DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 413

[CMS–1351–F]

RIN 0938–AQ29

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012

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

ACTION: Final rule.

SUMMARY: This final rule updates the payment rates used under the prospective payment system for skilled nursing facilities (SNFs) for fiscal year 2012. In addition, it recalibrates 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 currently under development within CMS. In addition, this final rule discusses the impact of certain provisions of the Affordable Care Act, and reduces the SNF market basket percentage by the multi-factor productivity adjustment. This rule also implements certain changes relating to the payment of group therapy services and implements new resident assessment policies. Finally, this rule announces that the proposed provisions regarding the ownership disclosure requirements set forth in section 6101 of the Affordable Care Act will be finalized at a later date.

DATES: *Effective Date:* This final rule is effective on October 1, 2011.

FOR FURTHER INFORMATION CONTACT:

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

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SUPPLEMENTARY INFORMATION:

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Acronyms

In addition, because of the many terms to which we refer by acronym in this final rule, we are listing these acronyms 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
HIPAA Health Insurance Portability and Accountability Act of 1996
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
SCPA Significant Correction of a Prior Assessment
SCSA Significant Change in Status Assessment
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

In the May 6, 2011 **Federal Register**, we published a proposed rule (76 FR 26364) (hereafter referred to as the FY 2012 proposed rule), setting forth potential updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2012. Annual updates to the PPS rates for (SNFs) are required by section 1888(e) of the Social Security Act (the Act), as added by section 4432 of the Balanced Budget Act of 1997 (BBA, Pub. L. 105–33, enacted on August 5, 1997), and amended by 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) for those payment rate updates. We respond to public comments which relate to the FY 2011 update notice, along with those relating to the FY 2012 proposed rule, in this 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 final rule, we are updating 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 final rule, we established per diem Federal rates for urban and rural areas using allowable costs from FY 1995 cost reports. These rates also included 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 final 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 information collection burden associated with the resident assessment is approved under OMB Control Number 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 fiscal year.

• *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 III.B.5. of this final rule, this approach includes an administrative presumption that utilizes a beneficiary's initial classification in one of the upper 52 RUGs of the 66-group RUG–IV case-mix classification system to assist in making certain SNF level of care determinations. In 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 III.B.5. of this final 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 III.G of this final rule.

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

access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF services furnished under a swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, these services 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 III.H. of this final rule.

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

Section 1888(e)(4)(H) of the Act requires that we 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 for these services during the upcoming FY.

(3) The factors to be applied in making the area wage adjustment for these services.

Along with other revisions discussed later in this preamble, this final 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 final 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 III.G. of this final rule. Further, for swing-bed hospitals with more than 49 (but less than 100) beds, section 408 of the BBRA provided for the repeal of certain statutory restrictions on length of stay and aggregate payment for patient days, effective with the end of the SNF PPS transition period described in section 1888(e)(2)(E) of the Act. In the 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 final 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 final rule. (As noted previously, in accordance with section 101(c)(2) of the BBRA, this temporary payment adjustment expired upon the implementation of case-mix refinements on January 1, 2006.)
- Section 315 of the BIPA authorized us to establish a geographic reclassification procedure that is specific to SNFs, but only after collecting the data necessary to establish a SNF wage index that is based on wage data from nursing homes. To date, this has proven to be 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 $401.48 (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 $915.37.

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 III.G. of this final 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 final 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 Notice with Comment Period (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 Notice with Comment Period (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 Notice with Comment period, we also invited public comment specifically on our plans for implementing section 10325 of the Affordable Care Act in this manner.

However, section 202 of the Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111–309, enacted December 15, 2010) repealed section 10325 of the Affordable Care Act. Therefore, we leave in place 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 eliminates the need for a subsequent transition to the HR–III system, this 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, 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), in the FY 2011 Notice with Comment Period (75 FR 42892–42893), and in the FY 2012 proposed rule (76 FR 26370 through 26377).

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 III.D. of this final rule, we discuss certain ongoing Affordable Care Act initiatives that relate to SNFs, and in section III.E.1, 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 final rule reflect an update to the rates that we published in the notice with comment period 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 III.F. of this final 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 FY 2012 market basket increase is 2.7 percent, which is based on IHS Global Insight, Inc. (IGI) second quarter 2011 forecast with historical data through first quarter 2011.

In addition, as explained in the final rule for FY 2004 (66 FR 46058, August 4, 2003) and in section III.F.2. of this final rule, the annual update of the payment rates includes, as appropriate, an adjustment to account for market basket forecast error. As described in the 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 second quarter 2011 IHS Global Insight forecast, with historical data through the first quarter 2011 (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 III.F.3 of this final rule, the MFP adjustment for FY 2012 is 1.0 percent.

II. Summary of the Provisions of the FY 2012 Proposed Rule

In the FY 2012 proposed rule (76 FR 26364), we presented 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, we examined recent changes in provider behavior relating to the implementation of the Resource Utilization Groups, version 4 (RUG–IV) case-mix classification system and considered 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. We also included a discussion of a Non-Therapy Ancillary component and outlier research currently under development within CMS. In addition, the proposed rule discussed the impact of certain provisions of the Affordable Care Act. We proposed 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. We also proposed 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, we proposed certain changes relating to the payment of group therapy services and proposed new resident assessment policies.

III. Analysis of and Responses to Public Comments on the FY 2012 Proposed Rule

In response to the publication of the FY 2012 proposed rule, we received over 170 timely public comments from individual providers, corporations, government agencies, private citizens, trade associations, and major organizations. The following are brief summaries of each proposed provision, a summary of the public comments that we received related to that proposal, and our responses to the comments.

A. General Comments on the FY 2012 Proposed Rule

In addition to the comments we received on the proposed rule's discussion of specific aspects of the SNF PPS (which we address later in this final rule), commenters also submitted the following, more general observations on the payment system. We received many comments expressing concern about the SNF PPS system as a whole and the MDS 3.0 and RUG–IV system.

Comment: We received a number of comments raising concerns about the complexity of the MDS 3.0 that included several new assessment types, the need to clarify the RAI manual, and the time required to become trained on the new MDS 3.0 requirements.

Response: We appreciate these concerns and we recognize that the transition to the MDS 3.0 was complex and labor-intensive. We provided extensive training and opportunities to assist with questions about the MDS 3.0 and RUG–IV models both prior to and after its October 1, 2010 implementation on audio conferences, at national training conferences, in the form of the RAI Manual and subsequent clarification updates, and postings to the MDS 3.0 and SNF PPS Web sites. We have also provided support in response to oral and written inquiries, and issued clarification during Open Door Forums, RAI Manual updates, and through online and telephone technical assistance. We are committed to continuing training on both the MDS 3.0 and RUG–IV systems. In fact, we are developing training programs to assist providers to adapt to any new policy changes introduced on and after October 1, 2011. Additionally, as we receive provider input through these efforts, we will continue to update and clarify the RAI manual to ensure that it continues to provide accurate information and guidance on CMS policies.

Comment: One commenter recommended that we address the need for stricter requirements for training and certification of food services directors and staff. The commenter states that stricter guidelines will improve patient health and safety.

Response: We appreciate this comment, but note that the specific issues the commenter raised about the requirements for food services staff relate to the certification standards for long-term care facilities and, therefore, are beyond the scope of this final rule. We have, however, shared these comments with CMS survey and certification staff so that they can consider these suggestions as part of their ongoing review and refinement of our policies.

B. FY 2012 Annual Update of Payment Rates Under the Prospective Payment System for Skilled Nursing Facilities

1. Federal Prospective Payment System

This final rule sets forth a schedule of Federal prospective payment rates applicable to Medicare Part A SNF services beginning October 1, 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.

a. Costs and Services Covered by the Federal Rates

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

b. Methodology Used for the Calculation of the Federal Rates

The FY 2012 rates reflect an update using the full amount of 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 final rule, is reduced by a 1.0 percent MFP adjustment, resulting in an MFP-adjusted market basket percentage of 1.7 percent. A complete description of the multi-step process used to calculate Federal rates initially appeared in the May 12, 1998 interim final rule (63 FR 26252), as further revised in subsequent rules. We note that the temporary increase of 128 percent in the per diem adjusted payment rates for SNF residents with AIDS, enacted by section 511 of the MMA (and discussed previously in section I.E of this final rule), remains in effect.

We used the SNF update factor 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 (FY 2011), and the midpoint of the Federal FY beginning October 1, 2011, and ending September 30, 2012 (FY 2012), to which the payment rates apply. In accordance with section 1888(e)(4)(E)(ii)(IV) of the Act, we update the payment rates for FY 2012 by a factor equal to the full market basket index percentage increase. As further explained in sections I.G.2 and III.F.2 of this final 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 III.F.3 of this final 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	$160.62	$120.99	$15.94	$81.97

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	$153.46	$139.51	$17.02	$83.49

2. Case-Mix Adjustments

a. Background

Section 1888(e)(4)(G)(i) of the Act requires the Secretary to make an adjustment to account for case-mix. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the relative resource use of different patient types, as well as resident assessment and other data that the Secretary considers appropriate. In first implementing the SNF PPS (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, payment levels under the PPS vary based on the patient's anticipated care needs and resource utilization. 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 used as the basis for 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 final 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.

b. Development of Case-Mix Indexes

In the FY 2012 proposed rule (76 FR 26370 through 36377), we discussed the implementation of the RUG–IV classification system, effective October 1, 2010. We also discussed the accompanying parity adjustment that was intended to ensure that estimated total payments under the RUG–IV model would be equal to those payments that would have been made under the 53-group RUG–III model that it replaced. We then explained that actual utilization patterns under the refined case-mix system differed significantly from the initial projections, and as a consequence, rather than achieving parity as intended, this adjustment to the new RUG–IV system triggered a significant increase in overall payment levels under the RUG–IV model, representing substantial overpayments to SNFs.

Accordingly, the FY 2012 proposed rule included a discussion of two options for updating the rates for FY 2012. The first option was to recalibrate the parity adjustment (using the methodology discussed in the FY 2012 proposed rule) to ensure that the adjustment actually achieves its intended purpose, to make the transition from RUG–53 to RUG–IV in a budget neutral manner, as discussed further below. Under the second option, CMS reserved the option not to implement a recalibration of the parity adjustment in FY 2012 if, as additional FY 2011 claims data became available, they indicated that utilization patterns are more consistent with our projections and expenditures are more in parity with those under the RUG–53 model. Under this second option, we stated we would simply update the payment rates for FY 2012 by the FY 2012 market basket adjustment of 2.7 percent, reduced by the MFP adjustment of 1.0 percent, for a net market basket increase factor of 1.7 percent.

As discussed in the FY 2012 proposed rule, the recalibration of the FY 2011 parity adjustment, which formed the basis of the first option discussed above, was initially determined through an analysis of utilization data from the first quarter of FY 2011. The methodology for determining the parity adjustment necessary given utilization patterns observed in the first quarter of FY 2011 is described in the FY 2012 proposed rule (76 FR 26370 through 26377) and follows the same basic methodology described in the FY 2006 SNF PPS

proposed rule (70 FR 29077 through 29079), the FY 2009 SNF PPS proposed rule (73 FR 25923) and the FY 2009 SNF PPS final rule (73 FR 46421–23).

In the FY 2012 proposed rule, we stated that this adjustment was based on a set of data derived from first quarter FY 2011 claims and MDS assessments. We further stated that we would continue to monitor claims data and utilization patterns in FY 2011 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 update the parity adjustment accordingly. For this final rule, as further discussed below, we have been able to update the recalibration of the FY 2011 parity adjustment with a data set which includes claims and MDS 3.0 assessments for the first 8 months of FY 2011.

Using the same methodology for determining the recalibration discussed in the FY 2012 proposed rule and approximately 2.2 million claims matched to the MDS 3.0 assessment, representing 8 months (or nearly 3 full quarters) of FY 2011 (from October 1, 2011 through May 31, 2011), we determined that the utilization patterns identified in our analysis of the first quarter FY 2011 data continued throughout the entire 8-month period (these data are available at *http://www.cms.gov/SNFPPS/02_Spotlight.asp*). We then repeated our recalibration calculation using the full 8-month data set, which is available at *http://www.cms.gov/SNFPPS/02_Spotlight.asp*. We found that, while retaining the original 61 percent adjustment to the CMIs assigned to each of the RUG–IV non-therapy groups, the necessary adjustment to the nursing CMIs of the RUG–IV therapy groups would be 19.84 percent, a difference of only .03 percent from the 19.81 percent adjustment discussed in the proposed rule. We believe that this updated analysis confirms our preliminary analysis, and demonstrates effectively that the utilization patterns observed in the first quarter of FY 2011 were not temporary aberrations or the result of a learning curve with respect to the RUG–IV and MDS 3.0 transition, but instead represent a new pattern of provider behavior that differs significantly from expected utilization patterns that were the basis for the original parity adjustment, and which resulted in significant increases in overall payment levels under RUG–IV.

In addition, the increased expenditure levels due to the implementation of the RUG–IV system have been validated by the Office of the Inspector General (OIG) in a separate review of SNF payments during the first 6 months of FY 2011. According to a preliminary analysis by OIG, the utilization trends related to the shifts in the modes of therapy and the classification of high percentages of SNF beneficiaries into the highest-paying RUG–IV groups were even more pronounced in the FY 2011 second quarter (January through April 2011) than in the first quarter (October through December 2010) that was used for the analyses included in the FY 2012 proposed rule (This OIG report is available at *http://oig.hhs.gov/oei/reports/oei-02-09-00204.asp*.)

As we stated in the proposed rule (76 FR 26371), 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 nursing CMIs, it is more appropriate to maintain the 61 percent adjustment to the nursing CMIS for the RUG–IV non-therapy groups, and reduce the 61 percent parity adjustment as it applied to the nursing CMIs for the RUG–IV therapy groups.

In the proposed rule, we invited comments on the two options discussed above. A discussion of these comments, including our responses, appears below.

Comment: We received a variety of comments regarding the two options presented in the proposed rule for updating the payment rates for FY 2012. Most commenters were opposed to the option to recalibrate the FY 2011 parity adjustment. Many of these commenters expressed their belief that the recalibration considered in the proposed rule will have a significantly negative impact on facilities and beneficiaries. These commenters believed that the recalibration discussed in the proposed rule should be either withdrawn or significantly reduced.

Response: In light of the previous recalibration of the SNF PPS case-mix indexes in FY 2010, which addressed excess payments associated with the RUG–53 implementation in FY 2006 but only after those excess payments had persisted for several years, we believe it is imperative that we act in a well-considered but expedient manner once excess payments such as those in FY 2011 are identified. Allowing these significant anomalies to persist and failing to take timely action to correct the situation creates instability under the RUG–IV system, in the SNF PPS, and the Medicare program generally, which ultimately affects Medicare beneficiary access and quality of care. As we explained in the FY 2012 proposed rule (76 FR 26370–26373), in recalibrating the CMIs under the RUG–IV model, we expect to restore payments to their appropriate level by correcting an inadvertent increase in overall payments. Because the recalibration is removing an unintended excess payment rather than decreasing an otherwise appropriate payment amount, we do not believe that the recalibration should negatively affect facilities, beneficiaries, or quality of care, or create an undue hardship on providers.

Further, in its March 2011 report to the Congress (available at *http://www.medpac.gov/documents/Mar11_EntireReport.pdf*), MedPAC reports that average Medicare margins have increased for freestanding SNFs since 2005. In 2009, the aggregate Medicare margin for freestanding SNFs, which represent more than 90 percent of all SNF facilities, was 18.1 percent, up from 16.6 percent in 2008 and representing the ninth consecutive year where the aggregate Medicare margin for freestanding SNFs was greater than 10 percent. For these reasons, we believe that the parity adjustment should not be withdrawn or reduced.

Comment: Several commenters asserted that the higher payments observed in FY 2011 were, at least partially, the result of real acuity changes which should be accounted for in the calculation of the parity adjustment. These commenters stated that, as an alternative approach, CMS should consider comparing data from FY 2010 and FY 2011 when calculating the recalibration factor, to account for changes in patient acuity.

Response: We disagree with this comment on the basis that, as described in the FY 2012 proposed rule (76 FR 26371), the same FY 2011 claims and MDS information were used to determine both RUG–III payments and RUG–IV payments. Using the same population for the same timeframe serves to control for acuity level changes, as well as other factors, such as patient volume, across the RUG–III and RUG–IV systems and provide an appropriate comparison for our financial analysis.

We would also note, as discussed further below, that we did a comparison of data from all of FY 2010 and from the first eight months of FY 2011 that did not control for changes in patient acuity, and found that it did not result in a significant difference in the recalibration factor necessary to equalize RUG–IV payments and RUG–III payments. In testing this alternative methodology, we did control for volume by calculating the percentage of FY 2010 days of service for each of the RUG–III groups, broken down by urban and rural days, and then multiplied each

percentage by the total number of urban or rural FY 2011 days of service, as appropriate, to determine the number of days of service for each RUG–III group, relative to the total volume for the first eight months of FY 2011. Therefore, even though the recalibration methodology discussed in the proposed rule (76 FR 26370–73) controls for changes in patient acuity, we note that the alternative approach above which was suggested by commenters would not change the recalibration factor.

Comment: Some commenters asserted that CMS failed to provide sufficient information for a third party to reproduce CMS's conclusions with regard to the parity adjustment. A few commenters stated that the lack of access to data, or the timeframe for when certain data were released, limited the ability of stakeholders to develop substantive comments on the recalibration considered in the proposed rule. Additionally, a few commenters referred to specific requests that were made by a few of the major nursing home trade associations for access to claims and MDS data for the fourth quarter of FY 2010 and the first quarter of FY 2011. They noted that we had declined to fulfill those data requests, due to certain data disclosure requirements in the privacy regulations that were promulgated under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191, enacted on August 21, 1996) (HIPAA). These commenters asserted that CMS should reconsider its data security policies in light of the use of more ''real–time'' data.

Response: We do not agree with assertions that CMS provided inadequate data to evaluate and comment upon the proposals described in our proposed rule. The methodology used to establish the case-mix adjustments is the same as that described in detail in the FY 2006 SNF PPS proposed rule (70 FR 29077 through 29079), the FY 2009 SNF PPS proposed rule (73 FR 25923), and the FY 2009 SNF PPS final rule (73 FR 46421 through 46422), as updated in the FY 2012 proposed rule (76 FR 26370 through 26377). In addition, the data used to calculate the adjustments are publicly available on the CMS Web site, as explained below. We tested the ability to reproduce the parity adjustment calculation using only information available on the CMS Web site as of May 3, 2011, and in the proposed rule and were able to do so. We used the first quarter FY 2011 days of service for the RUG–IV system and a distribution of what those days would have looked like under RUG–III (available in the Downloads section of our Web site at *http://www.cms.gov/SNFPPS/02_Spotlight.asp*). We multiplied the RUG–IV and RUG–III days of service by the FY 2012 unadjusted Federal per diem payment rate components, multiplied by the unadjusted case-mix indexes (the unadjusted RUG–IV case-mix indexes can be calculated by dividing the adjusted case-mix indexes, provided in the proposed rule in Tables 5A or 6A, by the adjustment factor of 1.1981) to establish expenditures under the RUG–III and RUG–IV systems. The parity adjustment was determined as the percentage increase necessary for the nursing CMIs of the RUG–IV therapy groups to generate estimated expenditure levels under the RUG–IV system that were equal to estimated expenditure levels under the RUG–III system.

While this data alone would have been sufficient for a third party to reproduce our results, in an effort to respond to data requests from stakeholders and give the public as much information as possible to evaluate the two parity adjustment options considered in the proposed rule, we also made available on our Web site, as of June 16, 2011, a distribution of paid days by provider number and by month for the fourth quarter of FY 2010 under RUG–III and the first quarter of FY 2011 under RUG–III and RUG–IV. This data could be used to allow stakeholders to analyze acuity trends and further evaluate the adequacy of the data used to determine the appropriate recalibration. Finally, we posted on our Web site a detailed memo which outlined how stakeholders could use MDS 3.0 data to determine the appropriate RUG–III group for a given RUG–IV patient, even though this information was also already available to facilities on their final validation reports. Thus, we provided stakeholders and their trade associations with extensive data described earlier, so that they had multiple avenues for analyzing the underlying data and verifying CMS's results. We believe the additional information provided was beyond the information necessary to replicate our calculation. In this way, we provided even greater transparency of our methods and data analysis while fulfilling our data security responsibilities under HIPAA.

Furthermore, with regard to the ability of stakeholders to provide substantive comments, we do not agree with the commenter's statement that the necessary data were released too late to allow for analyses that would generate substantive comment on the proposed rule. As illustrated above, the data provided on the CMS Web site and in the proposed rule were more than sufficient for stakeholders to reproduce, evaluate, and critique the recalibration methodology and results. This is evident in the notable breadth and detail of the commenters' critiques of our supporting data, methodology, and results, which we view as at least in part a reflection of the extensive amount of data that we have made available to the public throughout this process, and of the ability of commenters to provide both timely and substantive comments on the proposed rule. Even after the issuance of the FY 2012 proposed rule, we continued to respond to requests for technical assistance and posted additional technical materials on our Web site so that all stakeholders could have access to the responses to the technical questions that we received.

Certain data, such as specific MDS and claims data requested by certain trade associations, could not be made available upon the request of stakeholders. CMS' data security policy, which derives from our responsibilities under HIPAA, does not allow CMS to release patient identifiable data when such data are not necessary to accomplish the purpose of the disclosure (here, analyzing our proposals). As noted above, these data were not necessary to provide substantive and timely comments on the proposals contained in the proposed rule, as evidenced by the ability of internal staff to replicate and verify the results of our calculation using data available on our Web site well before the end of the comment period. Accordingly, as the non-patient identifiable information was itself adequate for purposes of assessing our proposals, we were not able to release the requested patient identifiable information.

That said, CMS does make certain information available from the claims and MDS files. CMS has an established timeline for the release of such information, which normally allows for up to a year after the data have been finalized in order to screen and cleanse the data properly of anything that would permit patient identification. Any attempt to speed up this process would result in the assumption of unacceptable risks that patient-identifiable information would be released by mistake, which would threaten the basic privacy protections that beneficiaries must be afforded. Finally, as discussed above, some commenters suggested that, given our increased use of more real-time data (that is, data from the current fiscal year as opposed to claims data

from a prior year) for our recalibration analyses, we should consider updates to our data security policies to ensure that stakeholders have adequate access to data and that the rulemaking process is as transparent as possible. We agree that the process should remain transparent, but we also note that the data security policies that cover the patient-level claims and MDS data used as the basis of the parity adjustment recalibration implemented in this final rule are required by the HIPAA privacy regulations and exist first and foremost to protect Medicare beneficiaries. While commenters requested certain claims and MDS data in order to evaluate our recalibration results, assumptions, and methodology, as discussed above, the data requested were not necessary to provide substantive and timely comments on the proposals contained in the proposed rule so we were unable to provide such data under the HIPAA privacy rule's ''minimum necessary'' provisions. As we stated above, we believe the data we provided on the CMS Web site and in the proposed rule were more than sufficient for stakeholders to reproduce, evaluate, and critique the recalibration methodology and results. We will continue to make data available to stakeholders within the limits of the law. Finally, we have updated the data on our Web site to reflect the use of the eight months of data used to finalize this rule.

Comment: Many commenters raised general concerns over the data used to determine the appropriate recalibration of the FY 2011 parity adjustment. Many of these commenters believed that one fiscal quarter of data was insufficient to justify a recalibration of the magnitude discussed in the proposed rule and that CMS should wait until it has a greater set of data from which to draw conclusions about utilization patterns in FY 2011. Several commenters were concerned that, given the increased burden associated with transitioning both to RUG–IV and MDS 3.0 simultaneously, it is possible that the first quarter of FY 2011 may represent facilities working to transition properly rather than accurately representing evolving provider behavior. One commenter specifically stated that using one quarter of data would not adequately control for the possibility of ''seasonality'' in SNF PPS claims submission, payments, and acuity levels, and provided a detailed analysis of previous fiscal quarters to demonstrate the possibility of a difference between the first fiscal quarter of a given year and the remainder of that year. One commenter also raised concerns related to the provider-level data that CMS made available to stakeholders upon their request, specifically that the data provided for a certain set of providers did not match the data that this commenter acquired independently for this provider. A few commenters highlighted potential calculation errors in the analysis and data presented in the proposed rule, with one commenter specifically highlighting an error in the calculation of the nursing CMI for a certain non-therapy RUG–IV group.

Response: We acknowledge the commenters' concerns about relying solely on one fiscal quarter of data to finalize a recalibration of the magnitude discussed here. However, as noted in the proposed rule, the first quarter of data served only as the basis for our preliminary analysis of FY 2011 utilization. In the proposed rule, we committed to monitoring FY 2011 utilization data continually to confirm the results of our preliminary analysis regarding the need to recalibrate the parity adjustment. The stated purpose of the discussion of this first quarter FY 2011 data in the proposed rule was to ''provide the public with information on the potential scope and impact of the recalibration'' we considered in the proposed rule (76 FR 26371). Given that we have updated the data file with claims and MDS assessments ranging over 8 months of FY 2011 and for the reasons outlined below, we believe that the utilization patterns observed as part of our preliminary analysis do, in fact, represent an accurate reflection of utilization for the whole of FY 2011.

