF PPS rates.

We considered various alternatives for implementing a recalibrated case-mix adjustment. Most notably, as described previously in section II.B.2 of this proposed rule, we considered applying a recalibration to all nursing CMIs, irrespective of RUG category. However, we found that such a recalibration most drastically affected non-therapy RUG groups, which seemed incongruent with the perceived reasons for differences between expected and actual utilization patterns, as noted in Table 4. We will continue to monitor utilization trends in case such a methodology might become more viable in the future.

In addition, we considered implementing partial adjustments to the case-mix indexes over multiple years until parity was achieved. However, we believe that this alternative 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 properly implementing and maintaining the integrity of the RUG–IV classification methodology and the SNF PPS as a whole. Therefore, for FY 2012, we are considering only the two options described in section II.B.2 above. We solicit comment on the alternatives considered in this analysis.

6. Accounting Statement

As required by OMB Circular A–4 (available online at *http://www.whitehouse.gov/sites/default/files/omb/assets/regulatory_matters_pdf/a-4.pdf*), in Table 14, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule, based on whether or not we implement the recalibration of the case-mix indexes. Tables 14A and 14B provide our best estimate of the possible changes in Medicare payments under the SNF PPS as a result of the policies in this proposed rule, based on the data for 14,266 SNFs in our database. All expenditures are classified as transfers to Medicare providers (that is, SNFs).

TABLE 14A—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2011 SNF PPS FISCAL YEAR TO THE 2012 SNF PPS FISCAL YEAR

[Including recalibration of case-mix indexes]

Category	Transfers
Annualized Monetized Transfers.	−$3.94 billion.*
From Whom To Whom?	Federal Government to SNF Medicare Providers.

*The net decrease of $3.94 billion in transfer payments is a result of the decrease of $4.47 billion due to the proposed recalibration of the case mix adjustment, together with the proposed market basket increase of $530 million.

TABLE 14B—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2011 SNF PPS FISCAL YEAR TO THE 2012 SNF PPS FISCAL YEAR

[Without recalibration of case-mix indexes]

Category	Transfers
Annualized Monetized Transfers.	$530 million.*
From Whom To Whom?	Federal Government to SNF Medicare Providers.

*The net increase of $530 million in transfer payments is a result of the proposed market basket increase of 1.5 percent.

7. Conclusion

If we implement the recalibration of the case-mix indexes, the overall estimated payments for SNFs in FY 2012 are projected to decrease by $3.94 billion, or 11.3 percent, compared with those in FY 2011. With this option, we estimate that under RUG–IV, SNFs in urban and rural areas would experience, on average, an 11.5 and 10.5 percent decrease, respectively, in estimated payments compared with FY 2011. Providers in the urban East North Central region would experience the largest estimated decrease in payments of approximately 11.9 percent. If we do not implement the recalibration of the case-mix indexes for FY 2012, the overall estimated payments for SNFs in FY 2012 are projected to increase by $530 million, or 1.5 percent, compared with FY 2011. We estimate that under this option, SNFs in urban and rural areas would experience, on average, a 1.5 and 1.6 percent increase, respectively, in estimated RUG–IV payments compared with FY 2011. Outlying urban providers and providers in the rural New England region would experience the largest estimated increase in payments of 2.7 and 2.6 percent, respectively.

The disclosure of ownership requirements in section 6101 of the Affordable Care Act that we now propose to implement involve necessary information that would provide the public with a greater assurance that there is transparency and, thus, improved oversight. We believe it was the intent of Congress to complement that information which is already being supplied by the facility. With that in mind, we propose specific disclosure information that would identify the unique business and operating structures of Medicare SNFs and Medicaid nursing facilities. By providing PECOS and OSCAR with this more detailed facility ownership information, this proposed revision would help ensure that program expenditures are made in the most efficient and appropriate manner.

B. Regulatory Flexibility Act Analysis

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, non-profit organizations, and small governmental jurisdictions. Most SNFs and most other providers and suppliers are small entities, either by their non-profit status or by having revenues of $13.5 million or less in any 1 year. For purposes of the RFA, approximately 91 percent of SNFs are considered small businesses according to the Small Business Administration's latest size standards, with total revenues of $13.5 million or less in any 1 year. (For details, see the Small Business Administration's Web site at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2465b064ba6965cc1fbd2eae60854b11&rgn=div8&view=text&node=13:1.0.1.1.16.1.266.9&idno=13*). Individuals and States are not included in the definition of a small entity. In addition, approximately 21 percent of SNFs classified as small entities are non-profit organizations. Finally, the estimated number of small business entities does not distinguish provider establishments that are within a single firm and, therefore, the number of SNFs classified as small entities may

be higher than the estimate above. We expect that the disclosure requirements discussed in section V.A of this proposed rule will aid us in determining which providers may be appropriately classified as small entities.