Additionally, as stated above, we have now updated the recalibration based on 8 months of FY 2011 data, and utilization patterns are virtually identical to FY 2011 first quarter findings (Data available at *http://www.cms.gov/SNFPPS/02_Spotlight.asp*). Therefore, we believe that observed utilization patterns are more likely the result of evolving provider behavior rather than errors and adjustments made during the early transition period to RUG–IV and MDS 3.0. Moreover, since facilities were given more than one year to prepare for the implementation of both RUG–IV and MDS 3.0, we believe that facilities were given ample time for education and preparation for the transition and that any confusion or mistakes due to transition issues would have been addressed prior to, or in the very early stages of, the RUG–IV and MDS transition.

With regard to commenters' claims related to ''seasonality'' of the first quarter FY 2011 data, our own analysis of FY 2010 claims data demonstrated that the first quarter of a given fiscal year does appear to provide a reasonable approximation of patient acuity levels and payments for the whole of that fiscal year. We reviewed the FY 2010 claims by RUG classification and by month for each month of FY 2010. Ultimately, we found that the distribution of RUG groups remained stable over the year and no particular quarter, or even month, stood out as demonstrating a different RUG distribution from the rest of that year (these data are available at *http://www.cms.gov/SNFPPS/02_Spotlight.asp*). In fact, the only real difference in SNF payment levels occurs in the transition between one fiscal year and another, where this difference is attributable to the annual payment update and market basket adjustment rather than to any ''seasonality'' existing between the fourth quarter of a given fiscal year and the first quarter of the following fiscal year.

Finally, with regard to the comment related to the provider-level data, we were unable to verify this commenter's claim as we were not provided with any details as to the location or type of provider in question. After a review of the data used to support the recalibration, we found the underlying data to be accurate, and sufficient to perform the proper calculation of the recalibration. We did identify one RUG category (LB2) where we incorrectly stated the nursing CMI as 1.46 in the proposed rule, when it should be 1.45. This correction, while it would have a very small effect on the per diem payment for that RUG group, did not have any impact on our calculation of the parity adjustment. This error has since been corrected and tables 5 and 6 in this final rule reflect the correct nursing CMI for LB2.

Comment: Many commenters expressed concern over the possibility of a reduction to Medicare payment rates in light of other reductions in areas such as Medicaid. Some commenters stated that Medicare should maintain SNF payment levels to cross-subsidize what they characterized as inadequate payment rates for nursing facilities under the Medicaid program. Other commenters urged CMS to reconsider the recalibration in light of the potential impact on the weak national economy. A few commenters discussed the importance of the health care industry, specifically SNFs, as representing a significant sector of job growth during the recent economic recession. Finally, a few commenters asserted that the recalibration would drive providers into bankruptcy, as they assert happened

when the SNF PPS was initially implemented in the late 1990s.

Response: We wish to clarify that it is not the appropriate role of the Medicare SNF benefit to cross-subsidize nursing home payments made under the Medicaid program. As noted by several commenters, the primary purpose of the Medicare SNF benefit is to provide accurate payment for Medicare Part A services provided in a SNF setting. Further, we note that MedPAC has also indicated that it is inappropriate for the Medicare program's SNF payments to be used to account for Medicaid shortfalls. Specifically, on page 159 of its March 2011 Report to Congress on Medicare Payment Policy (which is available online at *http://www.medpac.gov/documents/Mar11_EntireReport.pdf*), MedPAC stated:

* * * the Commission believes such cross-subsidization is not advisable for several reasons. First, on average, Medicare payments account for less than a quarter of revenues to freestanding skilled nursing facilities. A cross-subsidization policy would use a minority share of Medicare payments to underwrite a majority share of states' Medicaid payments. Second, raising Medicare rates to supplement low Medicaid payments would result in poorly targeted subsidies. Facilities with high shares of Medicare payments—presumably the facilities that need revenues the least—would receive the most in subsidies from the higher Medicare payments, while facilities with low Medicare shares—presumably the facilities with the greatest need—would receive the smallest subsidies. Third, increased Medicare payment rates could encourage states to further reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates. In addition, a Medicare subsidy would have an uneven impact on payments, given the variation across states in the level and method of paying for nursing home care. In States where Medicaid payments were adequate, the subsidy would add to excessive payments. Last, higher Medicare payments could further encourage providers to select patients based on payer source or to rehospitalize dual-eligible patients to qualify them for a Medicare-covered, higher payment stay.

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

We are also aware of the concerns that reductions in payment levels can have a negative impact on SNFs and the quality of care furnished to nursing home patients across the country. However, in this particular case, the recalibration discussed in the proposed rule and finalized in this final rule corrects, on a prospective basis only, the unintended excess payment that we observed for FY 2011. In addition, even with the recalibration, FY 2012 rates will still be 3.4 percent higher than FY 2010 rates, the period immediately preceding the introduction of RUG–IV and the unintended spike in payments. Also, FY 2010 expenditures increased by 4.8 percent over FY 2009, a period where both MedPAC and CMS have calculated margins for free-standing SNFs to average 18.1 percent. Moreover, we have not proposed any action to recoup retroactively the excess expenditures already made to SNFs during FY 2011. Instead, we are limiting the scope of the recalibration to restoring the intended SNF PPS payment levels on a prospective basis only effective October 1, 2011.

We have also considered the concerns raised by commenters that restoring the intended payment levels will result in job losses and add significant burden to health care workers and States. CMS cost report and Online Survey Certification and Reporting System (OSCAR) data show that, for the majority of freestanding SNFs and SNFs that operate as part of chains, there has been little change in staffing with the implementation of RUG–IV. Therefore, as data do not indicate that facilities increased staffing with the implementation of RUG–IV and aggregate payments will return to a level commensurate with those made under RUG–III, we do not believe that restoring payments to their intended and appropriate levels should necessarily result in job losses or add significant burden to health care workers or States.

As regards the comment that CMS should reconsider the recalibration in light of the potential impact on a weak economy, we do not believe that potential economic effects justify perpetuating observed and acknowledged excessive and inaccurate payments. Again, we note that MedPAC found in 2009 that the aggregate Medicare margin for freestanding SNFs, which represent more than 90 percent of all SNF facilities, was 18.1 percent, up from 16.6 percent in 2008 and representing the ninth consecutive year where the aggregate Medicare margin for freestanding SNFs was greater than 10 percent.

Finally, with regard to those comments which asserted that the recalibration would trigger bankruptcies similar to those that they attributed to the implementation of the SNF PPS in the late 1990s, studies have indicated multiple factors for nursing home closures during that time, such as chain membership, investment decisions in an uncertain market, and market competition. A more detailed analysis of the research in this area appears in the FY 2010 final rule (74 FR 40297 through 40298). Ultimately, the existing body of research fails to indicate that case-mix reimbursement is a significant contributor to nursing home bankruptcy, particularly considering the small percentage of facility revenues which derive from Medicare payments. Thus, we do not agree with those commenters who asserted that the recalibration, in and of itself, could lead to the bankruptcy of SNF providers or that it could create the degree of fiscal pressure that could impact negatively on facility staffing or the quality of care in SNFs.

Comment: Many commenters, while conceding that overpayments in FY 2011 do exist, questioned the magnitude of the recalibration deemed appropriate by CMS. Several commenters expressed concern with the distribution of RUG–III payment days used by CMS to calculate the parity adjustment. These commenters stated that the RUG–III distribution of days posted by CMS appeared to show incorrectly a decline in patient acuity (particularly in the case of Rehabilitation plus Extensive Services RUG groups) and that this apparent decline in patient acuity may have been due to flaws in the crosswalk methodology. These commenters believed that this led to an underestimation of RUG–III payments, thereby causing an overestimation of the necessary parity adjustment. A few commenters identified the methodology used by CMS to crosswalk between MDS 3.0 data and RUG–III group classification as potentially introducing certain biases and errors into the parity adjustment calculation. One commenter specifically referred to a potential inaccuracy in the crosswalk methodology as it related to ADL conversions, the depression scale used under MDS 2.0 and MDS 3.0, and certain MDS items (such as IV medications) which required facilities to ''look-back'' to services received during the patient's qualifying hospital stay.

Response: As stated above, several commenters suggested that the distribution of RUG–III payment days (which were derived from MDS 3.0 assessments submitted in FY 2011 or through review of final validation reports available to stakeholders) which appeared to reflect an apparent drop in patient acuity between FY 2010 and FY 2011, actually reflected a flaw in the crosswalk methodology used by CMS. In response to this comment and in response to the comments suggesting a potential inaccuracy in the RUG–III crosswalk, we conducted a detailed

analysis of this potential issue. We first confirmed that the physical programming for the crosswalk file was correct and found no errors in the programming. We then turned our attention to policy and assessment differences between the RUG–III and RUG–IV systems that could be affected by the simultaneous transition to MDS 3.0.

We identified a few areas where using the MDS 3.0 could possibly affect the determination of a patient's case-mix classification under RUG–III or RUG–IV. The first area was a difference on the depression scale used under MDS 2.0 and MDS 3.0 where we found, through an analysis of MDS data from July 2010 through April 2011, that the number of depression cases triggered under MDS 2.0 was greater than the number of depression cases triggered under MDS 3.0 by approximately 6.6 percent. However, since depression plays a small role in the determination of a patient's RUG classification (using either the MDS 2.0 FY 2010 data or the MDS 3.0 FY 2011 data, approximately 2 percent of all Medicare beneficiaries classified into RUG–III groups where depression was a qualifying factor), this difference would not have a significant impact on the RUG–III distribution or parity adjustment recalibration. We also examined the ADL scale used under MDS 2.0 and MDS 3.0 for the same period described above and found that the mean ADL scale score between the two assessments was virtually identical; that is, patients classified into the same ADL categories under both models. Therefore, the ADL scale could not be a source of differences in classification due to using the crosswalk.

Next, we examined the use of OMRAs, particularly the End of Therapy (EOT) OMRA and its accompanying policies. Specifically, under MDS 2.0, facilities could be paid at a therapy rate for 8 to 10 days after the discontinuation of all therapies before the EOT OMRA would be necessary. Under MDS 3.0, the ARD for the EOT OMRA must be set for 1 to 3 days after the discontinuation of all therapies, and the relevant non-therapy RUG rate is paid from the date that therapy was discontinued. We agree that the program used to estimate RUG–III payments did not adjust for the change in the EOT policy. Instead, any change from a therapy RUG group to a non-therapy RUG group that would normally result from the completion of an EOT OMRA, specifically under MDS 2.0, would only be picked up on the next scheduled MDS 2.0 assessment. As a result, the crosswalk in this case may have led to an overestimation of RUG–III payments, which would mean that we actually could have underestimated the parity adjustment necessary to bring RUG–IV payments in line with RUG–III payments.

Finally, one commenter specifically referred to a potential issue with the RUG–III crosswalk related to capturing IV services provided to SNF residents during the resident's qualifying hospital stay. The commenter stated that the crosswalk did not accurately account for these services, leading to an underestimation of RUG–III payments. Based on comments we received, we reviewed MDS assessment data related to the coding of IV medications received by the patient prior to admission to the SNF. After a review of MDS data from July 2010 through April 2011, we did find a significant drop in coding for IV services received prior to the resident's admission to the SNF between FY 2010 and FY 2011. However, given the lack of data, it would be very difficult to ascertain if this drop is the result of facilities admitting a lower volume of beneficiaries who had an IV while in the qualifying hospital stay or, as one commenter suggested, that it stemmed from the elimination of a payment incentive for collecting data from the prior hospital stay and failure to report this item accurately on the MDS 3.0. While this item would not affect the patient's RUG–IV classification, it would be necessary to provide an accurate classification of that patient into a RUG–III category, which is an essential aspect of the recalibration calculation. We note that many commenters believed that patient acuity likely did not drop from FY 2010 to FY 2011. Thus, it is possible that, as one commenter posited, some facilities failed to report accurately on the MDS 3.0 if the patient had received an IV prior to admission to the SNF, due to the elimination of the payment incentive for reporting this item. However, we do not have the data to confirm the basis for the drop in coding IV services.

We considered the potential impact of inaccurate reporting of IVs and other potential crosswalk issues, as described above. However, as stated above, it is impossible to ascertain the cause and extent of any observed reporting differences or to quantify the impact of the reporting change on aggregate expenditure levels. However, in order to approximate the impact of these coding changes, we compared the actual RUG–IV payments from first quarter FY 2011 with a data set from the fourth quarter of FY 2010 that included payments that were actually calculated under the RUG–III system. We found that the necessary recalibration using this much less precise methodology was remarkably similar to the recalibration results discussed in section III.B.2 of this final rule. In fact, these results were within 1.5 percent of the recalibration calculation performed using the FY 2011 data. It should be noted that by using different data sets for the comparisons, we could not control for acuity changes or any other factors, such as patient volume, but the difference in the final result was very minor. Therefore, we believe that any actual issues with the RUG–III crosswalk would have a negligible effect on the recalibration calculation. Moreover, because we cannot determine reliably whether the difference in observed versus historically predicted use of IVs during a patient's qualifying hospital stay reflects actual provider behavior and patient acuity changes, or merely a failure on the part of facilities to complete certain items on the MDS, we believe that an adjustment for any such potential factors would be inappropriate given its limited impact. We expect that facilities will report all necessary items on the MDS to capture accurately the patient's clinical and medical needs, rather than only coding those items relevant to the patient's payment level. Finally, we note that, as we discussed previously, we believe using FY 2011 data to determine the necessary recalibration factor controls for patient acuity, as the recalibration of the parity adjustment compares payments under the two case-mix systems using data from the same time period (FY 2011).

Comment: Many commenters questioned the appropriateness of the recalibration based on the potential impact of other proposed changes discussed in the proposed rule, such as the allocation of group therapy and other changes to the MDS 3.0. These commenters stated that reducing payments through a recalibration of the CMIs without accounting for the potential impact of other changes to the MDS will constitute a ''double hit'' on facilities. Some commenters requested that the recalibration be withdrawn until the impact of these other changes proposed for FY 2012 is better known.

Response: As illustrated by OACT baseline expenditure data from 2006 through 2011 (which can be ascertained by dividing the aggregate dollar impact of a rule for a given year by the aggregate percent impact listed in the impact table for the same rule), the SNF baseline has increased by over 40 percent between 2006 and 2011. Additionally, for 3 of the past 6 years, specifically in FY 2006, FY 2010, and FY 2011, we have attempted to restore budget neutrality in the transition to a

new case-mix classification system by applying a parity adjustment. In both case-mix transitions (from RUG–44 to RUG–53 and from RUG–53 to RUG–IV), we found that, rather than achieving budget neutrality, application of the parity adjustment to the new case-mix system resulted in excess payments to providers, because actual utilization patterns under the new case-mix system were different than we originally projected, thus necessitating a recalibration of the adjustment. After reviewing the effect of the FY 2011 RUG–IV policies, we have found that despite the adoption of clinical policies and coding changes, utilization patterns (as evidenced by the distribution of RUG groups) have not changed significantly in response to these policy revisions in ways that could be expected based on past operational and reporting practices. For example, while we anticipated certain changes in the case-mix distribution in response to the implementation of RUG–IV and the allocation of concurrent therapy along with several other policy and reporting changes, the percentage of residents classified into a rehab category between FY 2010 and FY 2011 remained stable at approximately 92 percent; moreover, the percentage of patients classified into the highest paying rehabilitation RUG category, Ultra High Rehabilitation, actually increased from 43 percent to 45 percent over the same period.

This analysis revealed that it can be difficult to predict provider behavior in response to any given policy changes. As a result, given the ability of facilities and stakeholders to adapt quickly to the changes in the SNF system in ways that maintain payments and consistent utilization patterns, from a practical and policy perspective, we do not believe it would be appropriate to attempt to consider the potential impact of other policy changes for FY 2012 as part of the FY 2011 recalibration calculation. Accordingly, given that it is unclear whether the FY 2012 changes to the MDS will have an effect on utilization patterns and the extent of any such effect, we do not agree that recalibrating the CMIs without accounting for such changes would necessarily result in a ''double hit.''

Further, consistent with past practice during a major case-mix system transition (that is, the transition from RUG–44 to RUG–53 in FY 2006 and the transition from RUG–53 to RUG–IV in FY 2011), aggregate payments under the new system have been adjusted to ensure parity with payments under the previous system. In the case of the transition from RUG–44 to RUG–53, the data used to recalibrate the parity adjustment were based on data from CY 2006 (the year the transition was first implemented), even though the recalibration was not made until FY 2010. As such, major changes in the SNF PPS case-mix classification system have been historically accompanied by a parity adjustment recalibration which uses data from the year in which the transition took place. In this case, consistent with past practice, the most appropriate data for recalibrating the FY 2011 parity adjustment are data from FY 2011, the year in which RUG–IV was implemented. If we were to use data from other years (including projected data for a future year such as FY 2012), this could skew the results due to changes in patient acuity, volume, or provider behavior, or other changes in SNF PPS policy.

Accordingly, because the policy refinements contained in this final rule (such as those related to the MDS 3.0) would apply starting in FY 2012, we believe that these changes should not be factored into the FY 2011 recalibration. As discussed above, we believe that it would be inappropriate to try to manipulate the FY 2011 recalibration to account for potential and unpredictable changes in payments resulting from policies to be implemented in FY 2012. As in prior years, policy refinements that do not constitute changes to the case-mix classification system as a whole are not necessarily made in a budget-neutral manner. Consistent with our past practice when implementing new policies, we will monitor utilization patterns and provider behaviors in response to the changes discussed in this final rule.

Comment: Several commenters suggested that CMS consider the possibility of phasing-in a recalibration over the course of several years. A few commenters further suggested that such a phase-in should also take into account the effects of any finalized FY 2012 policies.

Response: As discussed in section XII.A.5 of the proposed rule, we considered how the recalibration might be implemented so as to mitigate the economic impact of the recalibration on facilities. Specifically, we considered mitigating the impact of the recalibration by phasing in the negative adjustments prospectively over multiple years until parity was achieved. However, as noted in the proposed rule (76 FR 26404), phasing-in the recalibration would continue to reimburse facilities at levels that significantly exceed intended SNF payments. Further, as discussed in response to a preceding comment and elsewhere in this preamble, MedPAC found in 2009 that the aggregate Medicare margin for freestanding SNFs, which represent more than 90 percent of all SNF facilities, was 18.1 percent, up from 16.6 percent in 2008. Given these high Medicare margins, we do not believe that a phase-in approach is justified. It is also important to note that this recalibration would serve to remove an unintended spike in payments rather than decreasing an otherwise appropriate payment amount. Thus, we do not believe that the recalibration should negatively affect facilities, beneficiaries, or quality of care, or create an undue hardship on providers. In fact, notwithstanding the recalibration, the FY 2012 payment rates will actually be higher than the rates established for FY 2010, the period immediately preceding the unintended spike in payment levels. We continue to believe that in implementing RUG–IV, it is essential that we stabilize the baseline as quickly as possible without creating a significant adverse effect on the industry or to beneficiaries.

Furthermore, in response to the comment suggesting that a phase-in should take into account the effects of other policies finalized in FY 2012, as discussed in response to the previous comment, we do not believe it would be appropriate to take into account in the recalibration calculation, potential and unpredictable changes in payments resulting from policies to be implemented in FY 2012.

Comment: Several commenters stated that a shift in patients from Inpatient Rehabilitation Facilities (IRFs) to SNFs results in savings to the Medicare Trust Fund and that the current SNF spending levels are needed to treat higher-acuity patients that are now being treated in SNFs rather than in IRFs. Also, several commenters claimed that that providing increased levels of therapy has led to shorter lengths of stay for SNF residents, decreased the rate of hospital readmissions and increased discharges to the community, thereby creating significant savings for the Medicare program.

Response: We note that, in the absence of supporting evidence, and given the significant excess payments identified in FY 2011 and the Medicare profit margins for facilities identified by various sources, such as MedPAC, it is difficult to see how evolving utilization patterns have created savings for the Medicare program. In fact, MedPAC's analysis of recent quality measure data related to rehospitalizations, for example, which appears in their March 2011 Report to Congress (available at *http://www.medpac.gov/documents/Mar11_EntireReport.pdf*), suggests that

quality of care within SNFs has not been improving. On the topic of rehospitalizations, in its March 2011 report, MedPAC states:

''The quality of care furnished to patients during a Medicare-covered SNF stay continued to show mixed results. * * * Since 2000, one outcome measure * * * (the risk-adjusted rate of rehospitalization for any of five care-sensitive conditions) exhibited almost no change.''

Moreover, a basic principle of the SNF PPS is to pay appropriately for the services provided. CMS data are consistent with the commenters' statements that some patients formerly treated within IRFs are now being treated in SNFs. In fact, our data show that a portion of patients needing rehabilitation have always been treated at SNFs and other non-IRF post-acute care settings. The FY 2011 utilization data used to recalibrate the case-mix adjustments reflect an increase in rehabilitation patients, and likely includes patients who alternatively might have been admitted to IRFs prior to CMS enforcement of the IRF coverage criteria and more intensive medical review of IRF claims. However, we do not agree with the commenters' statement that these patients represent a higher level of acuity than the type of patients historically treated in SNFs. For some time, utilization data have demonstrated that nearly 90 percent of all SNF payment days are for rehabilitation services, with over 40 percent of those days falling into the Ultra High Rehabilitation category. For the former IRF patients who are appropriate for SNF care, we must pay the appropriate rate for the SNF services provided and cannot use a reduction in IRF payments as a reason to increase payments to SNFs arbitrarily. It is important to note that, as discussed above, recalibrating the case-mix system does not change the basic SNF PPS structure which provides higher payments for patients using more staff resources and services.

Finally, as one commenter highlighted, shifting IRF patients toward SNF care does not necessarily improve the quality of care provided to the beneficiaries. A March 2005 report in the Archives of Physical Medicine and Rehabilitation (available at *http://www.archives-pmr.org/article/PIIS0003999304012493/abstract*) found that 81.1 percent of IRF patients were discharged to home, compared to 45.5 percent of SNF residents. Additionally, IRF patients appeared to have shorter lengths of stay, averaging approximately a 13-day stay, compared to the average 36-day stay for a SNF resident. Finally, when patients discharged from each setting were reviewed 24 weeks after discharge, IRF patients had consistently better outcomes and displayed a faster rate of recovery. Given these findings, we do not agree with those commenters who would assume that shifting patients from the IRF setting to a SNF setting is necessarily more beneficial to the patient or the Medicare Trust Fund. We do, however, intend to conduct additional research to update these findings with more recent data. Any changes in utilization patterns, length of stay, and/or care outcomes will be addressed during future rule-making.

Comment: We received a number of comments related to our decision to apply the parity adjustment to only the nursing CMIs for therapy RUG–IV groups. Some commenters focused on reasons the parity adjustment should be applied to both the nursing and therapy indexes, while other suggested that the adjustment should be applied to the nursing CMIs for all RUG groups, as it has been applied in the past.

Response: We considered a variety of alternative applications of the parity adjustment, such as applying the adjustment to both the nursing and therapy CMIs, to all the nursing CMIs, or to the therapy CMIs only. However, we still believe it is most appropriate to apply the adjustment to the nursing CMIs within the therapy groups only. Even for RUG–IV therapy groups, the nursing component is a much larger portion of the associated per diem payment. When we tested adjusting only the therapy CMIs, we found that the reduction necessary to achieve parity was so significant as to reduce some of the recalibrated therapy CMIs to nearly a zero index, while reducing the relative differences between therapy groups significantly. To maintain the appropriate relative difference between each therapy group CMI, we found it best to apply the adjustment to the nursing CMIs for those therapy groups. Additionally, as the original parity adjustment discussed in the FY 2011 notice with comment period (75 FR 42886) was applied to the nursing CMIs, we considered it most appropriate to apply a recalibration of that adjustment to the nursing CMIs, albeit of select RUG–IV groups, rather than to apply the recalibration to the therapy CMIs or some combination of the nursing and therapy CMIs.

As discussed in the FY 2012 proposed rule (76 FR 26371), given that the most notable differences between expected and actual utilization patterns occurred within the therapy RUG categories, we believe it most appropriate to recalibrate the parity adjustment only as it applied to the RUG–IV therapy groups. As discussed in the proposed rule (76 FR 26372), we did evaluate the impact of applying a recalibration to all of the nursing CMIs, but found that rates for the complex medical groups were disproportionately affected negatively, in comparison to the therapy groups that represent 90 percent of SNF payment days. Since the vast majority of SNF residents are classified into a RUG–IV therapy group, and because the greatest differences between expected and actual utilization patterns could be found among the RUG–IV therapy groups, we believe that the most appropriate method for applying the recalibration is to apply it only to the RUG–IV therapy groups.

Comment: A few commenters discussed alternative parity adjustment methodologies, and recommended that instead of applying a fixed percentage increase to the nursing CMI (as is done in the case of the parity adjustment discussed in this final rule), we should apply a fixed percentage increase, or decrease presumably, to the final payment rates for each RUG group under the new classification system. CMS would then recalculate the appropriate nursing CMI necessary to reach the new total RUG payment. According to these commenters, this methodology would ensure that the relative difference in payments for each RUG group would remain the same.

Response: We agree that such a methodology would maintain the relative difference in the payments for each RUG category. However, the basic principle of the SNF PPS is to pay accurately for services based on the relative differences in resource and staff costs. The data underlying the RUG–IV CMIs, primarily the STRIVE study, are used to determine the relative difference between RUG groups with regard to their resource use. By applying the parity adjustment to the nursing CMIs, we are able to maintain the relative difference in resource use among the RUG–IV groups, rather than focusing on differences in payment. Ultimately, the prospective nature of the program demands that we focus more on predicting costs through relative utilization of resources, which are represented in the CMIs, rather than focusing solely on maintaining relative differences in the total payments for each RUG group.

Comment: A few commenters recommended that in lieu of or in addition to pursuing a recalibration, CMS should consider greater fraud and abuse monitoring, with one commenter suggesting that CMS consider medical review and audits of FY 2011 claims

and MDS data. One commenter pointed to the lack of program monitoring activities as an indication that there are no problems with the current parity adjustment.

Response: We appreciate these commenters' suggestions regarding the need for greater fraud and abuse monitoring and the need for audits of SNF records. We have increased our fraud and abuse monitoring efforts for SNFs and for the Medicare program in general. In fact, the Office of the Inspector General (OIG) has started a review of the increased frequency with which patients are assigned to the highest therapy groups. As discussed previously, OIG's initial research results also corroborate changes in SNF patterns of care that may have resulted in an inappropriate number of beneficiaries being classified into the highest-paying therapy groups. We will continue to work with OIG and with CMS contractors to provide greater monitoring of SNF utilization and reporting trends. (This research is available at *http://oig.hhs.gov/oei/reports/oei-02-09-00204.asp*.) Nevertheless, while we believe this monitoring activity is necessary, we also believe that it is necessary to implement the recalibration of the parity adjustment in FY 2012 to prevent continued reimbursement in amounts that significantly exceed our intended policy.

Accordingly, for the reasons specified in the FY 2012 proposed rule (76 FR 26370 through 26377) and the reasons discussed in this final rule, we are implementing the option discussed in the proposed rule to recalibrate the parity adjustment to the RUG–IV case-mix indexes to restore the intended parity in overall payments between the RUG–53 model and the RUG–IV model, using the methodology discussed in the proposed rule. As discussed previously, the parity adjustment finalized in this final rule is based on 8 months of FY 2011 claims and MDS 3.0 data. Thus, for FY 2012, the aggregate impact of this recalibration would be the difference between payments calculated using the original FY 2011 total nursing CMI increase for all RUG–IV groups of 61 percent, and payments calculated using the recalibrated total nursing CMI increase for all therapy RUG–IV groups of 19.84 percent, while maintaining the original 61 percent total nursing CMI increase for all non-therapy RUG–IV groups. The total difference is a decrease in payments of $4.47 billion (on an incurred basis) for FY 2012. We also note that the $4.47 billion reduction would be partly offset by the FY 2012 MFP-adjusted market basket update of 1.7 percent, or $600 million, with a net result of a 11.1 percent reduction, or $3.87 billion, in overall payments for FY 2012. As discussed previously, we are implementing the recalibration on a prospective basis beginning October 1, 2011, to restore payments to their intended levels and to end the current outflow of excess dollars. While the original FY 2011 system calibration had to be based on estimated data, this recalibration uses actual FY 2011 RUG–IV claims data, which we believe provide the best picture of the actual resources used under RUG–IV and result in more accurate payment. Consistent with past policy, we will continue to monitor utilization for the rest of FY 2011, but we do not anticipate that the remaining four months of FY 2011 will present a significantly different picture of SNF utilization patterns than using the first 8 months of data.

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

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TABLE 4: RUG-IV Case-Mix Adjusted Federal Rates and Associated Indexes--URBAN

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-Case Mix Therapy Component	Non-case Mix Component	Total Rate
RUX	2.67	1.87	$428.86	$226.25		$81.97	$737.08
RUL	2.57	1.87	$412.79	$226.25		$81.97	$721.01
RVX	2.61	1.28	$419.22	$154.87		$81.97	$656.06
RVL	2.19	1.28	$351.76	$154.87		$81.97	$588.60
RHX	2.55	0.85	$409.58	$102.84		$81.97	$594.39
RHL	2.15	0.85	$345.33	$102.84		$81.97	$530.14
RMX	2.47	0.55	$396.73	$66.54		$81.97	$545.24
RML	2.19	0.55	$351.76	$66.54		$81.97	$500.27
RLX	2.26	0.28	$363.00	$33.88		$81.97	$478.85
RUC	1.56	1.87	$250.57	$226.25		$81.97	$558.79
RUB	1.56	1.87	$250.57	$226.25		$81.97	$558.79
RUA	0.99	1.87	$159.01	$226.25		$81.97	$467.23
RVC	1.51	1.28	$242.54	$154.87		$81.97	$479.38
RVB	1.11	1.28	$178.29	$154.87		$81.97	$415.13
RVA	1.10	1.28	$176.68	$154.87		$81.97	$413.52
RHC	1.45	0.85	$232.90	$102.84		$81.97	$417.71
RHB	1.19	0.85	$191.14	$102.84		$81.97	$375.95
RHA	0.91	0.85	$146.16	$102.84		$81.97	$330.97
RMC	1.36	0.55	$218.44	$66.54		$81.97	$366.95
RMB	1.22	0.55	$195.96	$66.54		$81.97	$344.47
RMA	0.84	0.55	$134.92	$66.54		$81.97	$283.43
RLB	1.50	0.28	$240.93	$33.88		$81.97	$356.78
RLA	0.71	0.28	$114.04	$33.88		$81.97	$229.89
ES3	3.58		$575.02		$15.94	$81.97	$672.93
ES2	2.67		$428.86		$15.94	$81.97	$526.77
ES1	2.32		$372.64		$15.94	$81.97	$470.55
HE2	2.22		$356.58		$15.94	$81.97	$454.49
HE1	1.74		$279.48		$15.94	$81.97	$377.39
HD2	2.04		$327.66		$15.94	$81.97	$425.57
HD1	1.60		$256.99		$15.94	$81.97	$354.90
HC2	1.89		$303.57		$15.94	$81.97	$401.48
HC1	1.48		$237.72		$15.94	$81.97	$335.63
HB2	1.86		$298.75		$15.94	$81.97	$396.66
HB1	1.46		$234.51		$15.94	$81.97	$332.42
LE2	1.96		$314.82		$15.94	$81.97	$412.73
LE1	1.54		$247.35		$15.94	$81.97	$345.26
LD2	1.86		$298.75		$15.94	$81.97	$396.66
LD1	1.46		$234.51		$15.94	$81.97	$332.42
LC2	1.56		$250.57		$15.94	$81.97	$348.48
LC1	1.22		$195.96		$15.94	$81.97	$293.87
LB2	1.45		$232.90		$15.94	$81.97	$330.81
LB1	1.14		$183.11		$15.94	$81.97	$281.02
CE2	1.68		$269.84		$15.94	$81.97	$367.75
CE1	1.50		$240.93		$15.94	$81.97	$338.84
CD2	1.56		$250.57		$15.94	$81.97	$348.48
CD1	1.38		$221.66		$15.94	$81.97	$319.57
CC2	1.29		$207.20		$15.94	$81.97	$305.11
CC1	1.15		$184.71		$15.94	$81.97	$282.62
CB2	1.15		$184.71		$15.94	$81.97	$282.62
CB1	1.02		$163.83		$15.94	$81.97	$261.74
CA2	0.88		$141.35		$15.94	$81.97	$239.26
CA1	0.78		$125.28		$15.94	$81.97	$223.19
BB2	0.97		$155.80		$15.94	$81.97	$253.71
BB1	0.90		$144.56		$15.94	$81.97	$242.47
BA2	0.70		$112.43		$15.94	$81.97	$210.34
BA1	0.64		$102.80		$15.94	$81.97	$200.71
PE2	1.50		$240.93		$15.94	$81.97	$338.84
PE1	1.40		$224.87		$15.94	$81.97	$322.78
PD2	1.38		$221.66		$15.94	$81.97	$319.57
PD1	1.28		$205.59		$15.94	$81.97	$303.50
PC2	1.10		$176.68		$15.94	$81.97	$274.59
PC1	1.02		$163.83		$15.94	$81.97	$261.74
PB2	0.84		$134.92		$15.94	$81.97	$232.83
PB1	0.78		$125.28		$15.94	$81.97	$223.19
PA2	0.59		$94.77		$15.94	$81.97	$192.68
PA1	0.54		$86.73		$15.94	$81.97	$184.64

TABLE 5: RUG-IV Case-Mix Adjusted Federal Rates and Associated Indexes--RURAL

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-Case Mix Therapy Component	Non-case Mix Component	Total Rate
RUX	2.67	1.87	$409.74	$260.88		$83.49	$754.11
RUL	2.57	1.87	$394.39	$260.88		$83.49	$738.76
RVX	2.61	1.28	$400.53	$178.57		$83.49	$662.59
RVL	2.19	1.28	$336.08	$178.57		$83.49	$598.14
RHX	2.55	0.85	$391.32	$118.58		$83.49	$593.39
RHL	2.15	0.85	$329.94	$118.58		$83.49	$532.01
RMX	2.47	0.55	$379.05	$76.73		$83.49	$539.27
RML	2.19	0.55	$336.08	$76.73		$83.49	$496.30

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-Case Mix Therapy Component	Non-case Mix Component	Total Rate
RLX	2.26	0.28	$346.82	$39.06		$83.49	$469.37
RUC	1.56	1.87	$239.40	$260.88		$83.49	$583.77
RUB	1.56	1.87	$239.40	$260.88		$83.49	$583.77
RUA	0.99	1.87	$151.93	$260.88		$83.49	$496.30
RVC	1.51	1.28	$231.72	$178.57		$83.49	$493.78
RVB	1.11	1.28	$170.34	$178.57		$83.49	$432.40
RVA	1.10	1.28	$168.81	$178.57		$83.49	$430.87
RHC	1.45	0.85	$222.52	$118.58		$83.49	$424.59
RHB	1.19	0.85	$182.62	$118.58		$83.49	$384.69
RHA	0.91	0.85	$139.65	$118.58		$83.49	$341.72
RMC	1.36	0.55	$208.71	$76.73		$83.49	$368.93
RMB	1.22	0.55	$187.22	$76.73		$83.49	$347.44
RMA	0.84	0.55	$128.91	$76.73		$83.49	$289.13
RLB	1.50	0.28	$230.19	$39.06		$83.49	$352.74
RLA	0.71	0.28	$108.96	$39.06		$83.49	$231.51
ES3	3.58		$549.39		$17.02	$83.49	$649.90
ES2	2.67		$409.74		$17.02	$83.49	$510.25
ES1	2.32		$356.03		$17.02	$83.49	$456.54
HE2	2.22		$340.68		$17.02	$83.49	$441.19
HE1	1.74		$267.02		$17.02	$83.49	$367.53
HD2	2.04		$313.06		$17.02	$83.49	$413.57
HD1	1.60		$245.54		$17.02	$83.49	$346.05
HC2	1.89		$290.04		$17.02	$83.49	$390.55
HC1	1.48		$227.12		$17.02	$83.49	$327.63
HB2	1.86		$285.44		$17.02	$83.49	$385.95
HB1	1.46		$224.05		$17.02	$83.49	$324.56
LE2	1.96		$300.78		$17.02	$83.49	$401.29
LE1	1.54		$236.33		$17.02	$83.49	$336.84
LD2	1.86		$285.44		$17.02	$83.49	$385.95
LD1	1.46		$224.05		$17.02	$83.49	$324.56
LC2	1.56		$239.40		$17.02	$83.49	$339.91
LC1	1.22		$187.22		$17.02	$83.49	$287.73
LB2	1.45		$222.52		$17.02	$83.49	$323.03
LB1	1.14		$174.94		$17.02	$83.49	$275.45
CE2	1.68		$257.81		$17.02	$83.49	$358.32
CE1	1.50		$230.19		$17.02	$83.49	$330.70
CD2	1.56		$239.40		$17.02	$83.49	$339.91
CD1	1.38		$211.77		$17.02	$83.49	$312.28
CC2	1.29		$197.96		$17.02	$83.49	$298.47
CC1	1.15		$176.48		$17.02	$83.49	$276.99
CB2	1.15		$176.48		$17.02	$83.49	$276.99
CB1	1.02		$156.53		$17.02	$83.49	$257.04
CA2	0.88		$135.04		$17.02	$83.49	$235.55
CA1	0.78		$119.70		$17.02	$83.49	$220.21

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-Case Mix Therapy Component	Non-case Mix Component	Total Rate
BB2	0.97		$148.86		$17.02	$83.49	$249.37
BB1	0.90		$138.11		$17.02	$83.49	$238.62
BA2	0.70		$107.42		$17.02	$83.49	$207.93
BA1	0.64		$98.21		$17.02	$83.49	$198.72
PE2	1.50		$230.19		$17.02	$83.49	$330.70
PE1	1.40		$214.84		$17.02	$83.49	$315.35
PD2	1.38		$211.77		$17.02	$83.49	$312.28
PD1	1.28		$196.43		$17.02	$83.49	$296.94
PC2	1.10		$168.81		$17.02	$83.49	$269.32
PC1	1.02		$156.53		$17.02	$83.49	$257.04
PB2	0.84		$128.91		$17.02	$83.49	$229.42
PB1	0.78		$119.70		$17.02	$83.49	$220.21
PA2	0.59		$90.54		$17.02	$83.49	$191.05
PA1	0.54		$82.87		$17.02	$83.49	$183.38

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3. Wage Index Adjustment to Federal Rates

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

In the FY 2012 proposed rule, we proposed to continue that practice as we continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index is appropriate and reasonable for the SNF PPS. As explained in the 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.

In the FY 2012 proposed rule, we also proposed to continue using the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in which there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the FY 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 proposed to use the average wage index from all contiguous CBSAs as a reasonable proxy. This methodology was used to construct the wage index for rural Massachusetts for FY 2011. However, as indicated in the FY 2012 proposed rule (76 FR 26378), 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. Furthermore, we indicated that we would not apply this methodology to rural Puerto Rico due to the distinct economic circumstances that exist there, but instead would continue using the most recent wage index previously available for that area. For urban areas without specific hospital wage index data, we proposed to use the average wage indexes of all of the urban areas within the State to serve as a reasonable proxy for the wage index of that urban CBSA. At the time of the proposed rule, both CBSA 49700, Yuba City, CA, and CBSA 25980, Hinesville-Fort Stewart, GA, did not have wage index data. However, for this final rule, Yuba City, CA now has wage index data. Therefore, the only urban area without wage index data available is CBSA 25980, Hinesville-Fort Stewart, GA.

The comments that we received on the wage index adjustment to the Federal rates, and our responses to those comments, appear below.

Comment: A commenter recommended that CMS improve its area wage index methodology, and recommended that any design, development, or implementation of a revised hospital wage index must consider other post-acute care settings. The commenter noted research by the Medicare Payment Advisory Commission (MedPAC) and Acumen, LLC (Acumen) to support its concern regarding areas such as reclassification, SNF-specific wage index, the use of U.S. Bureau of Labor Statistics (BLS), and commuting patterns of health care workers employed by SNFs.

Response: As several commenters noted, we have research currently under way to examine alternatives to the wage index methodology, including the issues the commenters mentioned about ensuring that the wage index minimizes fluctuations, matches the costs of labor in the market, and provides for a single wage index policy. Section 3137 of the Affordable Care Act provides that the Secretary of Health and Human Services shall submit a report to Congress by December 31, 2011, that includes a plan to reform the hospital wage index system. Section 3137 of the Affordable Care Act further instructs the Secretary to take into account MedPAC's recommendations on the Medicare wage index classification system, and to include one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of the Act for purposes of the IPPS. The proposal(s) are to consider each of the following:

- The use of Bureau of Labor Statistics data or other data or methodologies to calculate relative wages for each geographic area.
- Minimizing variations in wage index adjustments between and within MSAs and statewide rural areas.
- Methods to minimize the volatility of wage index adjustments while maintaining the principle of budget neutrality.
- The effect that the implementation of the proposal would have on health care providers in each region of the country.
- Issues relating to occupational mix, such as staffing practices and any evidence on quality of care and patient safety, including any recommendations for alternative calculations to the occupational mix.
- Provide for a transition.

To assist us in meeting the requirements of section 106(b)(2) of the Tax Relief and Health Care Act of 2006 (Pub. L. 109–432, enacted on December 20, 2006) (TRHCA), in February 2008, we awarded a Task Order under our Expedited Research and Demonstration Contract to Acumen, LLC. Acumen, LLC conducted a study of both the current methodology used to construct the Medicare wage index and the recommendations reported to Congress by MedPAC. Parts 1 and 2 of Acumen's final report, which analyzes the strengths and weaknesses of the data sources used to construct the CMS and MedPAC indexes, is available online at *http://www.acumenllc.com/reports/cms.*

MedPAC's recommendations were presented in the FY 2009 IPPS final rule (available online at *http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf*). We plan to monitor these efforts closely, and to determine what impact or influence they may have on the SNF PPS wage index. At this time, we will continue to use the wage index policies and methodologies described in this final rule to adjust the SNF PPS Federal rates for differences in area wage levels. However, we will continue to monitor MedPAC and Acumen's progress on any revisions to the IPPS wage index to identify any policy changes that may be appropriate for SNFs and potential changes may be presented in a future proposed rule. We discuss the Federal rates by labor-related and non-labor related components for FY 2012 below.

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 68.693 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 9. 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 6 and 7 show the case-mix adjusted RUG–IV Federal rates by labor-related and non-labor-related components.

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TABLE 6: RUG-IV Case-Mix Adjusted Federal Rates for Urban SNFs by Labor and Non-Labor Component

RUG-IV Category	Total Rate	Labor Portion	Non-Labor Portion
RUX	737.08	$506.32	$230.76
RUL	721.01	$495.28	$225.73
RVX	656.06	$450.67	$205.39
RVL	588.60	$404.33	$184.27
RHX	594.39	$408.30	$186.09
RHL	530.14	$364.17	$165.97
RMX	545.24	$374.54	$170.70
RML	500.27	$343.65	$156.62
RLX	478.85	$328.94	$149.91
RUC	558.79	$383.85	$174.94
RUB	558.79	$383.85	$174.94
RUA	467.23	$320.95	$146.28
RVC	479.38	$329.30	$150.08
RVB	415.13	$285.17	$129.96
RVA	413.52	$284.06	$129.46
RHC	417.71	$286.94	$130.77
RHB	375.95	$258.25	$117.70
RHA	330.97	$227.35	$103.62
RMC	366.95	$252.07	$114.88
RMB	344.47	$236.63	$107.84
RMA	283.43	$194.70	$88.73
RLB	356.78	$245.08	$111.70
RLA	229.89	$157.92	$71.97
ES3	672.93	$462.26	$210.67
ES2	526.77	$361.85	$164.92
ES1	470.55	$323.23	$147.32
HE2	454.49	$312.20	$142.29
HE1	377.39	$259.24	$118.15
HD2	425.57	$292.34	$133.23
HD1	354.90	$243.79	$111.11
HC2	401.48	$275.79	$125.69
HC1	335.63	$230.55	$105.08
HB2	396.66	$272.48	$124.18
HB1	332.42	$228.35	$104.07
LE2	412.73	$283.52	$129.21
LE1	345.26	$237.17	$108.09
LD2	396.66	$272.48	$124.18
LD1	332.42	$228.35	$104.07
LC2	348.48	$239.38	$109.10
LC1	293.87	$201.87	$92.00
LB2	330.81	$227.24	$103.57
LB1	281.02	$193.04	$87.98
CE2	367.75	$252.62	$115.13
CE1	338.84	$232.76	$106.08
CD2	348.48	$239.38	$109.10
CD1	319.57	$219.52	$100.05
CC2	305.11	$209.59	$95.52
CC1	282.62	$194.14	$88.48
CB2	282.62	$194.14	$88.48
CB1	261.74	$179.80	$81.94
CA2	239.26	$164.35	$74.91
CA1	223.19	$153.32	$69.87
BB2	253.71	$174.28	$79.43
BB1	242.47	$166.56	$75.91
BA2	210.34	$144.49	$65.85
BA1	200.71	$137.87	$62.84
PE2	338.84	$232.76	$106.08
PE1	322.78	$221.73	$101.05
PD2	319.57	$219.52	$100.05
PD1	303.50	$208.48	$95.02
PC2	274.59	$188.62	$85.97
PC1	261.74	$179.80	$81.94
PB2	232.83	$159.94	$72.89
PB1	223.19	$153.32	$69.87
PA2	192.68	$132.36	$60.32

RUG-IV Category	Total Rate	Labor Portion	Non-Labor Portion
PA1	184.64	$126.83	$57.81

TABLE 7: RUG-IV Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component

RUG-IV Category	Total Rate	Labor Portion	Non-Labor Portion
RUX	754.11	$518.02	$236.09
RUL	738.76	$507.48	$231.28
RVX	662.59	$455.15	$207.44
RVL	598.14	$410.88	$187.26
RHX	593.39	$407.62	$185.77
RHL	532.01	$365.45	$166.56
RMX	539.27	$370.44	$168.83
RML	496.30	$340.92	$155.38
RLX	469.37	$322.42	$146.95
RUC	583.77	$401.01	$182.76
RUB	583.77	$401.01	$182.76
RUA	496.30	$340.92	$155.38
RVC	493.78	$339.19	$154.59
RVB	432.40	$297.03	$135.37
RVA	430.87	$295.98	$134.89
RHC	424.59	$291.66	$132.93
RHB	384.69	$264.26	$120.43
RHA	341.72	$234.74	$106.98
RMC	368.93	$253.43	$115.50
RMB	347.44	$238.67	$108.77
RMA	289.13	$198.61	$90.52
RLB	352.74	$242.31	$110.43
RLA	231.51	$159.03	$72.48
ES3	649.90	$446.44	$203.46
ES2	510.25	$350.51	$159.74
ES1	456.54	$313.61	$142.93
HE2	441.19	$303.07	$138.12
HE1	367.53	$252.47	$115.06
HD2	413.57	$284.09	$129.48
HD1	346.05	$237.71	$108.34
HC2	390.55	$268.28	$122.27
HC1	327.63	$225.06	$102.57
HB2	385.95	$265.12	$120.83
HB1	324.56	$222.95	$101.61
LE2	401.29	$275.66	$125.63
LE1	336.84	$231.39	$105.45
LD2	385.95	$265.12	$120.83
LD1	324.56	$222.95	$101.61
LC2	339.91	$233.49	$106.42
LC1	287.73	$197.65	$90.08
LB2	323.03	$221.90	$101.13
LB1	275.45	$189.21	$86.24
CE2	358.32	$246.14	$112.18
CE1	330.70	$227.17	$103.53
CD2	339.91	$233.49	$106.42
CD1	312.28	$214.51	$97.77
CC2	298.47	$205.03	$93.44
CC1	276.99	$190.27	$86.72
CB2	276.99	$190.27	$86.72
CB1	257.04	$176.57	$80.47
CA2	235.55	$161.81	$73.74
CA1	220.21	$151.27	$68.94
BB2	249.37	$171.30	$78.07
BB1	238.62	$163.92	$74.70
BA2	207.93	$142.83	$65.10
BA1	198.72	$136.51	$62.21
PE2	330.70	$227.17	$103.53
PE1	315.35	$216.62	$98.73
PD2	312.28	$214.51	$97.77
PD1	296.94	$203.98	$92.96
PC2	269.32	$185.00	$84.32
PC1	257.04	$176.57	$80.47
PB2	229.42	$157.60	$71.82
PB1	220.21	$151.27	$68.94
PA2	191.05	$131.24	$59.81
PA1	183.38	$125.97	$57.41

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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 1.0007. The wage index applicable to FY 2012 is set forth in Tables A and B, which appear in the Addendum of this final rule, and is also available on the CMS Web site at *http://www.cms.gov/SNFPPS/04_WageIndex.asp*.

Comment: One commenter estimated SNF reimbursements using both the FY 2012 SNF wage index in the proposed rule and in the absence of a wage index using simulation. The commenter found that SNF reimbursement was about $400 million lower with the wage index adjustment than without it. The commenter believes that CMS is incorrectly adjusting for the wage index and that payments during the 2002 to 2011 timeframe are nearly $3 billion too low.

Response: As previously stated in the final rule for FY 2010 (74 FR 40303), the intent of the wage index budget neutrality factor is to make sure that aggregate payments using the updated wage index are not greater or less than aggregate payments would be using the previous year's wage index. Because the wage index is based on the pre-floor, pre-reclassified, no occupational mix hospital wage index, the weighted average wage index would be equal to 1.0000 for hospitals. However, there are often multiple SNFs within a wage area with varying utilization levels. The weighted average wage index across all SNF providers may not be equal to 1.0000 for any given fiscal year, so payments could go up or down as a result of their application. Estimation of payments relies on the combination of the geographic wage index value for providers along with their distribution of service days. The change in the wage index values along with the utilization within each urban or rural area determines the change in aggregate payments related to the previous year, and therefore, the budget neutrality factor. The application of the budget neutrality factor ensures that aggregate payments will not increase or decrease due to the year-to-year change in the wage index. Therefore, we do not agree with the methodology used by the commenter, and believe that the 1.0007 budget neutrality factor will ensure equal payments after updating to the FY 2012 SNF PPS wage index, prior to any other policy changes.