This proposed rule updates the SNF PPS rates published in the update notice for FY 2011 (75 FR 42886, July 22, 2010) and the associated correction notice (75 FR 55801, September 14, 2010). We estimate that implementing the recalibration option considered under section II.B.2 above would result in a net decrease of $3.94 billion in payments to SNFs for FY 2012. This would reflect a $530 million increase from the update to the payment rates and a $4.47 billion reduction from the recalibration of the case-mix adjustment. As indicated in Table 13A, the estimated effect of this recalibration option on facilities for FY 2012 would be an aggregate negative impact of 11.3 percent. While it is projected in Table 13A that all providers would experience a net decrease in payments, we note that some individual providers may experience larger decreases in payments than others due to the distributional impact of the FY 2012 wage indexes and the degree of Medicare utilization.

Alternatively, we estimate that not implementing the recalibration option considered under section II.B.2 above would result in a net increase of $530 million in payments to SNFs for FY 2012, reflecting the standard update to the payment rates. As indicated in Table 13B, the estimated effect of this option on facilities for FY 2012 would be an aggregate positive impact of 1.5 percent. While it is projected in Table 13B that all providers would experience a net increase in payments, we note that some individual providers may experience larger increases in payments than others due to the distributional impact of the FY 2012 wage indexes and the degree of Medicare utilization.

Guidance issued by the Department of Health and Human Services on the proper assessment of the impact on small entities in rulemakings, utilizes a cost or revenue impact of 3 to 5 percent as a significance threshold under the RFA. According to MedPAC, Medicare covers approximately 12 percent of total patient days in freestanding facilities and 23 percent of facility revenue (March 2011). However, it is worth noting that the distribution of days and payments is highly variable. That is, the majority of SNFs have significantly lower Medicare utilization. As a result, for most facilities, when all payers are included in the revenue stream, the overall impact effect to total revenues should be substantially less than those presented in Table 13A, which reflects the impacts of implementing the recalibration of the case-mix indexes. However, not implementing the recalibration of the case-mix indexes, as presented in Table 13B, yields an aggregate positive net impact of 1.5 percent on all SNF providers, with outlying urban providers and providers in the rural New England region experiencing the largest estimated increase in payments of 2.7 and 2.6 percent, respectively. Therefore, the Secretary has determined that this proposed rule may have a significant impact on a substantial number of small entities, depending on the option considered (that is, recalibration of the parity adjustment for FY 2012 or application of the standard update without recalibration for FY 2012).

We offer an analysis of the alternatives considered in section XII.A.5 of this proposed rule. The analysis above, together with the remainder of this preamble, constitutes the initial regulatory flexibility analysis. We solicit comment on the RFA analysis.

In addition, section 1102(b) of the Social Security 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 would affect small rural hospitals that (a) furnish SNF services under a swing-bed agreement or (b) have a hospital-based SNF. We anticipate that the impact on small rural hospitals would be similar to the impact on SNF providers overall. Therefore, the Secretary has determined that this proposed rule may have a significant impact on the operations of a substantial number of small rural hospitals, depending on the option considered, as discussed above (that is, recalibration of the parity adjustment for FY 2012 or application of the standard update without recalibration for FY 2012).

C. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2011, that threshold is approximately $136 million. This proposed rule would not impose spending costs on State, local, or Tribal governments in the aggregate, or by the private sector, of $136 million.

D. Federalism Analysis

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

List of Subjects

42 CFR Part 413

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

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 455

Fraud, Grant programs—health, Health facilities, Health professions, Investigations, Medicaid, Reporting and recordkeeping requirements.

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

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

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

Subpart J—Prospective Payment for Skilled Nursing Facilities

2. Section 413.337 is amended by—

A. Revising paragraphs (d)(1) and (d)(2).

B. Adding paragraph (d)(3).

The revisions and addition read as follows:

§ 413.337 Methodology for calculating the prospective payment rates.