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

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

4. Updates to 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 final rule reflect an update equal to the full market basket, estimated at 2.7 percentage points, reduced by the MFP adjustment. As discussed in sections I.G.2 and VI.C of the FY 2012 proposed rule (76 FR 26368 through 26369 and 26394 through 26396), the annual update includes a reduction to account for the MFP adjustment described in the latter section. As discussed in section III.F.3 of this final rule, the final MFP adjustment is 1.0 percent, for a net update of 1.7 percent for FY 2012.

5. Relationship of RUG–IV 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 notice with comment period (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 final rule, we are continuing the designation of 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, after which the administrative presumption no longer applies.

Comment: One commenter stated that certain instructions contained in version 3.0 of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (available online at *https://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp*) are inconsistent with the SNF level of care presumption. Specifically, the commenter cited instructions in Chapter 3 (''Overview to the Item-by-Item Guide to the MDS 3.0''), Section O (''Special Treatments, Procedures, and Programs (V1.05)''), which provide that tracheostomy care may be coded on the assessment when performed by residents themselves. Similarly, these instructions provide for coding oxygen therapy when a resident places or removes his or her own oxygen mask/cannula, as well as when a resident performs his or her own dialysis. The commenter stated that allowing these items to be coded under such circumstances compromises not only the definition of ''skilled services'' but the entire RUG–IV case-mix classification system.

Response: We believe that the commenter errs in assuming that all of the ''special procedures'' described in this section of the manual necessarily equate directly to skilled services. For example, even though dialysis is a critically important, life-sustaining procedure, its various component tasks simply do not generally require the involvement of *skilled* personnel—as evidenced by the many instances in which beneficiaries can be successfully trained to self-dialyze (or where a friend or family member with no prior caregiving experience or training can readily be taught to perform the dialysis for them). Moreover, while it is true that dialysis is one of the discrete indicators for assignment to a RUG within the Special Care Low category—a category to which the level of care presumption applies for a short period of time at the start of a SNF stay—it is the *totality* of items and services included within a given RUG, not any one specific coded service, that actually serves to justify the presumption. As explained in the FY 2000 SNF PPS final rule (64 FR 41667, July 30, 1999), it is this entire cluster of services, when combined with the ''tendency * * * for the initial portion of an SNF stay to be the most intensive and unstable'' that provides the basis for making the level of care presumption, as triggered by a resident's assignment to one of the designated upper RUGs on the initial 5-day, Medicare-required assessment.

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

Using the hypothetical SNF XYZ described in Table 8, the following shows the adjustments made to the Federal per diem rate to compute the provider's actual per diem PPS payment. SNF XYZ's 12-month cost reporting period begins October 1, 2011. As illustrated in Table 8, SNF XYZ's total PPS payment would equal $40,053.06. We derive the Labor and Non-labor columns from Table 6 of this final rule.

TABLE 8—RUG–IV SNF XYZ: LOCATED IN CEDAR RAPIDS, IA (URBAN CBSA 16300)

[Wage index: 0.8831]

RUG–IV group	Labor	Wage index	Adjusted labor	Non-labor	Adjusted rate	Percent adjustment	Medicare days	Payment
RVX	$450.67	$0.8831	$397.99	$205.39	$603.38	$603.38	14	$8,447.32
ES2	361.85	0.8831	319.55	164.92	484.47	484.47	30	14,534.10
RHA	227.35	0.8831	200.77	103.62	304.39	304.39	16	4,870.24
CC2*	209.59	0.8831	185.09	95.52	280.61	639.79	10	6,397.90
BA2	144.49	0.8831	127.60	65.85	193.45	193.45	30	5,803.50
							100	40,053.06

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

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

1. Prospective Payment for SNF Non-Therapy Ancillary Costs

The FY 2012 proposed rule discussed the issue of payment for NTA costs under the SNF PPS (76 FR 26381 through 26384). This discussion described the previous research that has been conducted in this area, as well as current policy and analysis. Specifically, this discussion referenced the ongoing development of a two-part NTA component payment, as well as the conceptual analysis for the types of conditions and MDS-driven variables which may be used to predict and pay for patient NTA costs accurately. Finally, this discussion included reference to the impact of an NTA component payment as it relates to the temporary AIDS add-on payment established by section 511 of the MMA (as discussed in section I.E of this final rule). The comments that we received on this topic both this year and in response to the FY 2011 notice with comment period, and our responses, appear below.

Comment: All of the comments we received in response to this discussion supported CMS's broad objective to develop a new method for paying for NTAs received in the SNF, as well as the basic structure described in the proposed rule for a potential NTA rate component. The commenters also expressed their interest in working with CMS to develop an appropriate NTA rate component that is properly tailored to capture facility NTA costs accurately. Similarly, in response to the FY 2011 notice with comment period, several commenters also expressed their

support for development of a separate NTA component in line with CMS's current research.

Response: We appreciate the broad support that we received for the objective and overall model for designing a separate NTA rate component. The comments we received provided a number of interesting and creative ideas which will be considered during the research and development process. We look forward to working with providers and stakeholders in the future as we continue to develop this refinement to the SNF PPS.

Comment: A few commenters stated that the NTA rate component research should be updated to reflect data gathered on the MDS 3.0. One commenter asked that CMS consider the potential interplay between an NTA component and those drugs and services which may be subject to, or excluded from, consolidated billing. Several commenters also said that, given CMS's discussion related to reallocating some portion of the nursing component to fund the NTA component, CMS should ensure that the nursing component still reflects resource cost and utilization after the carve-out is done. Finally, one commenter, in response to the FY 2011 notice with comment period, requested that CMS pay special attention to NTA costs associated with providing ventilator services within the SNF.

Response: We agree with the commenters that our research must be aligned with continuous improvements made to the SNF PPS, particularly the MDS 3.0. We expect that, as more MDS 3.0 data become available, our NTA researchers will be able to incorporate these data into our analysis. Similarly, we are cognizant of the potential relationship between the NTA research and services and drugs which fall under consolidated billing. As we continue our analysis, we expect that such relationships will be considered in determining the appropriateness of the NTA component.

With regard to ensuring the adequacy of the nursing component after carving out a separate NTA component, we intend to ensure that the introduction of a new rate component for NTAs does not undermine the adequacy of payments for nursing services, and we will continue to monitor the adequacy of payments after any new rate component is implemented. It should be noted that any new carved-out NTA component would, in effect, remove from the nursing component only the costs of the NTA services themselves, which we would then adjust separately from nursing costs based on information that may better predict NTA costs.

Finally, as discussed in the FY 2010 final rule (74 FR 40341), ventilator patients are addressed to some extent within the RUG–IV system (through payments under the Extensive Services group), and we are continuing to monitor the adequacy of payments for this subset of SNF residents. Currently, payments for these services are still integrated into the nursing costs paid for the relevant case-mix group, but in our NTA research, we are considering a variety of special NTA subsets, including ventilator use, which might deserve special attention as part of the highest-tiered payment within the non-routine NTA tier system.

Comment: One commenter believed that the Post Acute Care Payment Reform Demonstration (PAC–PRD) and data collected as part of the research on the CARE tool would not serve as an appropriate source of data for the NTA research we are conducting. This commenter stated that it would be premature for CMS to make use of such data before it has been subject to both agency and Congressional review.

Response: We appreciate the commenter's concern regarding the use of these data and will certainly consider it as the research moves forward. We would note that data sources, such as the PAC–PRD, are being considered for their potential utility as part of developing an NTA component which would more accurately reimburse facilities for incurred NTA costs, though no final decision has been made as to what are the most appropriate sources. In the end, we will ensure that all data sources have been thoroughly reviewed for their accuracy and applicability within the SNF setting.

Comment: Several commenters discussed the possibility of including a cost pass-through for high-cost drugs and services as part of the outlier development.

Response: While we appreciate comments on the development of an SNF outlier policy, we would note that we do not have statutory authority to implement an outlier payment for certain NTA services.

D. Ongoing Initiatives Under the Affordable Care Act

1. Value-Based Purchasing (Section 3006)

In the FY 2012 proposed rule (76 FR 26384), we noted that section 3006(a) of the Affordable Care Act directs the Secretary to develop a plan to implement a value-based purchasing (VBP) program for SNFs, and submit a Report to Congress by October 1, 2011. As stated in the proposed rule, VBP is designed 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 also stated that, in accordance with section 3006(a) of the Affordable Care Act, we would consult with stakeholders in developing the implementation plan, and consider the outcomes of any recent demonstration projects related to VBP which we believe might be relevant to the SNF setting. The comments we received on this topic, along with our responses, appear below.

Comment: We received some comments in response to our description of the requirements of section 3006(a) of the Affordable Care Act to develop a plan to implement a VBP program for SNFs, and to submit to Congress a report by October 1, 2011. Commenters supported our efforts to consider a VBP program for SNFs, and made suggestions for the content and timing of the Report to Congress.

Response: Between December 2010 and January 2011, we held discussions with key stakeholders representing consumers, providers, and research organizations about the development of a plan to implement a VBP program for SNFs and the Report to Congress. We also held an Open Door Forum on March 10, 2011, in which more than 700 stakeholders participated in the call. A number of organizations submitted follow-up written comments, which we will share with the VBP project team.

We are in the process of developing the SNF VBP plan to address areas required by the statute. As required by the statute, in developing the plan, we will consider, among other things, measures of quality and efficiency in SNFs, reporting, collection, and validation of quality data, the structure of VBP adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for bonus payments. We plan to submit the Report to Congress by the statutory deadline of October 1, 2011.

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

One of the ongoing Affordable Care Act initiatives that we discussed in the FY 2012 SNF PPS proposed rule (76 FR 26384) is the payment adjustment added by section 3008(a) of the Affordable Care Act, which is intended to provide an incentive to reduce the occurrence of certain preventable hospital-acquired conditions. While this hospital provision is itself beyond the scope of the SNF PPS, in the proposed rule, we

additionally mentioned a study required under section 3008(b) of the Affordable Care Act, which directs the Secretary to evaluate possibly expanding the HAC policy from acute care hospitals to a variety of other settings, including SNFs, and to submit a report to Congress containing the results of the study by January 1, 2012.

Comment: We received a number of comments regarding the study referenced in the proposed rule that is required by section 3008(b) of the Affordable Care Act, which directs the Secretary to undertake a study and send a Report to Congress considering the feasibility of extending the Hospital Acquired Conditions-Present on Admission (HAC–POA) program to the other types of facilities. The commenters urged CMS to evaluate carefully the types of facility-acquired conditions that would be relevant to SNFs, and to avoid simply applying all of the hospital-acquired conditions to the postacute setting.

Response: We appreciate the comments we received on the issues that we should consider in the study and Report to Congress required by section 3008(b) of the Affordable Care Act. We are considering a broad range of issues related to extending the HAC–POA program to the other types of facilities specified in the Affordable Care Act. The required study and Report to Congress are currently in progress, and we intend to issue the report by the statutory deadline.

3. Nursing Home Transparency and Improvement (Section 6104)

In the FY 2011 proposed rule (76 FR 26385), we discussed section 6104 of the Affordable Care Act, which 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 enactment, and also requires the Secretary to perform certain related activities. We received no comments on this provision.

E. Other Issues

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

In the SNF PPS proposed rule for FY 2012 (76 FR 26364), we proposed 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 accordance with section 6101 of the Affordable Care Act.

In certain regulations that apply to Medicare SNFs and Medicaid nursing facilities, we proposed to add a definition for ''additional disclosable party'' and ''organizational structure'' and to revise the definition for ''managing employee.'' These proposed definitions were consistent with the requirements set forth in section 6101 of Affordable Care Act. Given the arguably broad nature of the term ''additional disclosable parties,'' we solicited comments on how best to narrow the scope of the definition for this term. We also proposed to revise § 424.516 to implement certain new disclosure requirements that pertain to Medicare SNFs and to amend § 455.104 to implement certain new disclosure requirements that pertain to Medicaid nursing facilities. Furthermore, we requested comments on a potential alternative approach in which we would collect certain information from Medicare SNFs 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. Section 424.515(d), however, provides for off-cycle revalidations. We received a number of comments on this potential alternative approach.

To respond properly to all of the comments received related to the disclosure of information requirements, we will publish a separate final rule specifically addressing these provisions at a later date. In accordance with the statutory requirements of section 6101 of the Affordable Care Act, we intend to publish that final rule early in CY 2012. Accordingly, we are not implementing these provisions in this SNF PPS final rule.

2. Therapy Student Supervision

In the FY 2012 proposed rule (76 FR 26385 through 26386), we proposed to revise a policy that had appeared previously in the preamble to the FY 2000 final rule, which had specified that a therapy student in the SNF setting must ''* * * be under the 'line-of-sight' level of supervision of the professional therapist'' (64 FR 41661, July 30, 1999). We proposed that line-of-sight supervision should no longer be required in the SNF setting. We proposed that, instead, each SNF would determine for itself the appropriate manner of supervision of therapy students consistent with applicable State and local laws and practice standards. We advanced this proposal in the interest of promoting greater conformity with the other inpatient settings under Part A (for example, acute care hospitals and IRFs), which already permit each provider to determine for itself the most appropriate manner of supervision in this context, consistent with applicable State and local laws and practice standards. The comments we received on this topic, along with our responses, may be found below.

Comment: The great majority of commenters were supportive of this revision, with some criticizing the existing policy as creating difficulty in securing therapy students in the SNF setting. One commenter expressed the belief that supervising therapists will now be able to offer an increased quality of care in the SNF setting, and that students will experience an elevated quality of learning that will prepare future clinicians to work in the SNF setting. Many commenters were concerned with how the time spent by therapy students with SNF patients could be billed, if at all. Several of the therapy trade associations offered detailed guidelines on therapy student supervision, with some of those also indicating that once a supervising therapist deems the student capable of treating a patient without line-of-sight supervision, the student's time should then be separately counted as skilled therapy minutes, over and above the therapist's own time. By contrast, another commenter stressed the importance of making clear that only the line-of-sight supervision requirement itself is being changed, to avoid triggering an inordinate increase in therapy student minutes that would create another distortion in the payment system. Several commenters suggested that CMS publish specific criteria that facilities should use to determine whether a student is capable to treat patients without line-of-sight supervision. Others suggested that beyond the specific criteria, CMS should specifically state that the supervising therapist, rather than the facility, should be the only entity to determine whether a student is capable of treating patients without line-of-sight supervision. However, two commenters were completely opposed to rescinding the line-of-sight requirement: One stated that eliminating this requirement would be inconsistent with existing Part B therapy instructions appearing in § 230 of the Medicare Benefit Policy Manual (MBPM), Chapter 15, while the other expressed concern that it could result in SNFs inappropriately misclassifying therapy time to increase reimbursement.

Response: Regarding the Part B instructions that one of the commenters cited in the MBPM, we note that these particular instructions do not actually mandate line-of-sight supervision for therapy students, but merely specify

that the services ''* * * performed by a student are not reimbursed *even if* provided under 'line of sight' supervision of the therapist'' (emphasis added). Further, with regard to the concerns over potential distortions in reimbursement, we wish to clarify that the change we have proposed would solely address the *specific manner* of supervision for a therapy student in this setting, but would in no way alter that individual's basic status as a student operating under the therapist's supervision. Thus, this policy change would not change the manner in which therapy minutes currently are recorded on the MDS or cause the student's time to become separately reimbursable.

In response to those commenters concerned with how to bill therapy student time spent with SNF patients, consistent with our existing policy as set forth in the RAI Manual, Chapter 3, Section O (pages O–20 through O–22), as the therapy student is under the direction of the supervising therapist (even if no longer required to be under line-of-sight supervision), the time the student spends with a patient will continue to be billed as if it were the supervising therapist alone providing the therapy. In other words, the therapy student, for the purpose of billing, is treated as simply an extension of the supervising therapist rather than being counted as an additional practitioner. It should be noted that all policies and definitions related to the type of therapy provided (individual, concurrent, and group) apply to the supervising therapist and therapy student as set forth in the RAI manual, Chapter 3, Section O (pages O–20 through O–22) even if the student is no longer required to be under line-of-sight supervision.

Finally, we agree that students who treat SNF residents without line-of-sight supervision should be qualified based on specific guidelines. As we stated in the proposed rule, ''* * * each SNF would determine for itself the appropriate manner of supervision of therapy students, consistent with applicable State and local laws and practice standards'' (76 FR 26835). We expect that professional associations, State and local licensing boards, and facilities should have very specific guidelines related to student clinicians' level of education and experience. Additionally, we expect that every student clinician should meet these standards and guidelines and that once met, the supervising therapist should have ultimate authority to determine whether a student clinician is adequately prepared to treat patients without line-of-sight supervision. In this context, we appreciate the detailed supervision guidelines that several of the trade associations have developed, which we recognize as playing a significant role in helping to define the applicable standards of practice on which providers rely in this context. However, we believe that the question of counting the student's time is actually a separate issue apart from providing guidance on appropriate supervisory practices themselves. As noted previously, a therapy student's time was not separately reimbursable prior to the elimination of the requirement for line-of-sight supervision, nor does it become so now as a result of this change.

Therefore, for the reasons outlined in this final rule and in the FY 2012 proposed rule (76 FR 26385 through 26386), we are finalizing our proposed revision to the line-of-sight supervision requirements as they pertain to students in a SNF setting. Accordingly, in this final rule, we are hereby discontinuing the policy announced in the FY 2000 final rule's preamble requiring line-of-sight supervision of therapy students in SNFs, as set forth in the FY 2012 proposed rule. Instead, effective October 1, 2011, as with other inpatient settings, each SNF will determine for itself the appropriate manner of supervision of therapy students consistent with State and local laws and practice standards. We will be monitoring student participation in SNFs and expect that facilities will ensure that students, though no longer required to be under line-of-sight supervision, will still be properly supervised for both the student's and patient's benefit.

3. Group Therapy and Therapy Documentation

Under our current policy, group therapy is the practice of one professional therapist treating multiple patients (up to a maximum of four) at the same time while the patients are performing either the same or similar activities, consistent with the policies first set forth in the FY 2000 SNF PPS final rule (64 FR 41662). In the FY 2012 proposed rule (76 FR 26386 through 26388), we proposed to make certain changes relating to the definition of group therapy and payment of group therapy services.

We noted that, using our STRIVE data as a baseline, we identified two 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, the minutes for which are divided between the two concurrent therapy participants when determining the patient's appropriate RUG classification. At the same time, we found a significant increase in the amount of group therapy services, which are currently not subject to the allocation requirement. Given this increase in group therapy services, we expressed concern that the current method for reporting group therapy on the MDS creates an inappropriate payment incentive to perform the group therapy in place of individual therapy, because the current method of reporting group therapy time does not require allocation among patients, as noted by several commenters. 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 otherwise may have been appropriate. In the proposed rule, we proposed to change our policies relating to group therapy as further discussed below.

First, we proposed to establish a standard that defines group therapy as therapy provided simultaneously to four patients who are performing the same or similar therapy activities (76 FR 26386 through 26387). As we stated in the proposed rule (76 FR 26386), because in group therapy patients are performing similar activities, 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 individual 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 we stated in the FY 2012 proposed rule (76 FR 26386), 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 and in the FY 2012 proposed rule (76 FR 26386 through 26387), 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. Accordingly, we proposed to define group therapy as therapy provided simultaneously to four patients who are performing similar therapy activities (76 FR 26387).

In addition, we proposed to allocate group therapy among the four group therapy participants. As we stated in the FY 2012 proposed rule (76 FR 26387), 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 would best capture the resource utilization and cost. 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). As we stated in the FY 2012 proposed rule (76 FR 26387), as is currently the procedure, the SNF would report the total unallocated group therapy minutes on the MDS 3.0 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. We stated in the FY 2012 proposed rule that 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.

Additionally, we made a number of clarifications with regard to clinical documentation requirements related to a patient's plan of care (76 FR 26387 through 26388). In the proposed rule, we discussed these requirements and clarified a number of regulatory provisions related to documentation within the SNF setting (see 76 FR 26387 through 26388 for a full discussion). Specifically, we noted (76 FR 26387) that SNFs are currently required to follow a prescribed plan of care for the therapy provided to a SNF resident (§ 409.23) and that the plan must meet the requirements of the regulations in § 409.17(b) through (d). We further clarified that supporting medical record documentation is needed so that SNFs can verify that the plan of care is being followed, and can identify when significant changes in a patient's medical condition occur. In addition, we stated that such supporting medical record documentation has always been required so that contractors can verify medical necessity when they review SNF claims (76 FR 26387). One example of appropriate documentation would be to use time stamps to indicate the exact start and ending time of a therapy session. These time stamps could be tracked on a beneficiary's record to determine what discipline and mode of therapy they received. If necessary, these time stamps could be compared with a therapist's log in order to streamline the medical review process. We also clarified that providers should ensure that skilled therapy services are appropriate to the goals of a patient's individualized plan of care, and that 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 progress toward the prescribed goals (76 FR 26388). We discussed the relationship between this documentation and the use of group therapy, clarifying that group therapy is not appropriate for every patient or for all conditions. Accordingly, SNFs should include justification for using group therapy as part of the patient's plan of care, to permit verification of the medical necessity and the appropriateness of the prescribed therapy plan (76 FR 26388). Finally, we discussed the need to update the patient's plan of care when changes occur that would affect the prescribed therapy plan or patient's condition, and clarified that any such changes in the therapy plan must be justified by changes in the beneficiary's underlying health condition, and that the provider is expected to describe in the plan of care the reasons for deviating from the original plan (76 FR 26388). We received a number of comments on these proposals and clarifications which, along with our responses, appear below.

Comment: Several commenters expressed support for the proposed change to allocate the group therapy minutes. Many others had general concerns about the allocation of group therapy. One commenter believed that during a group therapy session, every patient benefits for the full time of the session, rather than only one quarter of the session as the allocation of group time would suggest. Additionally, several commenters have expressed that there are psychosocial and functional benefits of group therapy and are concerned that residents will be negatively affected by the allocation of group therapy. We have received multiple comments claiming that the allocation of group therapy minutes will disincentivize therapists from performing group therapy in cases where group therapy may be the preferred mode of treatment, since their payments will decrease if they continue to provide the same volume of group therapy. Several commenters stated that planning and implementing group therapy tasks is a very time-consuming and challenging process, and that to allocate the group therapy minutes would mean that payment would not accurately reflect the time spent preparing for these therapy sessions and the additional costs of providing group therapy. One commenter stated it is more expensive to provide group therapy than individual or concurrent therapy.

Response: As we noted in the proposed rule (76 FR 26387), the allocation of group therapy time is based on accurately paying for the therapist's time, not the resident's time. During a one-hour group therapy session with four patients, while all four patients may receive a full hour of benefit from the therapy session, this still only constitutes one hour of the therapist's time. Given that the SNF PPS is based on resource utilization and cost, the payment for these services should reflect the amount of the therapist's time that was utilized as part of the therapy session.

As stated in our proposal, we agree with the commenters that there are unique benefits to group therapy. We do not believe that the allocation of group therapy minutes should be considered a deterrent to having group therapy

sessions or should negatively affect beneficiaries. Instead, allocation of group therapy brings Medicare payments in line with resource utilization and cost for these services and is intended to ensure that the therapist's time is being appropriately counted and reimbursed. We would expect therapists to continue to provide the mode of therapy that is most clinically appropriate for each patient.

Regarding the statement that the preparation for group therapy is a high-cost, time-consuming, and challenging process requiring careful evaluation of each patient, we agree that special care should be taken to plan for the most appropriate group therapy program for the designated patients. However, we expect that therapists will utilize high-quality standards of practice that require careful planning and documentation for all modes of therapy.

Moreover, these costs were included in the establishment of the per diem base rate, and are already being reimbursed as part of the SNF PPS. Additionally, while some commenters did maintain that group therapy costs more to provide than individual or concurrent therapy, other commenters believed the opposite, with one commenter stating the following regarding the allocation policy, ''The policy would undercut efficiency, while pushing patients into higher cost modes of care.'' We note that in allocating group therapy minutes, we are not dictating the mode of therapy that a SNF should provide to its patients. Instead, as discussed above, this policy brings Medicare payments more in line with resource utilization and cost for these services. Determinations regarding the appropriate mode of therapy should be made by the therapist based on the clinical needs of each patient.

Comment: Several commenters raised concerns regarding the strict allocation of group therapy minutes by four. The most common question we received from commenters was for clarification of why four was chosen to be the divisor, regardless of the number of participants in the group. Some commenters stated that using a hard divisor of four for group therapy minutes, rather than proposing to have facilities report the number of participants in the group and divide accordingly, contradicts CMS's reasoning that the allocation of group therapy is based on resource cost and utilization. These commenters also inquired as to how the facility should report the therapy time if four residents were scheduled for a group therapy session and one of the participants fell ill and was unable to participate. Several commenters asserted that we created a financial incentive to provide group therapy when we allocated concurrent therapy and did not address group therapy.