* * * * *

(d) * * *

(1) *Update formula.* The unadjusted Federal payment rate shall be updated as follows:

(i) For the initial period beginning on July 1, 1998, and ending on September 30, 1999, the unadjusted Federal payment rate is equal to the rate computed under paragraph (b)(5)(iii) of this section increased by a factor equal to the SNF market basket index percentage change for such period minus 1 percentage point.

(ii) For fiscal year 2000, the unadjusted Federal payment rate is equal to the rate computed for the initial period described in paragraph (d)(1)(i) of this section increased by a factor equal to the SNF market basket index percentage change for that period minus 1 percentage point.

(iii) For fiscal year 2001, the unadjusted Federal payment rate is equal to the rate computed for the previous fiscal year increased by a factor equal to the SNF market basket index percentage change for the fiscal year.

(iv) For fiscal years 2002 and 2003, the unadjusted Federal payment rate is equal to the rate computed for the previous fiscal year increased by a factor equal to the SNF market basket index percentage change for the fiscal year involved minus 0.5 percentage points.

(v) For each subsequent fiscal year, the unadjusted Federal payment rate is equal to the rate computed for the previous fiscal year increased by a factor equal to the SNF market basket index percentage change for the fiscal year involved.

(2) *Forecast error adjustment.* Beginning with fiscal year 2004, an adjustment to the annual update of the previous fiscal year's rate will be computed to account for forecast error. The initial adjustment (in fiscal year 2004) to the update of the previous fiscal year's rate will take into account the cumulative forecast error between fiscal years 2000 and 2002. Subsequent adjustments in succeeding fiscal years will take into account the forecast error from the most recently available fiscal year for which there is final data. The forecast error adjustment applies whenever the difference between the forecasted and actual percentage change in the SNF market basket index exceeds the following threshold:

(i) 0.25 percentage points for fiscal years 2004 through 2007; and

(ii) 0.5 percentage points for fiscal year 2008 and subsequent fiscal years.

(3) *Multifactor productivity (MFP) adjustment.* For fiscal year 2012 and each subsequent fiscal year, the SNF market basket index percentage change for the fiscal year (as modified by any applicable forecast error adjustment under paragraph (d)(2) of this section) shall be reduced by the MFP adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. The reduction of the market basket percentage change by the MFP adjustment may result in the market basket percentage change being less than zero for a fiscal year, and may result in the unadjusted Federal payment rates for a fiscal year being less than such payment rates for the preceding fiscal year.

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

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

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

Subpart P—Requirements for Establishing and Maintaining Medicare Billing Privileges

4. Section 424.502 is amended by—

A. Adding the definitions of "Additional disclosable party" and "Organizational structure" in alphabetical order.

B. Revising the definition of "Managing employee".

The revision and additions read as follows:

§ 424.502 Definitions.

* * * * *

Additional disclosable party means, with respect to a skilled nursing facility defined at section 1819(a) of the Act, any person or entity who—

(1) Exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

(2) Leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

(3) Provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

* * * * *

Managing employee means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W–2 employee of the provider or supplier. With respect to the additional requirements at § 424.516(e) of this chapter for a skilled nursing facility defined at section 1819(a) of the Act, a "managing employee" means an individual, including a general manager, business manager, administrator, director, or consultant, who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

* * * * *

Organizational structure means, with respect to a skilled nursing facility defined at section 1819(a) of the Act, in the case of—

(1) A corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

(2) A limited liability company, the members and managers of the limited liability company including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company;

(3) A general partnership, the partners of the general partnership;

(4) A limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

(5) A trust, the trustees of the trust; and

(6) An individual, contact information for the individual.

* * * * *

6. Section 424.516 is amended by adding paragraphs (e)(4) and (e)(5) to read as follows:

§ 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program.

* * * * *

(e) * * *

(4) In addition, a skilled nursing facility (as defined by section 1819(a) of the Act) must report upon enrollment and within 30 days of any change to the following information:

(i) The identity of and information on all of the following:

(A) Each member of the governing body of the facility, including the name,

title, and period of service for each member.

(B) Each person or entity who is an officer, director, member, partner, trustee, or managing employee (as defined in § 424.502) of the facility, including the name, title, and period of service of each such person or entity.