One commenter stated that as a rural provider, it is very rare ever to have a 4-person group. Another commenter discussed the ability of therapists to transition patients from a concurrent therapy environment to a group environment, and indicated that dividing by four makes it more difficult for providers to transition patients properly between concurrent and group therapy. Several commenters encouraged CMS to consult with clinical experts and professional therapy associations to determine the most appropriate number of group therapy participants based on clinical standards.

Response: Contrary to commenters' assertions, we did not propose to divide group therapy minutes by four regardless of the number of participants in the group. We proposed to divide by four in allocating group therapy minutes because we had proposed a definition of group therapy which requires four participants. In the FY 2012 proposed rule, we proposed to define group therapy as therapy provided simultaneously to four patients who are performing the same or similar activities. (76 FR 26387) Thus, based on our proposed definition of group therapy (which we are finalizing in this rule), we expect group therapy to be a structured, planned program with four participants for whom group therapy has been determined appropriate. As we stated in the proposed rule, we proposed ''allocating group therapy minutes among the *four* group therapy participants'' (76 FR 26387, emphasis added). Thus, given this definition of group therapy, dividing group therapy minutes by four captures resource utilization and cost associated with providing this mode of therapy, as under our proposed policy, groups would be required to have four participants. We note that, in situations where the definition of group therapy is not met, those minutes may not be coded on the MDS as group therapy.

We recognize that in some situations, one or more of the scheduled group therapy participants may not be able to attend a group session due to illness or otherwise, or may be unable to finish participating in the entire group session. Based on our definition of group therapy as finalized in this rule, we expect group therapy to be a structured, planned program with four participants. However, if one or more of the four participants are unexpectedly absent from a session or cannot finish participating in the entire session, rather than discontinuing payment or requiring the session to be rescheduled, we will continue to deem the therapy session as meeting the definition of group therapy as long as the therapy program originally had been planned for four patients. In this situation, we will continue to assume that there are four patients and, therefore, will divide the therapy minutes by four in allocating group therapy minutes among the group therapy participants. As discussed above, we believe the most appropriate size for group therapy in a SNF setting is four participants and, thus, we believe dividing by four reflects the resource utilization and cost associated with group therapy as we have defined it in this rule and as we expect it to be structured based on this definition.

Commenters have suggested that we recognize an alternative to allocating group therapy by four and, instead, divide the therapy minutes by the number of patients in the group. However, one commenter stated, ''Such an approach does not recognize the additional burdens and costs associated with the provision of group services, however, nor the difficulty providers and therapists would have in tracking the number of people in a group at all times and accurately counting minutes when patients are dropping in and dropping out throughout the session.'' As we stated above and in the FY 2012 proposed rule (76 FR 26387), we believe that most appropriate group therapy size in a SNF setting is four participants and, thus, we have defined group therapy accordingly. Given this definition, we believe that it is appropriate to allocate group therapy minutes among the participants by dividing by four. We note that the apparent lack of structure and discontinuity of the group interventions, as noted by the commenter, suggests that facilities may need to reassess their methods of providing group therapy services. In addition, we agree with many commenters that the implementation of RUG–IV created a payment incentive to provide group therapy and that the increase in group therapy may have been due to payment rather than clinical considerations. We note that by allocating group therapy among the four group therapy participants, we are also equalizing the reimbursement incentive across the modes of therapy. We believe this will once again encourage clinicians to choose the mode of therapy based on clinical rather than financial reasons. Several commenters agreed with this concept and one stated that ''Payments for different modalities of

therapy (concurrent, group, and individual) should reflect the different costs to provide the services. Otherwise providers will have financial incentives to furnish one modality over another, regardless of whether the modality is the most clinically appropriate for the patient.'' It is also important to keep in mind that every payment system has multiple incentives, both positive and negative. The management in each facility is faced with making cost/benefit choices on an almost daily basis. However, these choices must keep patient needs at the forefront of the decision-making process, and the existence of a payment incentive does not in itself justify the provision of a lower or less appropriate level of care merely in order to reduce facility costs.

We continue to believe that the provision of group therapy should be initiated only after determining that group therapy services are appropriate for each patient who receives them and that the group therapy provided is appropriate to the individual plans of care. As we noted in the proposed rule (76 FR 26388),

> 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 * * * 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 the beneficiary, SNFs should include 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.

Therefore, we believe that to every extent possible, group therapy sessions should not fluctuate in size and membership. As we stated above, we believe the most appropriate group therapy size in a SNF setting is four participants, and thus we are defining group therapy accordingly. Thus, as we are defining group therapy as consisting of four participants, we believe that allocating the minutes among the four participants best captures resource utilization and cost.

As discussed above, one commenter discussed the ability of therapists to transition patients from a concurrent therapy environment to a group environment, and indicated that dividing by four makes it more difficult for providers to transition patients properly between concurrent and group therapy. Historically, prior to the implementation of the RUG–IV system, SNFs reported a low utilization of group therapy. The limited use of group therapy programs may well be related to the logistical difficulties mentioned by this commenter, such as transitioning the patients properly between concurrent and group therapy. However, we do not see how allocating group therapy minutes would make it more difficult to transition patients from one therapy mode to another, as such transitions should be based on clinical determinations. The purpose of our allocation policy is to provide payment that better reflects resource utilization and cost, and we do not believe this policy should affect clinical determinations regarding the appropriate mode of therapy provided to a patient. We recognize the unique challenges that rural facilities face, but as we discussed above and in the FY 2012 proposed rule, we believe that the most appropriate group therapy size for a SNF setting is four. We believe that group therapy should be used to supplement individual therapy when suitable. In facilities where fewer than four patients are consistently being treated with the same or similar therapeutic interventions, group therapy programs may not always be appropriate. We expect all facilities to make the best clinical decisions when providing group therapy.

For the reasons discussed above and in the FY 2012 proposed rule (76 FR 26386 through 26388), as proposed, effective October 1, 2011, group therapy will be defined as therapy provided simultaneously to four patients who are performing the same or similar activities, and group therapy time will be divided by four in determining the reimbursable therapy minutes for each group therapy participant and, therefore, the appropriate RUG–IV group.

As discussed above and in the FY 2012 proposed rule, we believe it is appropriate to define group therapy as consisting of four participants. However, we will continue to monitor group therapy utilization and will continue to consult with clinical experts, professional therapy associations, and other stakeholders on this issue.

Comment: Many commenters questioned our choice of four as the most appropriate number of participants in a therapy group. Several commenters disagreed that the optimal number for patients in a group is four and stated that there is no research data to support this notion. Additionally, commenters stated that there are many instances when 2 or 3-person groups are more effective than 4-person groups and that in some specific instances, a 4-person group might pose serious patient risks. Many commenters stated that the choice of four as the optimal number for group therapy undermines the clinical judgment of therapists, and that CMS does not have the authority to dictate the practice of therapy and, therefore, cannot instruct therapists to allocate group therapy.

Response: For the reasons discussed above and in the FY 2012 proposed rule (76 FR 26386 through 26387), we believe the most appropriate size for group therapy in a SNF setting is four participants, which we believe is the size that permits the therapy participants to derive the maximum benefit from the group therapy setting. Although we conducted a literature search and were unable to find research data to support any prescribed number of participants in a therapy group, for the reasons stated above and in the FY 2012 proposed rule, we continue to believe it is appropriate to establish a standard that defines group therapy as therapy provided simultaneously to four participants performing the same or similar therapy activities.

In defining group therapy as therapy provided to four patients simultaneously who are performing the same or similar activities, we are not attempting to dictate clinical practice. Each therapist should use his or her best clinical judgment in determining the mode and manner in which to provide therapy services to patients. We understand that at times the therapist may decide in his or her clinical judgment to treat 2 or 3 patients simultaneously, and we are not prohibiting therapists from making this clinical decision. However, for purposes of Medicare payment policy, for the reasons discussed above and in the FY 2012 proposed rule, we are defining group therapy as therapy provided simultaneously to four patients who are performing the same or similar therapy activities. Further, we are allocating group therapy minutes by dividing the total minutes by four, the number of participants in a group therapy session as defined above. Our goal in allocating group therapy is to pay appropriately based on resource utilization and cost, not to dictate the practice of therapy.

Regarding the concept that groups of 4 may pose serious patient risks, we conducted a literature review and did not find any evidence that a group of 4 would pose any more of a patient risk than treating any other specific number of patients at a time. As discussed above, we expect therapists to use their best clinical judgment when choosing

which mode of therapy to use. If they believe that a particular mode of therapy would pose an increased degree of risk to a patient, we would expect them not to use that mode of therapy.

Comment: Several commenters stated that with the implementation of RUG–IV and its related policies, such as the allocation of concurrent therapy, we created a financial incentive for facilities to shift patients receiving concurrent therapy into group therapy, as long as the patient's therapy needs were still being met. These commenters stated that CMS should have expected some shift in the modes of therapy services provided. Additionally, these commenters believed that the data we used were inconclusive, since no data were collected on the modality of therapy delivered under MDS 2.0 and RUG–III. Others have stated that CMS' decision to use data from the STRIVE study is unsound because the STRIVE study was flawed. One commenter suggested that CMS should not allocate group therapy minutes until we have a full year's worth of data under the RUG–IV and MDS 3.0 system.

Response: We agree that the decision to allocate concurrent therapy inadvertently created an inappropriate financial incentive for facilities to emphasize more group therapy and that these incentives have resulted in excess Medicare expenditures. Accordingly, to fulfill our responsibilities to ensure appropriate payment based on resource utilization and cost, we proposed the allocation of group therapy minutes, which equalizes the reimbursement incentives across modes of therapy.

The statement that no data were collected to address the modality of therapy delivered under MDS 2.0 and RUG–III is incorrect. STRIVE collected data from the MDS 2.0 and RUG–III to examine the different modes of therapy delivery. Regarding the statement that the STRIVE study was flawed, we addressed this general concern in the FY 2010 final rule (74 FR 40304).

One commenter suggested that we defer allocating group therapy minutes until we have received more data. However, we believe we do not need a full year's worth of data before making changes to allocate group therapy. Regardless of whether the initial trends for utilization of group therapy continue, we believe that the group therapy allocation policy finalized in this final rule will increase the accuracy of our payments by more closely basing payments on actual resource utilization and cost and, thus, we believe that it is appropriate to finalize our policy regarding allocation of group therapy minutes effective October 1, 2011, as proposed.

Comment: Many commenters recognized the need to make changes to group therapy but suggested alternatives to the allocation of group therapy. Several commenters recommended that to reduce the incentive to overutilize group therapy, we should examine the current 25 percent cap on group therapy and make the necessary adjustments. One commenter suggested that we limit patients to one group therapy session per week.

Response: We appreciate the suggested alternatives to our proposal. We should note that the 25 percent cap for group therapy was designed to ensure that group therapy is utilized as an adjunct to individual (and concurrent) therapy. Conversely, the allocation of therapy minutes will be used to pay accurately for the therapy provided in a group therapy session based on resource utilization and cost. We also appreciate the suggestion to limit patients to one group therapy session per week and may explore this alternative or similar alternatives in the future in assessing the amounts of group therapy that may be beneficial to SNF patients.

Comment: Several commenters stated that the allocation of group therapy will cause operational inefficiencies in SNFs and will cause SNFs to need to hire more therapists in a field that currently has a significant shortage of professionals.

Response: We do not believe that the allocation of group therapy would cause operational inefficiencies or cause SNFs to hire more therapists. We note that the personnel decisions of SNFs are essentially private business arrangements that are outside the scope of this rule. Moreover, the allocation of group therapy does not require a change in MDS reporting procedures. As we stated in the FY 2012 proposed rule (76 FR 26387), as is currently the procedure, the SNF would report the total unallocated group therapy minutes on the MDS 3.0 for each patient. Then this total time would be automatically divided among the four group therapy participants to determine the appropriate number of RTM, and thus the RUG–IV classification and payment level for each patient. Thus, the allocation of group therapy will not require extra work on the part of SNF staff. Accordingly, we do not believe that allocation of group therapy minutes will cause operational inefficiencies in SNFs.

Comment: In the proposed rule, we solicited comments on types of patients for whom group therapy might be appropriate. We received several comments in response to this solicitation, which included different diagnoses (for example, aphasia) and treatment types (for example, a functional communication group). One commenter stated that while there are specific conditions that might prompt the consideration for group therapy, it is important for group therapy to be part of an integrated plan of care established under medical direction. Commenters noted that not all patients would benefit from group therapy, nor would all conditions be appropriate to incorporate into a group therapy program.

Response: We appreciate the comments which suggested various diagnoses and treatment types that might benefit from group therapy. As we stated in the proposed rule (76 FR 26387), group therapy is not appropriate for either all patients or all conditions and is primarily effective as a supplement to individual therapy. We agree with the comment noting that while there are specific conditions that might prompt the consideration of group therapy, it is important for group therapy to be part of an integrated plan of care established under medical direction. Additionally, we believe that diagnoses and treatment techniques (such as communication or feeding groups) should not be the sole basis for choosing to initiate group therapy. Therapists should determine for each resident, regardless of diagnosis or condition, whether the resident is a good candidate for group therapy based on functional level and treatment potential, and whether this particular form of treatment is in the patient's best interest and within the goals of the overall plan of care. We will take the commenters' suggestions under consideration in assessing the appropriate use of group therapy in SNFs and may address this further in future rulemaking.

Comment: One commenter requested clarification of a sentence in the proposed rule, which stated that ''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'' (76 FR 26387). The commenter believed that the number of group therapy minutes stated in the parentheses of the above sentence, given the scenario referred to in that sentence, should be 120.

Response: After reviewing the sentence quoted above from the proposed rule (76 FR 26387), we agree with this commenter and wish to clarify that there is an error in this sentence. In the above-quoted sentence from the FY

2012 proposed rule, the minutes referred to in the parentheses should read 120 minutes rather than 60 minutes, given the immediately preceding scenario to which it refers. Thus, this sentence should have stated, ''As is currently the procedure, the SNFs would report the total unallocated group therapy minutes on the MDS 3.0 (120 minutes in the scenario above) for each patient.''.

Comment: One commenter suggested that an inconsistency of CMS's definition of group therapy between the FY 2010 final rule (74 FR 40315) and the MDS RAI Manual (Chapter 3, Section O) may have led to the increase in group therapy utilization. The commenter specifically references the words ''same'' versus ''similar'' as regards to type of group therapy services/activities. This commenter recommended that CMS make the definitions of group therapy consistent between the regulations and the RAI Manual.

Response: In the FY 2010 final rule (76 FR 40315), we stated that group therapy is therapy where a ''therapist provides the same services to everyone in the group.'' We note that later in the preamble of the FY 2010 final rule (74 FR 40317), we define group therapy as ''consisting of 2 to 4 patients (regardless of payer source) who are performing similar activities * * *'' In the RAI Manual (Chapter 3, Section O)], group therapy is also defined as ''the treatment of 2 to 4 residents, regardless of payer source, who are performing similar activities, * * *.'' We do not believe that this inconsistency in the definition may have led to the increase in group therapy utilization as we are not aware of evidence to support this claim. Additionally, we provided extensive training to providers both prior to and after the implementation of MDS 3.0. At the time of training, we did not receive questions on this issue, suggesting that there was not a significant amount of confusion on this point. To clarify, from this point forward, the definition of group therapy will be consistent in regulation and in the RAI manual. For the purposes of coding group therapy for Medicare Part A SNF payment, the existing definition of group therapy has been: 2–4 patients (regardless of payer source) who are simultaneously performing the same or similar activities and are supervised by a therapist (or assistant) who is not supervising any other individuals. However, as discussed in this final rule, beginning October 1, 2011, this definition will be: 4 patients (regardless of payer source) who are simultaneously performing the same or similar activities and are supervised by a therapist (or assistant) who is not supervising any other individuals. For purposes of coding concurrent therapy for Medicare Part A SNF payment, the definition of concurrent therapy will remain: therapy consisting of 2 patients who are not performing the same or similar activity (regardless of payer source), both of whom must be in line-of-sight of the treating therapist (or assistant).

Comment: Several commenters supported the clarification of our expectations for documenting group therapy services. Some commenters stated that rehabilitation professionals need to support the work they do through documentation, and that the documentation should reflect the need for skilled care as well as demonstrate how the therapy provision will support patients' needs and goals. Further, professional therapy associations commented on the documentation clarifications, stating that the requirement for adequate documentation to justify the use of each mode of therapy is necessary and that there should be no additional burden to provide this documentation, as it should be a standard part of any documentation. Others expressed concern that we proposed new and stricter guidelines for documenting group therapy. Some commenters stated that requiring a therapist to document why a specific mode of therapy was chosen for a patient would create an undue burden on the therapist. One commenter stated that requiring an additional, separate plan of care for group therapy would not improve the quality or efficacy of this mode of therapy delivery, and that it would be a disincentive for clinicians to perform group therapy due to the increased paperwork.

Response: We would like to clarify that we did not propose new documentation requirements for group therapy provision. In fact, these documentation requirements have been in place all along, and the intent of the discussion in the proposed rule was to clarify our expectations. Contrary to the commenter's statement, we are not requiring an additional, separate plan of care for group therapy. The regulations at § 409.17(c) and § 409.23(c) require that, in order for Medicare to pay for therapy in a SNF, a therapy plan of care must be in place and that it must include certain information. In the FY 2012 proposed rule (76 FR 26387 through 26388), and as discussed previously, we simply clarified what we expect to be included in the plan of care and supporting medical record documentation in cases where group therapy is provided.

Therefore, as this discussion in the proposed rule simply clarified existing expectations, we do not agree that these documentation guidelines will increase or create undue burden on therapists, or that these guidelines create a disincentive for clinicians to perform group therapy due to increased paperwork. As the commenters above suggested, there should be no additional burden to provide this documentation, as it should be a standard part of any documentation. We agree with those commenters who stated that rehabilitation professionals need to support the work they do through documentation, and that the documentation should reflect the need for skilled care and the mode of therapy provided, as well as demonstrate how the therapy provision will support patients' needs and goals.

Comment: One commenter stated that the clarification of CMS coverage and documentation expectations included in the proposed rule inappropriately broadens the documentation requirements of group therapy by applying standards beyond those found in the current law and regulations for SNF care. Specifically, the commenter indicated that the clarification incorrectly applies hospital regulations and inaccurately characterizes guidelines set forth in program manuals as binding for SNFs. This commenter recommended that CMS clarify therapy documentation requirements using only SNF law and regulations.

Response: We do not agree with the claim that the requirement to establish structured and well-documented group therapy programs applies to hospitals but not to SNFs. We would note that while it is the regulations themselves from which legal authority derives, the program manuals and other interpretive guidelines can serve to clarify or interpret the regulations set forth in the Code of Federal Regulations (CFR). The clarifications set forth in the FY 2012 proposed rule (76 FR 26387 through 26388) are based on regulations at § 409.17 and § 409.23, and interpretive guidance in the RAI Manual, all of which are applicable to SNFs. While the cited regulations in the proposed rule, specifically § 409.17(b) through (d), fall within Part 409, Subpart B (Inpatient Hospital Services and Inpatient Critical Access Hospital Services), these particular regulations also apply to SNFs with regard to their patients' plans of care and for guidance on specific documentation requirements. Specifically, § 409.23, which is located in Part 409, Subpart C (Posthospital SNF

Care), states that Medicare pays for SNF therapy services if they are furnished, among other things, in accordance with a plan of care that meets the requirements of § 409.17(b) through (d), thereby making § 409.17(b) through (d) applicable to SNFs. When we initially revised the SNF therapy regulations at § 409.23(c) to incorporate these plan of care requirements in the Medicare Physician Fee Schedule final rule for Calendar Year (CY) 2008 (72 FR 66331, November 27, 2007), we noted our belief that ''* * * therapy services should be provided according to the same standards and policies in all settings, to the extent possible and consistent with statute.'' Moreover, in the Medicare Physician Fee Schedule final rule for CY 2011 (75 FR 73583, November 29, 2010), we revised the hospital regulations at § 409.17(d) on therapy treatment plans—to which the corresponding SNF therapy regulations cross-refer—specifically to clarify that those particular hospital regulations also apply to SNFs. Thus, our clarifications do not exceed the current law and regulations applicable to SNFs.

Further, we do not agree with the commenter's implicit assumption that program guidelines are not relevant to this process. We note that such guidelines are based on the provisions of the regulations, and are made available to each provider to advise it of those provisions as well as of CMS's or the surveyor's expectations. While these guidelines are disseminated to providers, all providers are nevertheless expected to comply fully with the regulations on which the guidelines are based.

For the reasons discussed in section V.C of the FY 2012 proposed rule (76 FR 26386 through 26388), and for the reasons discussed in this final rule above, we are finalizing our proposed policies related to group therapy effective October 1, 2011. First, we are defining group therapy as therapy provided simultaneously to four patients (regardless of payer source) who are performing the same or similar activities and are supervised by a therapist (or assistant) who is not supervising any other individuals (76 FR 26386 through 26387). In addition, we are finalizing our proposed policies related to the reporting and allocation of group therapy minutes as discussed above and in the FY 2012 proposed rule (76 FR 26387). As is currently the procedure, the SNF will report the total unallocated group therapy minutes on the MDS 3.0. In terms of RUG–IV classification, this total time will 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. In addition, as discussed above, if one or more of the four group therapy participants are unexpectedly absent from a session or cannot finish participating in the entire group session, rather than discontinuing payment or requiring the session to be rescheduled, we will continue to deem the therapy session as meeting the definition of group therapy as long as the therapy program originally had been planned for four patients. In this situation, we will continue to assume that there are four patients, and therefore will divide the therapy minutes by four in allocating group therapy minutes among the group therapy participants.

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

In the FY 2012 proposed rule (76 FR 26388 through 26393), we proposed to make certain modifications to the MDS assessment schedule and to the types of assessments to be completed. To receive proper payment for services provided during Part A Medicare SNF stays, SNFs must complete patient assessments in accordance with the assessment schedule established by CMS at § 413.343(b) and in the RAI Manual, version 3.0, Chapter 2. As we explained in the FY 2012 proposed rule (76 FR 26388 through 26389), we proposed to modify the current Medicare-required assessment schedule to incorporate new assessment windows and grace days to capture more appropriately the changes in patients' status and in services and treatments provided over the course of a stay, and to reduce the possibility that information from the same days of the patient's stay may be used on different scheduled MDS assessments. The current MDS assessment schedule and the proposed MDS assessment schedule may be found in Tables 10A and 10B in the proposed rule (76 FR 26389).

Additionally, regarding the completion of unscheduled PPS assessments, in the proposed rule (76 FR 26389 through 26390), we clarified the End of Therapy (EOT) OMRA policy (which first appeared in the FY 2010 final rule (74 FR 40347 through 40348)) by stating that the ARD for an EOT–OMRA must be set for 1 to 3 days after the discontinuation of all therapies, regardless of the reason for the discontinuation. Further, in determining the ARD for the EOT OMRA, we clarified that, as finalized in the FY 2010 final rule (74 FR 40348), currently days are counted differently for facilities that regularly provide therapy services 5 days per week as compared to facilities that regularly provide therapy services 7 days a week. Following the publication of the FY 2010 final rule, some SNFs expressed concern over the use of the phrase ''discontinuation of therapy services,'' as well as the distinction between 5- and 7-day-a-week facilities in determining the ARD for the EOT OMRA. In the FY 2012 proposed rule (76 FR 26389), we clarified that the term ''discontinuation of therapy services'' referred to both temporary, unplanned and planned discontinuations of therapy services. Accordingly, in the FY 2012 proposed rule (76 FR 26389 through 26390), we clarified that providers must complete an EOT OMRA for a patient classified in a RUG–IV therapy group if the patient goes 3 consecutive days without therapy, regardless of the reason for the discontinuation. Moreover, to mitigate confusion related to the distinction between 5-day and 7-day-a-week facilities, we proposed to eliminate the distinction altogether. We proposed that, effective October 1, 2011, an EOT OMRA would be required for a patient classified in a RUG–IV therapy group if that patient is not furnished any therapy services for 3 consecutive calendar days, regardless of whether the facility is a 5-day or 7-day facility. As we stated in the FY 2012 proposed rule (76 FR 26390), we believe that this policy appropriately reflects that the frail and vulnerable populations within SNFs require consistent therapy without significant breaks in services, and is consistent with § 409.34(b) (which states that a break of one or two days would not necessarily result in a provider having to complete an EOT OMRA).

In addition, in the proposed rule (76 FR 26390 through 26391), we addressed suggestions that the completion of an EOT OMRA and a subsequent Start-of-Therapy (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. Therefore, for the reasons discussed in the proposed rule (76 FR 26390 through 26391), we proposed 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 the resumption of therapy date is no more than 5 consecutive calendar days after the last day of therapy provided, and the therapy services have

resumed at the same RUG–IV classification level that had been in effect prior to the EOT OMRA. In the FY 2012 proposed rule, we stated that 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.