(C) Each person or entity who is an additional disclosable party of the facility, as defined in § 424.502.

(ii) The organizational structure (as defined in § 424.502 of this chapter) of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

(5) A skilled nursing facility (as defined by section 1819(a) of the Act) must certify as a condition of participation and payment under the program under Title XVIII of the Act that the information reported by the facility in accordance with these regulations is, to the best of the facility's knowledge, accurate and current.

* * * * *

PART 455—PROGRAM INTEGRITY: MEDICAID

7. The authority citation for part 455 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart B—Disclosure of Information by Providers and Fiscal Agents

8. Section 455.101 is amended by—

A. Adding the definitions of "Additional disclosable party" and "Organizational structure" in alphabetical order.

B. Revising the definition of "Managing employee".

The revision and additions read as follows:

§ 455.101 Definitions.

Additional disclosable party means any person or entity who—

(1) Exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

(2) Leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

(3) Provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

* * * * *

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly controls the day-to-day operation of an institution, organization, or agency. With respect to nursing facilities defined by section 1919(a) of the Act, a "managing employee" means an individual, including a general manager, business manager, administrator, director, or consultant who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

Organizational structure means, in the case of—

(1) A corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

(2) A limited liability company, the members and managers of the limited liability company including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company;

(3) A general partnership, the partners of the general partnership;

(4) A limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

(5) A trust, the trustees of the trust; and

(6) An individual, contact information for the individual.

* * * * *

9. Section 455.104 is amended by—

A. Redesignating paragraph (e) as paragraph (f).

B. Adding a new paragraph (e).

The addition reads as follows:

§ 455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

* * * * *

(e) *Disclosures from Medicaid nursing facilities.* (1) *What disclosures must be provided.* Medicaid nursing facilities must provide all disclosures required for disclosing entities, above. In addition, Medicaid nursing facilities (as defined by section 1919(a) of the Act) must provide disclosures regarding additional disclosable parties, organizational structure, and managing employees of the Medicaid nursing facility, as defined in § 455.101 of this part.

(i) These disclosures must include the identity of and information on all of the following:

(A) Each member of the governing body of the facility, including the name, title, and period of service for each member.

(B) Each person or entity who is an officer, director, member, partner, trustee, or managing employee (as defined in § 455.101) of the facility, including the name, title, and period of service of each such person or entity.

(C) Each person or entity who is an additional disclosable party (as defined in § 455.101) of the facility.

(ii) The organizational structure (as defined in § 455.101) of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

(2) *When the disclosures must be provided.* Medicaid nursing facilities must provide all the disclosures to the State Medicaid agency upon enrollment; on an annual basis to be determined by the State Medicaid agency; and within 30 days after any change to any of the above disclosures.

(3) *Medicaid nursing facility's certification.* Nursing facilities (as defined by section 1919(a) of the Act) must certify as a condition of participation and payment under the program under Title XIX of the Act that the information reported by the facility in accordance with these regulations is, to the best of the facility's knowledge, accurate and current.

* * * * *

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

Dated: March 24, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: April 26, 2011.

Kathleen Sebelius,

Secretary.

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

Addendum—FY 2012 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.

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TABLE A: FY 2012 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	0.8470
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	0.3622
10420	Akron, OH Portage County, OH Summit County, OH	0.8840
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.8643
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8706
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9579
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8051
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9285
11020	Altoona, PA Blair County, PA	0.8943
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8741
11180	Ames, IA Story County, IA	1.0039
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2170
11300	Anderson, IN Madison County, IN	0.9280
11340	Anderson, SC Anderson County, SC	0.8513

11460	Ann Arbor, MI Washtenaw County, MI	1.0158
11500	Anniston-Oxford, AL Calhoun County, AL	0.7987
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9253
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.8926
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9671
12060	Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA	0.8992
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1067
12220	Auburn-Opelika, AL Lee County, AL	0.8061
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9556

12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9557
12540	Bakersfield, CA Kern County, CA	1.1786
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	1.0182
12620	Bangor, ME Penobscot County, ME	1.0009
12700	Barnstable Town, MA Barnstable County, MA	1.2876
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	0.8549
12980	Battle Creek, MI Calhoun County, MI	0.9891
13020	Bay City, MI Bay County, MI	0.8954
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8749
13380	Bellingham, WA Whatcom County, WA	1.1784
13460	Bend, OR Deschutes County, OR	1.1429
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0335
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8602
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8757
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	0.8453
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7254
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8290
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8751
14060	Bloomington-Normal, IL McLean County, IL	0.9506
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9298
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2313

14500	Boulder, CO Boulder County, CO	1.0116
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8625
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.1321
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2920
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9211
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.8484
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9617
15500	Burlington, NC Alamance County, NC	0.8691
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0051
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1208
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0215
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8966
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9369
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.8698
16180	Carson City, NV Carson City, NV	1.0628
16220	Casper, WY Natrona County, WY	1.0147
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8857
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9911
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8195
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9090
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9311
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9215
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.8763

16940	Cheyenne, WY Laramie County, WY	0.9873
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	1.0632
17020	Chico, CA Butte County, CA	1.1345
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	0.9453
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8216
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.7697
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.8967
17660	Coeur d'Alene, ID Kootenai County, ID	0.9395
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9719
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9877
17860	Columbia, MO Boone County, MO Howard County, MO	0.8130
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8760
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8989
18020	Columbus, IN Bartholomew County, IN	0.9752
18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	1.0024
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8703
18700	Corvallis, OR Benton County, OR	1.0930

18880	Crestview-Fort Walton Beach-Destin, FL Okaloosa County, FL	0.8988
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.7849
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	0.9874
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8399
19180	Danville, IL Vermilion County, IL	0.9862
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.7919
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.9084
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9309
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7356
19500	Decatur, IL Macon County, IL	0.8032
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8892
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	1.0679
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9812
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9561
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.6944
20100	Dover, DE Kent County, DE	0.9939
20220	Dubuque, IA Dubuque County, IA	0.8724
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0366
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9663
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9626

20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.0892
20940	El Centro, CA Imperial County, CA	0.9630
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8745
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9433
21300	Elmira, NY Chemung County, NY	0.8547
21340	El Paso, TX El Paso County, TX	0.8541
21500	Erie, PA Erie County, PA	0.8171
21660	Eugene-Springfield, OR Lane County, OR	1.1621
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8697
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1356
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.3834
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8161
22140	Farmington, NM San Juan County, NM	0.9825
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9464
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9291
22380	Flagstaff, AZ Coconino County, AZ	1.2464
22420	Flint, MI Genesee County, MI	1.1150
22500	Florence, SC Darlington County, SC Florence County, SC	0.8235
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.7752
22540	Fond du Lac, WI Fond du Lac County, WI	0.9319
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9906
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0190
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7084
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9396
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9558

23420	Fresno, CA Fresno County, CA	1.1128
23460	Gadsden, AL Etowah County, AL	0.8125
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9403
23580	Gainesville, GA Hall County, GA	0.9029
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9220
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8530
24140	Goldsboro, NC Wayne County, NC	0.8713
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7595
24300	Grand Junction, CO Mesa County, CO	0.9422
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9172
24500	Great Falls, MT Cascade County, MT	0.8488
24540	Greeley, CO Weld County, CO	0.9582
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9694
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.8784
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9665
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9465
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3742
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.8531
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9196
25260	Hanford-Corcoran, CA Kings County, CA	1.0732
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9428
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.8800
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.0716
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7956
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.8881

25980	Hinesville-Fort Stewart, GA[1] Liberty County, GA Long County, GA	0.8817
26100	Holland-Grand Haven, MI Ottawa County, MI	0.8548
26180	Honolulu, HI Honolulu County, HI	1.1610
26300	Hot Springs, AR Garland County, AR	0.9103
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7864
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 Waller County, TX	0.9976
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.8919
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9022
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9364
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	0.9689
26980	Iowa City, IA Johnson County, IA Washington County, IA	1.0100
27060	Ithaca, NY Tompkins County, NY	0.8845
27100	Jackson, MI Jackson County, MI	0.8965
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8197
27180	Jackson, TN Chester County, TN Madison County, TN	0.7996
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.8905
27340	Jacksonville, NC Onslow County, NC	0.8011
27500	Janesville, WI Rock County, WI	0.9262
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8247

27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7839
27780	Johnstown, PA Cambria County, PA	0.8741
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7680
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8214
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	0.9939
28100	Kankakee-Bradley, IL Kankakee County, IL	0.9837
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 Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	0.9663
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	0.9611
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.9529
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.7421
28740	Kingston, NY Ulster County, NY	0.9198
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.7863
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9214
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9714
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9536
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8335
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.8022
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0338
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	0.9997
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8457
29540	Lancaster, PA Lancaster County, PA	0.9467