In addition, as discussed in the proposed rule (76 FR 26391), 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 believe 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 in the FY 2012 proposed rule (76 FR 26392), we believe that such 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). Accordingly, we proposed (76 FR 26392) 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 reimbursable therapy minutes, or 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 that resident's most recent assessment used for Medicare payment. The COT OMRA would be a new type of required PPS assessment. The ARD of the COT OMRA would be set for Day 7 of a COT observation period, which is a successive 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), and ending every 7 calendar days thereafter. We proposed 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 level of therapy.

We received a number of comments on these proposals and clarifications which, along with our responses, appear below.

Comment: Many commenters supported the changes to the MDS assessment schedule and agreed that the current assessment schedule does allow providers to use information from the same days of the patient's stay on different scheduled MDS assessments intended to capture changes in the patient's condition over time.

Others suggested that CMS conduct a detailed analysis to determine the efficacy of the proposed changes prior to implementation. These commenters opposed changes to the assessment schedule based on their belief that the changes would not reduce the frequency with which information from the same days of the patient's stay is used on different scheduled MDS assessments. Other commenters raised concerns that the proposed changes to the assessment schedule would limit flexibility in scheduling assessments and would be burdensome because the shorter window for providers to set the ARD for a scheduled PPS assessment would reduce the SNF staff's ability to stagger MDS due dates among residents.

One commenter stated that the proposed changes to the MDS schedule and assessments will take the clinical judgment away from licensed therapists. This commenter stated that the use of clinical judgment is crucial in ensuring that the patients receive needed services for which they qualify and that produce a positive clinical outcome. One commenter expressed concern that the proposed changes to the MDS assessments and schedules would impose an additional burden on software vendors, billing offices, and medical records personnel. Furthermore, the commenter stated that the proposed changes would affect MDS scheduling tools, calendars, billing effective dates, budget, and billing reports.

Response: We are pleased with the comments received in support of the proposed changes. Prior to proposing changes to the assessment schedule, we did conduct a detailed analysis on the likely effect of the updated policies. For this reason, we do not agree that the proposed changes to the MDS assessment schedule should be withdrawn until another study is completed. However, as with all new and revised policies, we will monitor the effects of the changes, and make any necessary modifications through future rulemaking. We recognize that, while the proposed changes eliminated most of the overlap in setting the observation periods for Medicare-required scheduled assessments, it is impossible to eliminate totally the potential for information from the same days of the patient's stay to be used on different scheduled MDS assessments, since changes in a beneficiary's condition can also require completion of several different types of unscheduled assessments (such as OMRAs, discharge assessments, significant change assessments, *etc.*) within short periods of time. However, as discussed in the proposed rule (76 FR 26388 through 26389), we believe by making the proposed changes to the assessment schedule (that is, by narrowing the assessment and grace day windows), we reduce the amount of information from the same days of the patient's stay that may be used on different scheduled MDS assessments while still allowing providers some flexibility in setting the ARD.

In terms of regular scheduled PPS assessments, the 5-day and 14-day scheduled Medicare assessments are used to determine payment for the first 30 days of a SNF stay. Under the current policy, it is possible that the clinical characteristics of a resident on days 5 through 8 of the resident's stay could be used on both the 5-day and 14-day assessments. In such a case, this effectively reduces the number of days that clinical information is collected and used to observe changes in the patient's condition over time. In cases where this overlap is used, payment is established for the first 30 days of the patient's stay based on only 10 days of service, with 4 days overlapping between observation windows, rather than the intended 14 days of service with little to no overlap between observation periods. We are confident that the proposed changes allow sufficient time to perform all required assessments, allow for flexibility in scheduling the assessments, and provide a more accurate method for determining payment across the entire 30-day period. As discussed above, we believe that these changes are necessary to reduce the possibility that information from the same days of the patient's stay may be used on different scheduled MDS assessments and to allow us to capture more appropriately the changes to patients' status and in

services and treatments provided over the course of a SNF stay and, as such, these changes will allow us to reimburse more accurately for SNF services.

Additionally, we do not agree that our proposed changes to the MDS schedule and assessments would take away clinical judgment from therapists. 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). It is true that our proposed changes to the MDS assessments and schedules will affect the reporting and reimbursement of SNF services, including therapy services; however, we have not mandated the manner of providing these services. We agree that the licensed therapists are to use their clinical judgment to treat the patients in the most appropriate manner, and to maintain professional standards while providing all necessary services.

With regard to commenters' concern related to the burden arising from changes in the MDS assessment schedule and assessments, we would note that we gave draft specifications to vendors as soon as possible after we published the proposed rule. We acknowledge that the proposed changes to the MDS schedule and assessments may affect items listed by the commenter (scheduling tools, calendars, billing effective dates, budget, and billing reports), but believe that, for the reasons outlined here and in the proposed rule, such changes are nevertheless necessary to provide appropriate payment for services provided to residents, to enhance the reliability of the MDS, and to ensure the stability of the SNF PPS.

Comment: One commenter stated that in practice, by reducing the length of the assessment windows, we have minimized the usefulness of grace days to providers, and suggested that we officially eliminate the concept of grace days. Other commenters requested that we remove the grace days from the assessment schedule completely, and combine them with the ARD days. On the other hand, several commenters recommended expanding the assessment window to allow providers more flexibility in using grace days when determining the observation period. These commenters were concerned that, as CMS has stated that grace days should be used sparingly, any claim which makes use of an assessment where grace days are used might be considered as potentially inappropriate and subject to medical audit.

Response: Grace days are a longstanding part of the SNF PPS in order to allow clinical flexibility when setting the ARD dates of scheduled PPS assessments. We agree that in practice, there is no difference between regular ARD windows and grace days and we encourage the use of grace days if their use will allow a facility more clinical flexibility or will more accurately capture therapy and other treatments. Thus, we do not intend to penalize any facility that chooses to use the grace days for assessment scheduling or to audit facilities based solely on their regular use of grace days. We may explore the option of incorporating the grace days into the regular ARD window in the future; nevertheless, we will retain them as part of the assessment schedule at the present time consistent with the current policy and the new assessment schedule proposed in the proposed rule.

Comment: Many commenters supported the proposed change to consider all facilities 7-day facilities for purposes of setting the ARD for the EOT OMRA and the clarification that facilities are required to complete an EOT OMRA to classify residents into non-therapy RUG categories when therapy has been missed for 3 consecutive days. Others believed that an EOT OMRA should only be required if three scheduled days of therapy are missed, rather than unscheduled days, since it may be possible for a patient to receive the required amount of weekly therapy while still not being provided with any therapy for 3 consecutive days. Many commenters stated that it would not be unusual for patients to have 3-day lapses in therapy, especially if a weekend were involved. The commenters explained that it is common for patients in the SNF population to have brief episodes of illness or refusals, doctor appointments, or religious holidays that may cause a missed therapy day on a Friday or Monday, and that requiring an EOT OMRA following 3 consecutive calendar days of missed therapy is not logical, as it will entail a provider burden of additional paperwork.

Response: We are pleased that some commenters supported the proposal to eliminate the distinction between 5–day and 7-day facilities and to apply a uniform policy in setting the ARD for the EOT OMRA. However, we do not agree with comments that an EOT OMRA should only be required if 3 scheduled days of therapy are missed, rather than any three consecutive day periods. As stated in § 409.31(b)(1), to meet the skilled level of care requirement for coverage of post-hospital SNF care, ''the beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.'' Additionally, the criteria for ''daily basis'' under § 409.34(a)(2) state, '' As an exception, if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week.'' Therefore, according to these regulations, while a facility may determine that it does not have adequate resources to provide therapy 7 days a week, the facility is still required to ensure that therapy is provided for at least five days a week. In addition, the policy requiring an EOT OMRA to be completed when therapy has been discontinued for 3 consecutive calendar days is consistent with our discussion of § 409.34(b) in the FY 2010 final rule (74 FR 40348), in which we stated that a break of 1 or 2 days would not necessarily result in a provider having to complete an EOT OMRA. As we stated in the FY 2012 proposed rule (76 FR 26390), we believe that the policy of requiring all SNFs to set the ARD for the EOT OMRA by the third consecutive calendar day after the last day of therapy was provided appropriately reflects that the frail and vulnerable populations within SNFs require consistent therapy without significant breaks in service. Accordingly, we believe that regardless of whether the missed therapy day was scheduled, and no matter what the reason was for the missed therapy, if the resident missed 3 consecutive calendar days of therapy, we believe an EOT OMRA should be completed.

Commenters cited several specific examples of situations that would cause a resident to miss therapy. We realize that there may be a variety of reasons that therapy would be missed, whether the reason for the missed therapy was planned or unplanned. At the same time, it is the facility's responsibility to ensure that patients receive ongoing, rather than sporadic, care to promote each patient reaching his or her full potential. Thus, we emphasize that the EOT OMRA should be completed if therapy was missed for 3 consecutive calendar days for *any* reason, planned or unplanned. Additionally, the idea that a resident can receive the required amount of weekly therapy while still not being provided therapy for 3 consecutive days, as suggested by the commenter, assumes that there is a prescribed ''Medicare therapy week''. It should be noted, however, that there is no prescribed ''Medicare therapy week''

that spans across any specific days. Therapy utilization is measured across a rolling 7-day period as reported on the MDS assessments. Thus, for the reasons discussed above, the EOT OMRA should always be completed when a resident misses 3 consecutive calendar days of therapy.

Comment: One commenter recommended that CMS recalibrate the therapy thresholds, specifically in the Ultra High and Very High Rehabilitation RUG categories to distribute minutes more accurately and to establish more realistic sub-categories.

Response: We appreciate the commenter's recommendation. We intend to monitor these policies as well as provider behavior and we may consider such approaches in the future.

Comment: Several commenters requested additional guidance and clarification on the requirements for providing a SNF Advance Beneficiary Notice of Noncoverage (SNF ABN) or an expedited determination notice, also known as the Notice of Medicare Non-Coverage (NOMNC) when a beneficiary misses 3 consecutive days of skilled therapy and will enter into a noncovered stay because they will no longer be receiving skilled services. One commenter thought that CMS required a SNF ABN to be issued 48 hours prior to the delivery of noncovered care. The commenter was concerned that this 48-hour SNF ABN delivery ''requirement'' could not be met when a beneficiary receives no therapy on a weekend and refuses therapy on Monday.

Response: The SNF ABN is issued prior to delivering services for which Medicare might not pay because they are not medically reasonable and necessary and/or constitute custodial care, and the beneficiary is expected to receive these services and possibly incur financial liability. The policy for issuance of the SNF ABN has not changed in light of the policies being finalized in this rule. Please see the current manual instructions for the SNF ABN in the Medicare Claims Processing Manual, IOM 100–04, Chapter 30, Section 70, which can be accessed via this link: *http://www.cms.gov/Manuals/IOM/list.asp*.

There is no ''48-hour notice'' requirement associated with the SNF ABN. However, the SNF ABN should be given in a timely manner to provide the beneficiary or the representative sufficient time to make an informed decision about whether to receive care that may not be covered by Medicare, and/or make other arrangements for care. SNF providers should issue the SNF ABN as soon as it is clear that the beneficiary may enter into a non-covered stay.

We appreciate the commenters' concerns regarding understanding the requirements for the issuance of the SNF ABN in light of this rule; however, as noted previously, our policies related to issuance of the SNF ABN remain unchanged. Specifically, the timing of SNF ABN delivery remains unchanged, and as per current policy and as discussed above, it should be given prior to delivery of care for which Medicare might not pay, allowing the beneficiary or the representative a reasonable amount of time to make an informed decision about whether to receive the care and/or make other arrangements for care. Finally, we note that where the beneficiary misses 3 consecutive days of skilled therapy and will enter into a noncovered stay, either because therapy is not offered on those days or the beneficiary refuses or declines therapy, or any combination of the preceding, it is unlikely that a provider will need to issue the NOMNC. The NOMNC is a notice issued prior to the termination of Medicare-covered services, when the provider determines that such services are no longer covered based on Medicare coverage policies (see 42 CFR §§ 405.1200 and 405.1202). The NOMNC informs the beneficiary of the right to appeal the discontinuation of covered services. Our policies regarding issuance of an NOMNC have not changed in light of this rule. Consistent with current policy, if SNF covered services end solely because a beneficiary fails to meet the consecutive days of therapy requirement for the reasons set forth above, the NOMNC would not be issued. The NOMNC is a provider notice of termination of services and is not issued when a beneficiary initiates the end of care. The NOMNC is also not issued when care ends for provider business reasons, such as when a SNF does not offer therapy on certain days. We intend to publish guidance on NOMNC delivery in the Medicare Claims Processing Manual in the near future. We will also include further clarification on NOMNC delivery in other vehicles, such as CMS Open Door Forums, as deemed necessary.

Comment: Several commenters have stated that the requirement of the EOT OMRA after discontinuation of therapy for 3 consecutive days inhibits facilities from gradually reducing therapy services as residents approach the end of their SNF stay. The commenters explained that it is common to reduce the frequency and intensity of treatment prior to facility discharge to assure the resident will maintain their current level of function without the need for daily therapy.

Response: We do not agree that the requirements to complete an EOT OMRA following discontinuation of therapy for three consecutive calendar days discourages facilities from gradually reducing therapy services prior to discharge. The EOT OMRA would only need to be completed if 3 consecutive calendar days of all three therapy disciplines were missed. We believe that it is likely to be inconsistent with good clinical judgment for practitioners to purposely not provide any rehabilitation services in a 3-day period prior to an imminent discharge, especially given the frail and vulnerable nature of SNF populations.

Comment: Several commenters remarked that the requirement to complete an EOT OMRA after 3 consecutive days of missed therapy will negatively affect residents who are classified into Low Rehabilitation RUG groups. They stated that facilities might be required to complete an EOT OMRA on a weekly basis if these residents do not receive therapy on a Monday or Friday.

Response: Residents who fall into the Rehabilitation Low RUG groups continue to benefit from skilled therapy. Even though their conditions indicate that they only need to receive therapy for a minimum of 45 minutes per week over at least 3 days to be classified into these RUG groups, we believe that a significant break in therapy services may still be detrimental to their therapy goals and recovery. For example, if a facility treats one of these residents on a Monday, Tuesday, and Wednesday and they do not have another treatment session until the following Monday or Tuesday, this resident will go for 4 or 5 consecutive calendar days without therapy services. We believe that this significant break in therapy may cause this resident to regress from functional gains made during therapy thus far. For this reason, we require that an EOT OMRA also be completed for residents who are in the Rehabilitation Low RUG groups, when therapy services have been discontinued for 3 consecutive calendar days.

Comment: We have received numerous comments stating that providing 7-day-a-week therapy for rural facilities is very difficult. The commenters stated that it is quite possible that the EOT OMRA would be triggered frequently by 3 missed days of therapy over the weekend plus the adjoining days. The commenters suggested that the policy that requires an EOT OMRA in the event of 3 missed

days of therapy should be revised to at least 4 missed days.

Response: We recognize the concern of the rural facilities. However, our primary concern is that the SNF residents receive daily skilled rehabilitation as required under §§ 409.31 and 409.34. We expect that rural facilities and SNFs that cannot meet the ''daily basis'' requirement under § 409.34 will revisit their hiring and staffing practices as well as recruitment and retention options to assure they have the appropriate amount of staff to ensure that daily skilled care can be provided. Additionally, if facilities are having difficulty meeting the daily skilled needs of the residents in their care, they should also revisit their admissions policies and determine if they are accepting patients for whom they have the resources to provide the necessary daily skilled therapy services.

We do not agree with the suggestion to allow SNFs to discontinue therapy for 4 consecutive days prior to completing the EOT OMRA. As stated above, § 409.34 requires skilled nursing and/or rehabilitation services on a daily basis. We have made limited allowances for facilities that are unable to provide therapy services 7 days a week based on logistical constraints; however, we still expect SNFs to provide an adequate amount of skilled rehabilitation services to meet the patient's clinical needs. Allowing 4 missed days of therapy prior to completion of the EOT OMRA would undermine this concept. As we stated previously, the EOT OMRA policy we proposed and are finalizing in this final rule reflects that the frail and vulnerable populations in SNFs require consistent therapy without significant breaks in service.

Comment: One commenter asked if it is possible for computer software to calculate the appropriate RUG when therapy ends without another MDS being completed.

Response: The information needed to calculate a non-therapy RUG–IV group when therapy is discontinued is only reported on the MDS. The only option for automating the recalculation of the RUG–IV group would be to use a previously-submitted MDS. Since that assessment would reflect the beneficiary's condition in a prior period rather than the patient's condition when therapy ended, there would be no way to determine the most appropriate non-therapy RUG category for the patient from that assessment.

Comment: Many commenters stated that the proposed COT OMRA could accommodate for the missed 3-day treatment scenarios that necessitate EOT OMRA completion.

Response: We do not agree that the COT OMRA could address both changes in therapy provision and missed therapy days. The intent of the EOT OMRA is to pay SNFs the per diem medical RUG rate for the consecutive days that the resident did not receive therapy services. The COT OMRA addresses changes in minutes of therapy provided, not missed days.

Comment: Several commenters asked us to define the term ''treatment day'' for purposes of the EOT OMRA. These commenters asked us if a resident received less than 15 minutes of therapy a day, whether this time could still count toward the definition of a ''treatment day'' rather than as a missed therapy day.

Response: For purposes of determining when an EOT OMRA must be completed, a treatment day is defined exactly the same way as in the RAI Manual in Chapter 3, Section O, page O–16: 15 minutes of therapy a day. If a resident receives less than 15 minutes of therapy in a day, it is not coded on the MDS and it cannot be considered a day of therapy.

Comment: Several commenters expressed confusion about the process of re-starting therapy after an EOT OMRA was completed. Some were unsure about when to complete an SOT OMRA or an EOT–R OMRA. Others asked whether a new therapy evaluation is necessary in all cases of resumption. Additionally, although many commenters supported the proposal to implement the optional EOT–R OMRA, and approved of this option to lessen the burden of SNFs when the need to complete the EOT OMRA arose, many others expressed confusion and/or requested clarification as to whether the EOT–R OMRA is a new assessment type or a modification of an old assessment.

Response: As explained in the proposed rule (76 FR 26389 through 26390), the ARD for the EOT OMRA must be set 1 to 3 consecutive calendar days following the last day of therapy. Under current policy, if the patient was discharged from therapy with no expectation for it to continue or restart, then the EOT OMRA would classify the resident into a non-therapy RUG group which would be the basis of payment until the next PPS assessment. However, even if the resident was not discharged from therapy services and missed 3 or more consecutive days of therapy, an EOT OMRA still would have to be completed to classify the resident into a non-therapy RUG group for those days of missed therapy.

As explained in the FY 2012 proposed rule (76 FR 26390 through 26391), we recognize that the completion of an EOT OMRA and subsequent SOT OMRA may not be necessary for all patients. This may be the case where therapy was discontinued (for example, due to non-clinical reasons such as scheduling conflicts), and resumes shortly thereafter at the same RUG classification level. Therefore, we proposed the option to complete an EOT with Resumption or an EOT–R OMRA, rather than an SOT OMRA, in cases where the therapy resumption date is no more than 5 consecutive calendar days following the last day of therapy provided and the therapy services have resumed at the same RUG–IV classification level that had been in effect prior to the discontinuation of therapy services. As we stated in the FY 2012 proposed rule (76 FR 26390), 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. We appreciate the support for the proposal of the EOT–R OMRA.

We would like to clarify that the EOT–R OMRA is not a new assessment type. As explained in the FY 2012 proposed rule (76 FR 26390), it is an EOT OMRA with two additional items (O0450A and O0450B) to indicate whether therapy is expected to resume and the date of resumption of therapy. As stated above, an EOT–R OMRA may be used when therapy has been missed for at least 3 consecutive calendar days and is expected to resume (and actually does resume) within 5 calendar days following the last day of therapy. For example: Mr. A. received therapy every day Monday through Friday. He missed therapy on Saturday and Sunday because the SNF he was in did not provide therapy during the weekend. On Monday, Mr. A.'s family came to visit and he refused therapy. At this point, Mr. A. missed three days of therapy and an EOT OMRA would be required. He also missed therapy on Tuesday, due to a scheduled doctor's appointment. The interdisciplinary team made the determination that Mr. A.'s missed therapy did not result in a change in clinical condition that would make him tolerate less therapy and change his RUG–IV classification. Therefore, the facility completed an EOT OMRA on Monday indicating that

therapy had not occurred for at least three days. Then, on Wednesday, the EOT is modified into an EOT–R by reporting the actual date of resumption, which was Wednesday. In this case, a new therapy evaluation was not required and Mr. A resumed therapy on Wednesday at the same RUG–IV classification level.

If the reason for missed therapy was clinical in nature (meaning there was a possibility that the resident's clinical therapy status was affected by the missed therapy), it may not be appropriate for the facility to complete an EOT–R OMRA. In cases where the patient resumes therapy more than 5 consecutive calendar days after discontinuation of therapy services or where the patient resumes therapy at a different RUG classification level (even if it is no more than 5 consecutive calendar days after the date the last therapy service was furnished), an EOT–R OMRA cannot be used. In this case, the facility could either complete an optional SOT–OMRA and new therapy evaluation if therapy resumes, or wait until the completion of the next scheduled PPS assessment to classify the resident into a RUG–IV group. If the facility chooses not to complete an SOT OMRA and if the next scheduled PPS assessment is used to classify the patient into a therapy RUG group, a new therapy evaluation would also be required. Thus, in situations where an EOT OMRA was completed and therapy subsequently resumes, a new therapy evaluation is required when either an SOT OMRA or a scheduled PPS assessment is used to classify the resident into a RUG–IV therapy group. For example: Mr. B. received therapy every day Wednesday through Monday. On Tuesday, he felt ill and missed therapy that day and Wednesday. He then went to dialysis on Thursday and missed therapy that day as well. He missed a total of 3 days of therapy. Due to his illness and dialysis, he could not immediately resume therapy at the same level he was receiving prior to the three missed days. However, on Friday he felt well enough to start therapy again. The facility completed an EOT OMRA on Thursday to classify Mr. B. into a non-rehabilitation RUG group and to get paid the non-rehabilitation RUG rate for Tuesday, Wednesday, and Thursday. As Mr. B. could not resume therapy at the same RUG–IV classification level, a new therapy evaluation was completed by each discipline (physical therapy, occupational therapy, and/or speech therapy) treating Mr. B. and then an SOT OMRA was completed, and he was placed back into a rehabilitation RUG group. The facility was paid at the rehabilitation RUG rate from the day therapy restarted until the next PPS assessment was completed.

Comment: One commenter highlighted a potential error in an example we provided on page 26392 of the proposed rule, where we stated that ''* * * 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) * * *'' (76 FR 26392). According to this commenter, the phrase ''30-day assessment'' should be replaced by ''EOT OMRA'' because the non-therapy RUG on the EOT OMRA is used to establish the payment for services during the period where no therapy services are provided.

Response: After careful review of the example in the proposed rule cited by the commenter, we agree with the commenter that we misstated the relevant assessment that would determine payment for Days 36 through 39 in the example provided. The text quoted above on page 26392 of the proposed rule should read ''* * * paid for Days 36 through 39 at the corresponding non-therapy rate, based on the patient's clinical condition reported on the EOT OMRA (because therapy services were discontinued on Day 36 and an EOT OMRA was completed) * * *'', as this accurately reflects how the payment for this resident would be calculated. We have reviewed the remainder of the example and found no additional errors.

Comment: Several commenters questioned whether therapy service changes outside of the MDS observation window are a significant issue. One commenter requested evidence that there is a widespread instance of misreporting therapy services. One commenter suggested that if this were such a major threat to the Medicare program, they would assume CMS would have involved the Recovery Audit Contractors (RACs), the Medicare Administrative Contractors (MACs), and CMS surveyors in the medical review process to address this issue.

Response: As we stated in the FY 2012 proposed rule (76 FR 26391), 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 SNF resident outside the observation window for the most recent assessment. While in some of these cases, a patient's clinical status may have changed outside of the observation window requiring an adjustment to the intensity of therapy during that time, we have also been presented with a multitude of anecdotal evidence claiming the misreporting of therapy services. In addition, the Office of the Inspector General (OIG) of the Department of Health and Human Services conducted an independent study into questionable billing practices in SNFs. Report No: OEI–02–09–00204 (available online at *http://oig.hhs.gov/oei/reports/oei-02-09-00204.asp*) demonstrates that the OIG concurs with our statements in the FY 2012 proposed rule and supports the changes we have proposed to curb these practices. As cited in the OIG Report (page 11), ''Lastly, the data highlight the need for further changes to make RUGs and Medicare payments more consistent with beneficiaries' care and resource needs. These changes could include requiring SNFs to recalculate a beneficiary's RUG whenever his or her level of therapy changes substantially, as well as reducing the overlap that occurs in assessment periods.'' We agree with the commenter that we should utilize all of our available tools to identify and correct abusive practices. These issues have been referred to the appropriate entities for more intensive monitoring.