29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0497
29700	Laredo, TX Webb County, TX	0.7753
29740	Las Cruces, NM Dona Ana County, NM	0.9133
29820	Las Vegas-Paradise, NV Clark County, NV	1.2083
29940	Lawrence, KS Douglas County, KS	0.8879
30020	Lawton, OK Comanche County, OK	0.8571
30140	Lebanon, PA Lebanon County, PA	0.8066
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9088
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9065
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.8860
30620	Lima, OH Allen County, OH	0.9399
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9638
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	0.8571
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8617
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8556
31020	Longview, WA Cowlitz County, WA	1.0019
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.2305
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	0.8927
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8820
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8792
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9082
31460	Madera-Chowchilla, CA Madera County, CA	0.8139

31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1267
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0050
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS	0.7936
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9374
31900	Mansfield, OH Richland County, OH	0.9242
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3687
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.8904
32780	Medford, OR Jackson County, OR	1.0349
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	0.9247
32900	Merced, CA Merced County, CA	1.2451
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0116
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9386
33260	Midland, TX Midland County, TX	1.0546
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	0.9954
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	1.1173
33540	Missoula, MT Missoula County, MT	0.9181
33660	Mobile, AL Mobile County, AL	0.7986
33700	Modesto, CA Stanislaus County, CA	1.2678
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7939
33780	Monroe, MI Monroe County, MI	0.8754
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8119
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8222
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.6977

34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0266
34620	Muncie, IN Delaware County, IN	0.7841
34740	Muskegon-Norton Shores, MI Muskegon County, MI	0.9997
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.8669
34900	Napa, CA Napa County, CA	1.4739
34940	Naples-Marco Island, FL Collier County, FL	0.9769
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	0.9239
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2450
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1346
35300	New Haven-Milford, CT New Haven County, CT	1.1591
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	0.9053
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 Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.3063
35660	Niles-Benton Harbor, MI Berrien County, MI	0.8654
35840	North Port-Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	0.9464
35980	Norwich-New London, CT New London County, CT	1.1261
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6090
36100	Ocala, FL Marion County, FL	0.8475
36140	Ocean City, NJ Cape May County, NJ	1.0673
36220	Odessa, TX Ector County, TX	0.9839
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9248

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	0.8960
36500	Olympia, WA Thurston County, WA	1.1373
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 Washington County, NE	0.9894
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9155
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9342
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8226
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.2841
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9069
37380	Palm Coast, FL Flagler County, FL	0.9402
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL	0.8413
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7670
37700	Pascagoula, MS George County, MS Jackson County, MS	0.7909
37764	Peabody, MA Essex County, MA	1.0481
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8037
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.8856
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0786
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0595
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.7723
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8695
38340	Pittsfield, MA Berkshire County, MA	1.0648

38540	Pocatello, ID Bannock County, ID Power County, ID	0.9455
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4188
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	0.9690
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.1489
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	0.9814
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1361
39140	Prescott, AZ Yavapai County, AZ	1.2298
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	1.0666
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9432
39380	Pueblo, CO Pueblo County, CO	0.8697
39460	Punta Gorda, FL Charlotte County, FL	0.8827
39540	Racine, WI Racine County, WI	0.8651
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9626
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0233
39740	Reading, PA Berks County, PA	0.9240
39820	Redding, CA Shasta County, CA	1.5023
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0623
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	0.9824
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1434

40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.9169
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.0834
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8627
40420	Rockford, IL Boone County, IL Winnebago County, IL	0.9968
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH	1.0216
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9125
40660	Rome, GA Floyd County, GA	0.8854
40900	Sacramento-Arden-Arcade-Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.3786
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.8519
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.0757
41100	St. George, UT Washington County, UT	0.9097
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0286
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 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	0.9172
41420	Salem, OR Marion County, OR Polk County, OR	1.1258
41500	Salinas, CA Monterey County, CA	1.5650
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9254
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9444
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8293

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	0.9028
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1951
41780	Sandusky, OH Erie County, OH	0.8192
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.5813
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.4626
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.6826
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 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	0.4353
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.3106

42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2034
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.2279
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.6910
42140	Santa Fe, NM Santa Fe County, NM	1.0692
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.5837
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9007
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8353
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1575
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9059
43100	Sheboygan, WI Sheboygan County, WI	0.9222
43300	Sherman-Denison, TX Grayson County, TX	0.8035
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8530
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9566
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9181
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9454
43900	Spartanburg, SC Spartanburg County, SC	0.9353
44060	Spokane, WA Spokane County, WA	1.0541
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.8987
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0270
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8706
44220	Springfield, OH Clark County, OH	0.9008
44300	State College, PA Centre County, PA	0.9279
44600	Steubenville-Weirton, OH-WV Jefferson County, OH Brooke County, WV Hancock County, WV	0.7075
44700	Stockton, CA San Joaquin County, CA	1.3087
44940	Sumter, SC Sumter County, SC	0.7573
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9806

45104	Tacoma, WA Pierce County, WA	1.1411
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8619
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9099
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9237
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.7961
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9175
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8844
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0092
46060	Tucson, AZ Pima County, AZ	0.9346
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8387
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8691
46340	Tyler, TX Smith County, TX	0.8361
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8437
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.7846
46700	Vallejo-Fairfield, CA Solano County, CA	1.4680
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8460
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0253
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 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	0.9028
47300	Visalia-Porterville, CA Tulare County, CA	1.0310

47380	Waco, TX McLennan County, TX	0.8584
47580	Warner Robins, GA Houston County, GA	0.8129
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9633
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 Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.0839
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8391
48140	Wausau, WI Marathon County, WI	0.8989
48300	Wenatchee-East Wenatchee, WA Chelan County, WA Douglas County, WA	1.0199
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9853
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6755
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.8673
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	1.0128
48700	Williamsport, PA Lycoming County, PA	0.8108
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0694
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9120
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	0.9134
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.8317
49340	Worcester, MA Worcester County, MA	1.1027
49420	Yakima, WA Yakima County, WA	1.0464
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3768

49620	York-Hanover, PA York County, PA	0.9704
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8360
49700	Yuba City, CA[1] Sutter County, CA Yuba County, CA	1.2783
49740	Yuma, AZ Yuma County, AZ	0.9378

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

TABLE B: FY 2012 WAGE INDEX BASED ON CBSA LABOR MARKET AREAS FOR RURAL AREAS

State Code	Nonurban Area	Wage Index
1	Alabama	0.7249
2	Alaska	1.2885
3	Arizona	0.8853
4	Arkansas	0.7215
5	California	1.1428
6	Colorado	1.0136
7	Connecticut	1.1317
8	Delaware	1.0038
10	Florida	0.8386
11	Georgia	0.7566
12	Hawaii	1.1003
13	Idaho	0.7553
14	Illinois	0.8450
15	Indiana	0.8570
16	Iowa	0.8644
17	Kansas	0.8079
18	Kentucky	0.7846
19	Louisiana	0.7787
20	Maine	0.8601

State Code	Nonurban Area	Wage Index
21	Maryland	0.9319
22	Massachusetts	1.4004
23	Michigan	0.8320
24	Minnesota	0.9037
25	Mississippi	0.7549
26	Missouri	0.7699
27	Montana	0.8641
28	Nebraska	0.8898
29	Nevada	0.9672
30	New Hampshire	1.0473
31	New Jersey[1]	-----
32	New Mexico	0.8905
33	New York	0.8176
34	North Carolina	0.8291
35	North Dakota	0.7317
36	Ohio	0.8480
37	Oklahoma	0.7869
38	Oregon	1.0308
39	Pennsylvania	0.8456
40	Puerto Rico[1]	0.4047
41	Rhode Island[1]	-----
42	South Carolina	0.8313
43	South Dakota	0.8324
44	Tennessee	0.7744
45	Texas	0.7946
46	Utah	0.8745
47	Vermont	0.9738
48	Virgin Islands	0.7528
49	Virginia	0.7841
50	Washington	1.0234
51	West Virginia	0.7393
52	Wisconsin	0.8997
53	Wyoming	0.9422
65	Guam	0.9611

[1] All counties within the State are classified as urban, with the exception of Puerto Rico. Puerto Rico has areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for FY 2012. The Puerto Rico wage index is the same as FY 2011.

[FR Doc. 2011–10555 Filed 4–28–11; 4:15 pm]

BILLING CODE 4120–01–C