Comment: We received several comments supporting the addition of the COT OMRA. These commenters agreed that the COT OMRA would improve the accuracy of reimbursement for therapy services and quality of care to SNF patients. The commenters also believed that the implementation of the COT OMRA would help ensure that Medicare payments more accurately reflect the differences in resources utilized for patient care. However, many commenters stated that the COT OMRA would create an undue burden for facilities. Several commenters stated that the COT OMRA would increase supply costs associated with completing the actual form and that the additional paperwork required would affect the ''green'' efforts of many facilities. Some commenters stated that the additional assessments would reduce actual patient care due to the amount of time spent regulating and monitoring these assessments during the SNF stay. Some commenters expressed concern that the COT OMRA would require facilities to add new evaluation processes to monitor RTM. One commenter stated that the COT OMRA would increase confusion about the MDS process. One comment expressed concern that when the COT OMRA causes a resident to classify into a lower RUG category, this would cause facility workloads to

increase without an increase in personnel reimbursement.

Response: We would like to stress that SNFs would be required to complete a COT OMRA only if the intensity of therapy changes to such an extent that the patient's RUG classification, based on their last PPS assessment, is no longer an accurate representation of the patient's current clinical condition. Regarding the need for a new evaluation process to monitor and count RTM, we believe that facilities currently have processes in place that monitor the total amount of therapy minutes provided over any given period of time. Therefore, we do not agree that the process of evaluating RTM will add a significant time burden to facilities or reduce actual patient care. We would like to stress that if facilities tailor treatment time to the needs of each individual patient and continue to provide that therapy outside of the assessment window, facilities will be less likely to be required to complete as many COT OMRAs.

We cannot assess the accuracy of the statement that the COT OMRA will increase supply costs for form completion and affect the green efforts of facilities, as it depends on the facility management and environmental efforts of each specific facility. Nevertheless, we believe the COT OMRA is an appropriate measure to enhance the accuracy of payments and patient care. As we stated in the proposed rule (76 FR 26392), we believe the COT OMRA will allow us to track changes in the patient's condition and in the provision of therapy services more accurately, allowing reimbursement to reflect resource use more accurately, thereby improving the accuracy of reimbursement. Also, we believe that the ability to track changes in the patient's condition and in the provision of service more accurately will enhance a SNF's ability to provide quality care to residents.

We do not believe that the COT OMRA will increase confusion about the MDS process. As we have done in the past, we will update the RAI Manual to incorporate the changes and instructions for assessments and we will provide training opportunities prior to the October 1, 2011 implementation. Finally, we do not agree with the commenter who stated that when a COT OMRA causes a resident to classify into a lower RUG category, this will cause facility workload to increase without an increase in personnel reimbursement. We note that RUG–IV classification is based on resource utilization and cost. If a patient is classified into a lower therapy RUG category based on a change to the therapy delivered during the COT observation period, then the SNF would appropriately be paid the lower rate associated with that RUG category. The SNF PPS rates are designed to cover the costs of providing care, including related administrative costs.

Comment: Several commenters have asked whether the COT OMRA should be completed in cases of an increase in RTM to classify a resident into a higher RUG category in addition to cases where the resident would be classified into a lower RUG category based on the provision of RTM in the COT look-back period. One commenter asked if a COT OMRA would be required if there were a scheduled decrease in therapy provision (such as one that was caused by the discontinuation of one therapy discipline) or if the COT OMRA would be required for any reason that would cause a decrease in therapy. Additionally, commenters have questioned whether a resident's ADL score should be taken into account when determining whether a COT OMRA is required. One commenter asked whether COT OMRA requirements, including the COT observation period requirement, would apply if a resident was receiving therapy but was classified into a nursing RUG because of index maximization.

Response: As we stated in the FY 2012 proposed rule (76 FR 26392), a COT OMRA would be completed for a patient in a therapy RUG, if a patient's RTM has changed during the COT observation period to such a degree that the patient's current RUG classification, based on their last PPS assessment, is no longer an accurate representation of the patient's clinical condition (and the patient should be placed in a different RUG category). This applies whether the change in RTM is a scheduled change or an unscheduled or unplanned change, and whether the different RUG category is higher or lower than the RUG category in which the resident is currently placed. In addition, in response to the comment regarding whether other therapy changes such as the discontinuation of a particular therapy discipline would be sufficient to require a COT OMRA, upon further consideration, we believe that a COT OMRA should be required in any case where there is a change in the provision of therapy such that the patient's current RUG classification based on their last PPS assessment, is no longer an accurate representation of the patient's clinical condition and the patient should be placed in a different RUG–IV category. As we stated in the proposed rule (76 FR 26392) and in this final rule above, the purpose of the COT OMRA is to track changes in a patient's condition and in the provision of therapy services more accurately to ensure that the patient is placed in the appropriate RUG category, thereby improving the accuracy of reimbursement. Based on comments received in response to the proposed rule, we will require that the COT OMRA be completed where the provision of therapy services has changed in any manner as observed during the COT observation period such that the patient should be placed in a different RUG category (not just in cases where the RTM has changed). Therefore, if a therapy discipline is discontinued and this results in a patient no longer meeting the required number of therapy disciplines for the patient's current RUG category then a COT OMRA would be required. In addition, if a patient fails to receive the requisite number of days of therapy required for classification into the RUG category, then a COT OMRA would be required to change the patients' RUG category as appropriate. As discussed previously, the purpose of the COT OMRA is to ensure that the patient is placed in the appropriate therapy RUG category based on therapy services needed and received and to ensure more accurate payment. For example, a facility is evaluating whether a COT OMRA is required for a resident who was placed in a Very-High Rehabilitation RUG group after the last PPS assessment. Upon informal evaluation at the end of the COT observation period, the facility determines that the resident has had 720 minutes of therapy during the COT look-back period and meets all of the other criteria for classification in an Ultra-High Rehabilitation RUG group. A COT OMRA would be completed to place that resident into an Ultra High Rehabilitation RUG group. In response to the commenter's question regarding whether a resident's ADL score should be taken into account when determining whether a COT OMRA is required, ADL scores are not considered when deciding whether a COT OMRA needs to be completed as they are a refined grouping within the RUG category. However, when the COT OMRA is completed, the ADL score will be used in determining the appropriate RUG group in the grouper.

Additionally, one commenter asked whether a SNF would be required to comply with the COT OMRA requirements, including the COT observation period requirement, in cases where a resident is receiving therapy but is classified into a nursing RUG because of index maximization. Upon

consideration of this comment, we believe that the COT OMRA requirements, including the COT observation period requirement, should also apply in cases where a resident is receiving therapy but is classified into a nursing RUG because of index maximization. While this type of index maximization will affect only a small subset of beneficiaries receiving therapy, because such patients are receiving therapy services sufficient for classification into a therapy RUG and would be classified into a therapy RUG if index maximization had not been applied, we believe that it is appropriate to apply the COT OMRA policy as finalized in this rule to these patients as well, so that any changes in the intensity of therapy services delivered to the patient may be captured. For example, the evaluation performed at the end of the COT observation period for such a patient may indicate an increase in RTM delivered, which may necessitate placing the patient into a rehabilitation RUG category. Therefore, the COT OMRA policy, as finalized in this rule, will also apply to patients who are receiving a level of therapy sufficient for classification into a therapy RUG category, but are classified into a nursing RUG because of index maximization.

Comment: Many comments requested clarification about the COT OMRA. Specifically, several commenters asked whether the COT OMRA could replace or be combined with other scheduled PPS assessments. Also, one commenter asked us to clarify whether, if the ARD for the COT OMRA were not set for Day 7, a missed or late assessment penalty would be applied.

Response: As specified in Chapter 6, Section 30.3 of the Medicare Claims Processing Manual (CMS Pub. 100–04, which is available online at *http://www.cms.gov/manuals/downloads/clm104c06.pdf*), special billing requirements apply when there are multiple assessments within one Medicare-required assessment window. Consistent with our current policy, if an unscheduled PPS assessment (OMRA, Significant Change in Status Assessment (SCSA), or Significant Correction of a Prior Assessment (SCPA)) is required while in the assessment window of a scheduled PPS assessment that has not yet been completed, then facilities must combine the scheduled and unscheduled assessments by setting the ARD of the scheduled assessment for the same day that the unscheduled assessment is required. In such cases, facilities should provide the proper response to A0310 items to indicate which assessments are being combined, as completion of the combined assessment will be taken to fulfill the requirements for both the scheduled and unscheduled assessments. The purpose of this policy is to minimize the number of assessments required for SNF PPS payment purposes and to ensure that the assessments used for payment provide the most accurate picture of the patient's clinical condition and service needs. In practice, in cases where the COT OMRA is combined with a regularly scheduled assessment, the facility would complete the scheduled assessment, rather than the COT OMRA, since the COT OMRA only includes a subset of the required MDS data. This single full MDS assessment is then used to determine payment for both the COT OMRA observation period and the regular payment window for the scheduled assessment. Thus, for example, in cases where Day 7 of the COT observation period falls within the ARD window of the 30-day PPS assessment, a provider would set the ARD for the 30-day assessment on day 7 of the COT OMRA observation period, and code the reasons for assessment as both the 30-day and the COT OMRA assessment (MDS items A0310(B) and A0310(C)). Consistent with the COT OMRA policy we proposed in the FY 2012 proposed rule (76 FR 26392), the HIPPS code derived from the combined COT OMRA and scheduled PPS assessment would be effective starting the first day of the COT observation period (for example, for the first COT observation period after the previous assessment used for Medicare payment, the first day of the COT observation period is the day after the ARD of the previous assessment used for Medicare payment) and would remain in effect until the end of the payment window for the 30-day assessment (that is, day 60) or until a new unscheduled assessment (an OMRA, SCSA, or SCPA) is completed.

The ARD for the COT OMRA is Day 7 following the last scheduled or unscheduled PPS assessment or Day 7 following the end of the last COT observation period (in cases where therapy had not changed sufficiently to require a COT OMRA assessment to be performed for the previous COT observation period). If a COT OMRA is required but is completed late, the facility is still required to submit the late COT OMRA to CMS. The facility will be paid at the default rate for any days not in compliance with the ARD requirement. The ARD of the late COT OMRA restarts the 7-day review period for the next COT OMRA. Since SNFs are only permitted to bill after the appropriate assessment has been accepted into the CMS data base, failure to submit a required assessment while continuing to bill for services that would be covered by the assessment, would subject the claim to denial.

Comment: Many commenters offered suggestions and alternatives to the COT OMRA. Several commenters offered the general suggestion that CMS should seek alternate, less burdensome options to address the issue of therapy service level changes outside of the MDS observation windows. More specifically, commenters recommended that if we move forward with this proposal, we should allow flexibility in the choice of the ARD of the COT OMRA. One commenter suggested that we do this by allowing for grace days either at the beginning or end of the 7-day window for the COT observation period. Similarly, one commenter suggested that we incorporate the concept of ''grace minutes'' to offer facilities the flexibility to allow for an unexpected decrease in therapy minutes outside of the assessment window. Additionally, we received suggestions that the COT OMRA should be required only after the first 30 days of a patient's SNF stay.

Response: We appreciate the suggestions and alternatives offered. However, we believe that allowing flexibility in the choice of ARD by adding grace days and by allowing grace minutes, as suggested by the commenter, would defeat the purpose and intent of the COT OMRA, which is to determine whether the therapy provided during a successive 7-day window of therapy following the ARD of a scheduled or unscheduled PPS assessment (the COT observation period) corresponds to the resident's RUG–IV classification as reflected on the most recent PPS assessment. Adding grace days would allow facilities to provide a count of therapy minutes that may not be an accurate reflection of the actual therapy minutes provided during the successive 7-day period discussed above, contrary to the intent of the COT OMRA. Furthermore, we believe that allowing grace minutes would allow the facility to provide less therapy than anticipated with the expectation that CMS will reimburse the facility at a higher rate than appropriate. Additionally, the concept of ''grace minutes'' would indicate that providers are targeting a minimum threshold of minutes to qualify for a specific RUG category. We stress that there are not ''minimum minutes'' that should be met when determining how much therapy a resident will receive. We expect that facilities are determining the therapy minutes provided based on the needs of

each individual resident. Furthermore, we do not agree that we should require the COT OMRA only after the first 30 days of the SNF stay; instead, accurate payment should occur throughout the SNF stay. The majority of Medicare A Part stays are an average of 30 days in length, and thus, a COT OMRA that was only completed after day 30 would not adequately monitor for changes in therapy services during the Medicare Part A stay, which is the purpose of the COT OMRA.

Comment: Several commenters stated that the implementation of the COT OMRA implies that SNF payment is no longer prospective in nature. One commenter suggested that the retrospective nature of the COT OMRA undermines the principles of risk sharing inherent in a prospective payment system. One commenter suggested that rather than changing the nature of the PPS, we should modify the case-mix indexes (CMIs) and payment rates associated with the Rehabilitation RUG categories.

Response: As noted previously, we believe that the SNF PPS payments should reflect, as accurately as possible, resource utilization and cost. Classification of patients into therapy RUGs and payment for therapy services have always been based on the therapy services provided and reported on the MDS, and we do not view the COT OMRA as changing this. In implementing the COT OMRA, we are attempting to ensure that the therapy reported on the MDS and the therapy regimen chosen for the patient are a better reflection of the therapy needs of the patient, thereby ensuring more accurate payment. We appreciate the suggestion regarding modifying the CMIs and payment rates associated with the Rehabilitation RUG categories, and may consider this in the future to the extent appropriate. As stated in the proposed rule, CMS is 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. A discussion of these possible future initiatives is included in section III.E.5 below.

Comment: Several commenters raised concerns regarding the inability of the COT OMRA to account for the natural progression in a patient's therapy regimen. One commenter stated that as patients approach the end of their skilled therapy program, it is common practice to taper therapy down to prepare for discharge. Another commenter alleged that the requirement for the ARD of the COT OMRA to be set on Day 7 is arbitrary and that during any given payment period, clinical changes occur daily, especially at the beginning and end of the SNF stay. Other commenters were concerned that adhering to a strict 7-day evaluation schedule could prompt a patient's RUG category to change for as little as one lost minute of therapy.

Response: We believe that the COT OMRA, while based on changes in a therapy regimen, is primarily intended to capture the patient's appropriate RUG classification and, therefore, the payment level. Therapists should exercise their professional discretion with regard to the appropriate amount and modality of the therapy provided to a resident during a given SNF stay. We acknowledge the natural progression of a patient's therapy needs throughout a stay, and do not believe that the COT OMRA precludes therapists from having the freedom to tailor their provision of therapy services to the individual patient.

We do not agree that setting the ARD of the COT OMRA on Day 7 following the last PPS assessment or Day 7 of any succeeding COT observation period is arbitrary. The resident is placed in a Rehabilitation or Rehabilitation Plus Extensive Services RUG category partially based the amount of therapy that was received during a 7-day look-back period. One of the basic principles underlying the SNF PPS is that an assessment completed in one time period can be used in accurately calculating reimbursement for a future period. While we realize that there will be changes based on individual needs, it is expected that, on average, residents will receive approximately the same amount of therapy within the next 7-day period after a PPS assessment. The COT OMRA is an instrument that will better align payment with the amount of therapy that a resident actually needs and receives. Our analysis of therapy utilization across Medicare Part A stays indicates that patients tend to remain in the same therapy groups for the first 30 days of care; that is, as reported on the 5-day and 14-day assessments. Since the average length of stay is approximately 30 days, facilities that maintain a stable therapy schedule should not see a large volume of COT OMRAs. While it is more common to see changes in therapy and RUG–IV groups during longer stays, the volume of patients receiving Medicare Part A SNF care for stays exceeding 30 days is much lower.

In response to the comment that a strict 7-day evaluation schedule could prompt a patient's RUG category to change for as little as one lost minute of therapy, this is theoretically possible if the plan of care is designed to provide only the minimum number of minutes that qualify the patient for a specific therapy category. As noted above, the purpose of the COT OMRA is to determine whether the therapy provided during the 7 days of therapy following the ARD of a scheduled or unscheduled PPS assessment (and any succeeding COT observation period) correspond to the resident's RUG–IV classification, as reflected on the most recent PPS assessment. Slight variations during the 7-day period are expected, and it is up to the therapist to ensure that the patient receives the amount of therapy appropriate to his/her condition.

Accordingly, for the reasons discussed in this final rule and in the FY 2012 proposed rule (76 FR 26388 through 26393), we are finalizing our proposed policies related to the MDS Assessment Schedule, the EOT–OMRA, the EOT–R OMRA, and the COT OMRA. Specifically, effective October 1, 2011, as discussed in the proposed rule and in the final rule above, we are revising the Medicare-required assessment schedule in the manner set forth in Table 10B of the proposed rule (76 FR 26389); removing the distinction between 5-day and 7-day facilities for purposes of setting the ARD for the EOT OMRA, and requiring all facilities to set the ARD for the EOT ORMA by the third consecutive calendar day after a patient's therapy services have been discontinued (76 FR 26390); and permitting providers the option to complete an EOT–R OMRA rather than the optional SOT OMRA, in cases where the therapy resumption date is no more than 5 consecutive calendar days following the last day of therapy provided, and therapy services have resumed at the same RUG–IV classification level that had been in effect prior to the EOT OMRA (76 FR 26390 through 26391). In addition, effective October 1, 2011, we are requiring facilities to complete a COT OMRA for patients classified into a RUG–IV therapy category, whenever the intensity of therapy (that is, the total RTM delivered or other therapy category qualifiers, such as the number of days the patient received therapy during the week or the number of therapy disciplines) 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 (as proposed, the need for a COT OMRA will be based on therapy services delivered during the COT observation period) (76 FR 26391 through 26393). In addition, as proposed, 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. Finally, as discussed above, the COT OMRA policy, as finalized in this rule, will also apply to patients who are receiving a level of therapy sufficient for classification into a therapy RUG, but are classified into a nursing RUG because of index maximization.

5. Discussion of Possible Future Initiatives

In the FY 2012 proposed rule (76 FR 26393), we discussed some 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. Specifically, we discussed three possible future initiatives. First, we discussed the possibility of evolving the manner in which we pay for therapy services toward a model that has previously been advocated by MedPAC, which would base payments for therapy services on the patient's characteristics. Similarly, we discussed the possibility of making partial prospective payments for therapy services, based on patient characteristics, and then reconciling payments after the services have been verified. Lastly, we discussed the possibility of annual recalibrations of the CMIs to account for fluctuations in provider practices, and MedPAC's analysis regarding the possibility of rebasing the system. As we stated in the FY 2012 proposed rule, we were not proposing any new Medicare policy in this discussion, as we recognized that depending on how such modifications are ultimately formulated, their implementation may require new statutory authority.

The comments we received related to this discussion, along with our responses, appear below.

Comment: We received a few general comments related to this discussion, the majority of which stated their support for working with CMS in the future on any future initiatives. We did not receive any comments about any specific initiatives discussed.

Response: We appreciate the support we received from commenters for considering these future initiatives and will continue to work with stakeholders on developing policies and programs that we consider necessary and appropriate to improve the SNF PPS.

F. The Skilled Nursing Facility Market Basket Index

Section 1888(e)(5)(A) of the Act requires us to establish a SNF market basket index (input price index), that reflects changes over time in the prices of an appropriate mix of goods and services included in the SNF PPS. In the FY 2012 proposed rule, we stated that the proposed rule incorporates the latest available projections of the SNF market basket. In this final rule, we are updating projections based on the latest available projections of the SNF market basket index at the time of publication. Accordingly, we have developed a SNF market basket index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses.

Each year, we calculate a revised labor-related share based on the relative importance of labor-related cost categories in the input price index. Table 9 summarizes the updated labor-related share for FY 2012.

TABLE 9—LABOR-RELATED RELATIVE IMPORTANCE, FY 2011 AND FY 2012

	Relative importance, labor-related, FY 2011 10:2 forecast *	Relative importance, labor-related, FY 2012 11:2 forecast **
Wages and salaries	50.654	50.129
Employee benefits	11.511	11.502
Nonmedical professional fees	1.32	1.31
Labor-intensive services	3.427	3.394
Capital-related (.391)	2.399	2.358
Total	69.311	68.693

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

1. Use of the Skilled Nursing Facility Market Basket Percentage

Section 1888(e)(5)(B) of the Act defines the SNF market basket percentage as the percentage change in the SNF market basket index from the average of the previous FY to the average of the current FY. For the Federal rates established in this final rule, we use the percentage increase in the SNF market basket index to compute the update factor for FY 2012. This is based on the IGI (formerly DRI–WEFA) second quarter 2011 forecast (with historical data through the first quarter 2011) 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 final rule. As discussed in section III.F.3 of this final 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 final rule, we no longer compute update factors to adjust a facility-specific portion of the SNF PPS rates, because the initial three-phase transition period from facility-specific to full Federal rates that started with cost reporting periods beginning in July 1998 has expired.

2. 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 final 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.

Comment: Several commenters suggested that CMS apply a cumulative forecast error adjustment to account for all of the variations in the market basket forecasts since FY 2004. These commenters stated that while the industry has accepted the adjustment process, the lack of any cumulative adjustment in recent years violates the precedent set by CMS in 2003 when the last cumulative adjustment was made and that the cumulative adjustment in 2003 demonstrated recognition by CMS of the cumulatively erosive effect of multi-year forecasting errors. The commenters recommended that CMS adopt a policy which recognizes the cumulative effect of multi-year market basket forecast errors and that adjustment be made to account for the cumulative errors, estimated at 0.7 percent, thus far.

Response: For FY 2004, we applied a one-time, cumulative forecast error correction of 3.26 percent (68 FR 46036, 46058). Since that time, the forecast errors have been relatively small and clustered near zero. As we stated in the FY 2004 final rule, we believe the forecast error correction should be applied only when the degree of forecast error in any given year is such that the SNF base payment rate does not adequately reflect the historical price changes faced by SNFs. Accordingly, we continue to believe that the forecast error adjustment mechanism should appropriately be reserved for the type of major, unexpected change that initially gave rise to this policy, rather than the minor variances that are a routine and inherent aspect of this type of statistical measurement. Further, we note that all of the Medicare prospective systems use an annual market basket adjustment factor to update rates to reflect inflation in the prices of goods and services used by providers.

3. 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 care 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. 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 10, 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 10—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 final rule, the BLS has published a historical time series of private nonfarm business MFP for 1987 through 2010, with 2010 being a preliminary value. Using this historical MFP series and the IGI forecasted series, IGI developed a forecast of MFP for 2011 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 2011 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, 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. 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 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.

a. 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 final rule, we 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.

We received the following comment on the incorporation of the MFP adjustment into the SNF market basket which, along with our response, appears below.

Comment: One commenter proposed to remove the statutory language requiring a multi-factor productivity adjustment to the SNF market basket increase and recommended an alternative approach to measuring productivity. The commenter recommended that CMS achieve productivity gains by implementing a mechanism that recognizes that the average length of stay in SNFs can be reduced, potentially resulting in aggregate savings.

Response: The commenter's proposal would require a change to the existing statute governing the SNF PPS and, therefore, the request is outside the scope of rulemaking. As stated previously, 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) of the Act is to be reduced annually by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

Accordingly, we are finalizing the methodology for calculating the MFP adjustment, and the incorporation of the MFP adjustment into the SNF market basket as discussed in this section of the final rule, and in section VI.C of the FY 2012 proposed rule (76 FR 26394 through 26396).

To calculate the MFP-adjusted update for the SNF PPS, we subtract the MFP percentage adjustment from the FY 2012 market basket percentage calculated using the FY 2004-based SNF market basket. In the FY 2012 proposed rule (76 FR 26395), we proposed that the end of the 10-year moving average of changes in the MFP would 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 is calculated as the 10-year moving average of changes in MFP for the period ending September 30, 2012. We 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 round the number up; if the number we are rounding is followed by 0, 1, 2, 3, or 4, we 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 2nd 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 is then reduced by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2012) of 1.0 percent, which is calculated as described above and based on IGI's 2nd quarter 2011 forecast. The resulting MFP-adjusted market basket increase factor is equal to 1.7 percent, or 2.7 percent less 1.0 percentage points.

Furthermore, we proposed that 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 will 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.

As discussed in the FY 2012 proposed rule (76 FR 26396), we proposed to revise § 413.337 to reflect the policies discussed above and to conform the regulations to the corresponding statutory requirements at section 1888(e)(4)(E) of the Act. As we did not receive any comments on our proposed changes to § 413.337, we are finalizing these changes as proposed in the FY 2012 proposed rule, subject to the technical correction noted below. Accordingly, as we proposed in the FY 2012 proposed rule, we are revising § 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), as we proposed, we are further revising § 413.337(d)(3) to state that the reduction of the market basket index percentage change by the MFP adjustment may result in the market basket index 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. We note that we have made a technical correction to the language we proposed for § 413.337(d)(3). In the last sentence, we are replacing the term ''market basket percentage change'' with ''market basket index percentage change'' to be consistent with the terminology used in the first sentence of § 413.337(d)(3) and in § 413.337(d)(1).

In addition, as we proposed, we are revising existing paragraphs (d)(1) and (d)(2) of § 413.337, as discussed below. First, we are revising § 413.337(d)(1) so that the text more accurately tracks the corresponding statutory requirements at section 1888(e)(4)(E) of the Act. As we stated in the FY 2012 proposed rule (76 FR 26396), 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 final 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 inadvertently failed to update the regulation text to conform with the BIPA requirements. Therefore, we are now revising § 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, as we proposed, we are revising § 413.337(d)(2) to specify the existing thresholds we employ in determining whether a forecast error adjustment is applicable.

b. Federal Rate Update Factor

Section 1888(e)(4)(E)(ii)(IV) of the Act requires that the update factor used to establish the FY 2012 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 is 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 1.0 percent as described in section III.F.3. The resulting MFP-adjusted market basket increase factor is equal to 1.7 percent, or 2.7 percent less 1.0 percentage point. We used this MFP-adjusted market basket update factor to compute the SNF PPS rate shown in Tables 2 and 3.

G. 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 final 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.hhs.gov/transmittals/downloads/ab001860.pdf.*

Section 313 of the BIPA further amended this provision by repealing its Part B aspect; that is, its applicability to services furnished to a resident during a SNF stay that Medicare Part A does not cover. (However, physical, occupational, and speech-language therapy remain subject to consolidated billing, regardless of whether the resident who receives these services is in a covered Part A stay.) We discuss this BIPA amendment in greater detail in the proposed and final rules for FY 2002 (66 FR 24020 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 45818–45819, July 30, 2004), as well as in Medicare Learning Network (MLN) Matters article MM3575, issued December 10, 2004, 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, enacted July 15, 2008). Specifically, section 149 of MIPPA amended section 1834(m)(4)(C)(ii) of the Act to create a new subclause (VII), which adds SNFs (as defined in section 1819(a) of the Act) to the list of entities that can serve as a telehealth ''originating site'' (that is, the location at which an eligible individual can receive, through the use of a telecommunications system, services furnished by a physician or other practitioner who is located elsewhere at a ''distant site'').

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

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

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

To date, the Congress has enacted no further legislation affecting the consolidated billing provision. However, as noted above and explained in the proposed rule for FY 2001 (65 FR 19232, April 10, 2000), the amendments enacted in section 103 of the BBRA not only identified for exclusion from this provision a number of particular service codes within four specified categories (that is, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices), but also gave the Secretary ''* * * the authority to designate additional, individual services for exclusion within each of the specified service categories.'' In the proposed rule for FY 2001, we also noted that the BBRA Conference Report (H.R. Rep. No. 106–479 at 854 (1999) (Conf. Rep.)) characterizes the individual services that this legislation targets for exclusion as ''* * * high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment [SNFs] receive under the prospective payment system * * *''. According to the conferees, section 103(a) ''is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs. For example * * * specific chemotherapy drugs * * * not typically administered in a SNF, or * * * requiring special staff expertise to administer * * *.'' By contrast, the remaining services within those four categories are not excluded (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 the FY 2012 proposed rule, we specifically invited public comments identifying codes in any of these four service categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) representing recent medical advances that might meet our criteria for exclusion from SNF consolidated billing (76 FR 26397). The comments that we received on this subject, and our responses, appear below.

Comment: A review of the particular codes that commenters submitted in response to the proposed rule's solicitation for comment revealed that a significant number were identical to

codes that had already been submitted for consideration during the public comment period on the FY 2010 SNF PPS proposed rule or in earlier years, and which we had already decided previously not to exclude. These included items such as hyperbaric oxygen treatments, total parenteral nutrition, wound care devices, blood products, and ''chemotherapy'' drugs that are actually used in treating diseases other than cancer. Other codes that commenters submitted did fall within the particular service categories that the BBRA authorizes for exclusion; however, these were codes that were already in existence as of the BBRA's enactment, but did not fall within the specific statutory code ranges that the BBRA designated for exclusion. Examples would include customized prosthetic device codes L5010 (''partial foot, molded socket, ankle height, with toe filler''), L5020 (''partial foot, molded socket, tibial tubercle height, with toe filler''), and L5987 (''all lower extremity prosthesis, shank foot system with vertical loading pylon'').

Response: As discussed in the applicable prior final rules, we decline to add to the exclusion list those services submitted by commenters that have already been considered and not excluded in previous years based on their being outside the particular service categories that the statute authorizes for exclusion. These services include hyperbaric oxygen treatments as discussed previously in the SNF PPS final rules for FY 2001 (65 FR 46790–91, July 31, 2000), FY 2002 (66 FR 39588, July 31, 2001), FY 2004 (68 FR 46060–62, August 4, 2003), FY 2006 (70 FR 45048–50, August 4, 2005), FY 2008 (72 FR 43430–32, August 3, 2007), FY 2009 (73 FR 46435–37, August 8, 2008), and FY 2010 (74 FR 40353–56, August 11, 2009); total parenteral nutrition as discussed previously in the SNF PPS final rules for FY 2002, FY 2004, and FY 2006; and wound care devices as discussed previously in the SNF PPS final rules for FY 2004 and FY 2006. For the same reason—that is, being outside the particular service categories that the statute authorizes for exclusion—we decline to adopt the suggestion to exclude certain blood products, hemophilia clotting factor and intravenous infusion of immunoglobulin (IVIG). With respect to the reiteration of previous requests to exclude as chemotherapy drugs certain medications that are actually used to treat diseases other than cancer, we note that as indicated previously in the FY 2010 SNF PPS final rule (74 FR 40354, August 11, 2009), such medications do not fall within the scope of ''chemotherapy'' drugs for purposes of this exclusion. In addition, regarding those particular codes (such as the three L codes specified above) that were already in existence as of the BBRA's enactment, we explained previously in the FY 2010 SNF PPS final rule (74 FR 40354, August 11, 2009) that our position has always been that the BBRA's discretionary authority to exclude codes within certain designated service categories applies solely to codes that were created subsequent to the BBRA's enactment, and not to those codes that were already in existence as of July 1, 1999 (the date that the legislation itself uses as the reference point for identifying the codes that it designates for exclusion). As we explained in the FY 2010 final rule (74 FR 40354), this position reflects the assumption that if a particular code was already in existence as of that date but not designated for exclusion, this meant that it was intended to remain within the SNF PPS bundle, subject to the BBRA Conference Report's provision for a GAO review of the code set that was conducted the following year (H.R. Rep. No. 106–479 at 854 (1999) (Conf. Rep.)). Accordingly, we decline to add these codes to the exclusion list.

Comment: One commenter requested us to consider a particular chemotherapy drug, TREANDA® (HCPCS code J9033), that the commenter recommended as meeting the BBRA's ''high-cost, low probability'' criteria for exclusion.

Response: We note that in one respect, this drug would appear to be similar to the three L codes discussed in the preceding comment, in that it falls within one of the particular service categories (that is, chemotherapy items) that the BBRA authorizes for exclusion, but the excluded code ranges specified in the BBRA skip over the particular code number to which it was assigned. However, in contrast to those L codes, code J9033 was not in use at the time of the BBRA's enactment; in fact, this drug did not actually come into existence until almost a decade later. Accordingly, as there is no basis for assuming at the outset that this particular code's omission from the excluded ranges indicated an intent for it to remain bundled, it then becomes appropriate for us to consider the possibility of excluding the drug from consolidated billing. We have determined that this drug does, in fact, qualify for exclusion in that its cost is comparable to other excluded chemotherapy drugs and it is rarely administered to SNF inpatients. Thus, it meets the ''high-cost, low probability'' standard in the SNF setting, as discussed in the BBRA Conference Report. Accordingly, this new exclusion will appear in a forthcoming consolidated billing update, with an effective date of October 1, 2011.

Comment: Some commenters suggested that we consider the exclusion of PROVENGE® (Sipuleucel-T, HCPCS code Q2043), which is used in treating certain cases of metastatic prostate cancer. PROVENGE® is made by selectively removing leukocytes (white blood cells) from the patient's blood and sending them to a factory, which adds a protein commonly found in prostate cancer and an immune stimulating agent to the leukocytes. All three are mixed with lactated ringers and then sent back to the physician to administer to the patient. The commenters cited this drug as meeting the applicable standards for exclusion of high cost and low probability.

Response: We note that in accordance with the National Coverage Determination that was released on June 30, 2011 (available online at *http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=247&fromdb=true*), PROVENGE® is not classified as a drug for purposes of this particular coverage, but rather, as a service that is furnished as an incident to the physician's professional services. As such, it remains subject to SNF consolidated billing, consistent with the longstanding policy that we first enunciated in the May 12, 1998 interim final rule (63 FR 26297):

> * * * while the SNF Consolidated Billing provision does not apply to the professional services that a physician or other exempt practitioner performs personally, it does apply to those services that are furnished to an SNF resident by someone other than the practitioner, as an incident to the practitioner's professional service. This position is consistent with the approach that has long been taken under the hospital bundling requirement, as well as with section 1888(e)(2)(A)(ii) of the Act, which specifically identifies ''physicians' services'' themselves as the service category that is excluded from SNF Consolidated Billing. Physicians' services, in turn, are covered by Part B under section 1861(s)(1) of the Act and are defined in section 1861(q) as being performed by a physician, while ''incident to'' services are covered under a separate statutory authority (section 1861(s)(2)(A) of the Act) and are, by definition, not performed by a physician * * * We believe that to do otherwise with regard to these ''incident to'' services would effectively create a loophole through which a potentially broad and diverse array of services could be unbundled, merely by virtue of being furnished under the general auspices of such practitioners. This, in turn, would ultimately defeat the very

purpose of the SNF Consolidated Billing provision—that is, to make the SNF itself responsible for billing Medicare for essentially all of its residents' services, other than those identified in a small number of narrow and specifically delimited exclusions. Further, as noted above, both the Consolidated Billing and SNF PPS provisions employ the same statutory list of excluded services. Thus, the approach we are adopting with regard to the limited range of services that qualify for exclusion is essential not only to safeguard the integrity of the Consolidated Billing requirement, but also that of the SNF PPS itself.

Comment: Some commenters reiterated previous suggestions on expanding the existing chemotherapy exclusion to encompass related drugs that are commonly administered in conjunction with chemotherapy to ameliorate the side effects of the chemotherapy drugs, such as anti-emetics (anti-nausea drugs).

Response: As we have noted previously in this final rule and in response to comments on this issue in the past (most recently, in the August 11, 2009 SNF PPS final rule for FY 2010 (74 FR 40354)), the BBRA authorizes us to identify additional service codes for exclusion only within those particular service categories—chemotherapy items; chemotherapy administration services; radioisotope services; and, customized prosthetic devices—that it has designated for this purpose, and does not give us the authority to exclude other services which, though they may be related, fall outside of the specified service categories themselves. Thus, while anti-emetics, for example, are commonly administered in conjunction with chemotherapy, they are not inherently chemotherapeutic in nature (that is, they are not themselves oncolytic drugs that actively destroy cancer cells) and, consequently, do not fall within the excluded chemotherapy category designated in the BBRA.

Comment: One commenter repeated calls from previous years to expand the existing exclusion for certain high-intensity outpatient hospital services to encompass services furnished in other, nonhospital settings, stating that such nonhospital services may be cheaper and more accessible in certain localities (such as rural settings) than those furnished by hospitals. In urging us to expand the administrative exclusion in this manner, the commenter also advanced the view that the test of service intensity under this exclusion was intended to be applied independently, regardless of whether the service in question is actually being furnished in the hospital setting.

Response: We have included in a number of previous rules an explanation of the setting-specific nature of the exclusion for certain high-intensity outpatient hospital services—most recently, in the FY 2010 SNF PPS final rule (74 FR 40355, August 11, 2009):

> We believe the comments that reflect previous suggestions for expanding this administrative exclusion to encompass services furnished in non-hospital settings indicate a continued misunderstanding of the underlying purpose of this provision. As we have consistently noted in response to comments on this issue in previous years * * * and as also explained in Medicare Learning Network (MLN) Matters article SE0432 (available online at *www.cms.hhs.gov/MLNMattersArticles/downloads/SE0432.pdf*), the rationale for establishing this exclusion was to address those types of services that are so far beyond the normal scope of SNF care that they require the intensity of the hospital setting in order to be furnished safely and effectively.
>
> Moreover, we note that when the Congress enacted the consolidated billing exclusion for certain RHC and FQHC services in section 410 of the MMA, the accompanying legislative history's description of present law acknowledged that the existing exclusions for exceptionally intensive outpatient services are specifically limited to ''* * * certain outpatient services from a Medicare-participating hospital or critical access hospital * * *'' (emphasis added). (See the House Ways and Means Committee Report (H. Rep. No. 108–178, Part 2 at 209), and the Conference Report (H. Conf. Rep. No. 108–391 at 641).) Therefore, these services are excluded from SNF consolidated billing only when furnished in the outpatient hospital or CAH setting, and not when furnished in other, freestanding (non-hospital or non-CAH) settings.

Further, the authority for us to establish a categorical exclusion for these services that would apply irrespective of the setting in which they are furnished does not exist in current law.

Finally, we do not agree with the commenter's analysis regarding the applicable standard for determining service intensity under this exclusion. Contrary to that commenter's statement, when we originally established the administrative exclusion for certain designated categories of high-intensity outpatient services, we did not envision creating a separate standard of service intensity that would exist independently from the service's performance in the hospital setting. In fact, the applicable discussion in the May 12, 1998 interim final rule (63 FR 26298) clearly indicates that this exclusion was created within the specific context of the concurrent development of a new PPS specifically for outpatient hospital services, reflecting the need ''* * * to delineate the respective areas of responsibility for the SNF under the Consolidated Billing provision, and for the *hospital* under the outpatient bundling provision, with regard to these services'' (emphasis added). This point was further reinforced in the subsequent SNF PPS final rule for FY 2000 (64 FR 41676, July 30, 1999), where we noted that

> * * * a key concern underlying the development of the consolidated billing exclusion of certain outpatient hospital services specifically involves the need to distinguish those services that comprise the SNF bundle from those that will become part of the outpatient hospital bundle that is currently being developed in connection with the outpatient hospital PPS. Accordingly, we are not extending the outpatient hospital exclusion from consolidated billing to encompass any other, freestanding settings.

Comment: One commenter noted that the administrative exclusion from consolidated billing for certain designated, highly intensive outpatient hospital services (such as emergency services) also serves to encompass an associated, medically necessary ambulance roundtrip from the SNF. The commenter requested clarification on whether this exclusion would still apply to an ambulance trip returning to the SNF following the receipt of emergency services, even though the emergency condition itself would have already been stabilized by that point.

Response: The return ambulance trip would still be excluded from consolidated billing in this scenario. As explained on page 3 of Medicare Learning Network (MLN) Matters Special Edition article #SE0433 (available online at *http://www.cms.gov/MLNMattersArticles/downloads/SE0433.pdf*),

> Since a beneficiary's departure from the SNF to receive one of these excluded types of outpatient hospital services is considered to end the beneficiary's status as an SNF resident for CB [consolidated billing] purposes with respect to those services, any associated ambulance trips are, themselves, excluded from CB as well. Therefore, an ambulance trip from the SNF to the hospital for the receipt of such services should be billed separately under Part B by the outside supplier. *Moreover, once the beneficiary's SNF resident status has ended in this situation, it does not resume until the point at which the beneficiary actually arrives back at the SNF; accordingly, the return ambulance trip from the hospital to the SNF would also be excluded from CB* (emphasis added).

Comment: One commenter requested that all chemotherapy drugs and customized prosthetic devices be excluded from consolidated billing, as well as transportation relating to the receipt of excluded radiation therapy services.

Response: As indicated previously in this final rule, in creating a statutory

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

Regarding the comment concerning transports related to radiation therapy, we note that radiation therapy is one of the administratively excluded categories of high-intensity outpatient hospital services. As indicated in the preceding comment, this exclusion already encompasses not only the service itself, but also any associated, medically necessary ambulance transportation between the SNF and the hospital.

H. 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 final rule for the SNF PPS also apply to all non-CAH swing-bed rural hospitals. A complete discussion of assessment schedules, the MDS and the transmission software (RAVEN–SB for Swing Beds) appears in the 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.* We received no comments on this aspect of the proposed rule.

IV. Analysis of and Responses to Public Comments on the FY 2011 Update Notice With Comment

In addition to responding to comments received on the FY 2012 proposed rule, we are also taking the opportunity to respond in this section to those comments not addressed elsewhere in this final rule that were received on the FY 2011 notice with comment period, as discussed in the FY 2012 proposed rule (76 FR 26368).

Comment: We received a number of comments related to the delayed implementation of RUG–IV, the implementation of HR–III, and the transition from RUG–IV to HR–III. Many commenters asked for details on how the transition would be done and how claims would be reprocessed upon successful implementation of HR–III. One commenter requested further detail on educational materials that would be made available to providers to ease the system transition once the HR–III grouper has been developed. Some commenters asked that CMS be as transparent as possible in its management of the transition to HR–III.

Response: As discussed in section I.F of this final rule, section 202 of the ''Medicare and Medicaid Extenders Act of 2010'' (Pub. L. 111–309), enacted December 15, 2010, repealed section 10325 of the Affordable Care Act, effectively leaving in place the RUG–IV system as implemented on October 1, 2010. Therefore, HR–III is no longer necessary and there will be no reprocessing of claims related to HR–III. Moreover, as we also noted previously in the FY 2012 SNF PPS proposed rule (76 FR 26368), the repeal of this provision ''* * * effectively renders moot any further discussion of public comments that we had invited on our planned implementation'' of the transition to the HR–III system.

V. Provisions of the Final Rule

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

As discussed previously in section III.F.3.a of this final rule, we are implementing section 3401(b) of the Affordable Care Act by revising § 413.337. We are adding a new paragraph (d)(3) to that section to require that, for FY 2012 and each subsequent FY, 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. In addition, consistent with section 1888(e)(5)(B)(ii) of the Act (as added by section 3401(b) of the Affordable Care Act), revised § 413.337(d)(3) also states that the reduction of the market basket index percentage change by the MFP adjustment may result in the market basket index 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 III.F.3, we are also revising 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 that we apply in determining whether a forecast error adjustment is appropriate (§ 413.337(d)(2)).

VI. Collection of Information Requirements

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

- 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 final rule with regard to resident assessment information used to determine facility

payments are currently approved under OMB control number (OCN): 0938–0739, which relates to the Medicare PPS Assessment Form (MPAF) information collection, and OCN: 0938–0872, which relates to the Minimum Data Set for Swing-Bed Hospitals. We note that this final rule will not affect the burden associated with either of those collections.

Section III.E.4 of this final rule 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 III.E.4 of this final rule, we are making certain modifications in the existing requirements for completing OMRAs. We introduced a new COT OMRA, to be completed whenever the intensity of therapy 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.

SNFs are 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 therapy changes 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 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) of 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 the first eight months of FY 2011 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 will 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 will also be used when providers find that the therapy provided a given resident warrants the resident being classified into a higher therapy RUG category. As stated above, providers currently are not required to report therapy changes that occur outside the observation window of a given PPS assessment; therefore, we do not have the relevant data to predict with certainty the number of COT OMRAs that may be required per year due to an increase in therapy. We have used the historical data available at this time to quantify situations where an increase in therapy occurs. 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 eight months of FY 2011 projected for the entire year, we estimate that the total COT OMRAs required due to an increase in therapy would be 71,330, or 5 times per facility per year. Therefore, the estimated total number of COT OMRAs per facility per year is 62. The total annual hour burden for completing COT OMRAs is estimated to be 737,003 hours for reporting, 147,401 hours for coding, and 29,480 hours for transmission, for a total burden of 913,884 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 $29.93 million, or $2,097.87 per facility.

Further, we note that the completion of an EOT–R OMRA, as discussed in section III.E.4, would be entirely voluntary on the part of the facility and, thus, would not represent the imposition of a mandatory burden.

VII. Economic Analyses

A. Regulatory Impact Analysis

1. Introduction

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

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated an economically significant rule, under section 3(f)(1) of Executive Order 12866. 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 final rule updates 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 factors to be applied in making the area wage adjustment. As these statutory provisions prescribe a detailed methodology for calculating and disseminating payment rates under the SNF PPS, we do not have the discretion to adopt an alternative approach.

3. Overall Impacts

We estimate the aggregate impact of the FY 2012 final rule would be a net decrease of $3.87 billion in payments to SNFs, resulting from a $600 million increase from the update to the payment rates and a $4.47 billion reduction from the recalibration of the case-mix adjustment. Accordingly, we have prepared a RIA that, to the best of our ability, presents the costs and benefits of the rulemaking.

The update set forth in this final 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.

4. Detailed Economic Analysis

This final 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, we estimate that the FY 2012 aggregate impact would be a net decrease of $3.87 billion in payments to SNFs, resulting from a $600 million increase from the update to the payment rates and a $4.47 billion reduction from the recalibration of the case-mix adjustment. The impact analysis of this final rule represents the projected effects of the changes in the SNF PPS from FY 2011 to FY 2012. We assess the effects by estimating payments 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 FY 2011 payment rates 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 fewer than 3,500 beneficiaries who qualify for the AIDS add-on payment. The impact to Medicare is included in the ''total'' column of Table 11. In updating the rates for FY 2012, we made a number of standard annual revisions and clarifications mentioned elsewhere in this final rule (for example, the update to the wage and market basket indexes used for adjusting the Federal rates).

We estimate that the aggregate impact for the FY 2012 updates discussed in this final rule would be a net decrease of $3.87 billion in payments to SNFs, resulting from a $600 million increase from the update to the payment rates and a $4.47 billion reduction from the recalibration of the case-mix adjustment. The FY 2012 impacts are presented in Table 11.

The breakdown of the various categories of data in Table 11 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 11 shows the number of facilities in the impact database.

The third column in Table 11 shows the effects of recalibrating the nursing CMIs of the RUG–IV therapy groups. As explained previously in section III.B.2 of this final rule, we are implementing the 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 the initial eight months of FY 2011 claims and MDS data. The total impact of this change is a decrease of 12.6 percent. We note that some individual providers may experience larger or smaller decreases in payment than others due to case-mix utilization.

The fourth column of Table 11 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 11 shows the effect of all of the changes on the FY 2012 payments. The update of 1.7 percent, consisting of the market basket increase of 2.7 percentage points, reduced by the 1.0 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 11.1 percent, assuming that facilities do not change their care delivery and billing practices in response.

As shown in Table 11, the combined effects of all of the changes vary by specific types of providers and by location.

TABLE 11—RUG–IV PROJECTED IMPACT TO THE SNF PPS FOR FY 2012

	Number of facilities	Revised CMIs percent	Update wage data	Total FY 2012 change (percent)
Group:				
Total	14,706	−12.6	0.0	−11.1
Urban	10,321	−12.8	0.0	−11.3
Rural	4,385	−11.9	0.1	−10.3
Hospital based urban	454	−12.4	0.1	−10.8
Freestanding urban	9,867	−12.8	0.0	−11.3
Hospital based rural	341	−11.3	0.0	−9.8
Freestanding rural	4,044	−11.9	0.1	−10.3
Urban by region:				
New England	807	−12.6	0.0	−11.1
Middle Atlantic	1,436	−12.9	0.1	−11.3
South Atlantic	1,714	−12.8	−0.1	−11.4
East North Central	2,001	−12.9	−0.5	−11.8
East South Central	493	−12.7	−0.4	−11.6
West North Central	848	−12.8	0.2	−11.1
West South Central	1,167	−12.6	0.5	−10.7
Mountain	472	−12.9	0.1	−11.3
Pacific	1,378	−12.8	0.3	−11.1
Outlying	5	−8.9	1.2	−6.3
Rural by region:				
New England	142	−11.7	1.0	−9.3
Middle Atlantic	236	−12.3	−0.1	−10.9
South Atlantic	558	−11.8	−0.2	−10.4
East North Central	891	−12.1	−0.2	−10.7
East South Central	464	−11.7	−0.5	−10.7
West North Central	1,043	−12.0	0.4	−10.1
West South Central	713	−11.7	0.8	−9.5
Mountain	219	−11.8	0.3	−10.0
Pacific	119	−11.8	1.0	−9.4
Ownership:				
Government	769	−12.4	−0.1	−11.0
Profit	10,172	−12.6	0.0	−11.1
Non-profit	3,765	−12.7	0.0	−11.2

Note: The Total column includes the 2.7 percent market basket increase, reduced by the 1.0 percentage point MFP adjustment. Additionally, we found no SNFs in rural outlying areas.

5. Alternatives Considered

As described above, the aggregate impact for FY 2012 of the updates discussed in this final rule would be a net decrease of $3.87 billion in payments to SNFs, resulting from a $600 million increase from the update to the payment rates and a $4.47 billion reduction from the recalibration of the case-mix adjustment. In view of the potential economic impact, we considered the alternatives described below.

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

pursuing alternatives for 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 final rule finalizes 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 results in case-mix weights that better reflect the resources used, produces more accurate payment, and represents an appropriate case-mix adjustment. Using FY 2011 data is consistent with our intent to make the change from the RUG–53 model to the RUG–IV model in a budget neutral manner.

In reviewing our initial projections, we found that the disparity between projected RUG–IV utilization for FY 2011 and actual RUG–IV utilization in FY 2011, 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 significant portion of the SNFs reporting 0 minutes of concurrent therapy for all MDS 3.0 assessments submitted for FY 2011. Many of these facilities reported large increases in the amount of group therapy provided during the same time period.

For the proposed rule, we used 3 months of data (first quarter FY 2011) to calculate the initial parity adjustment and stated that we would observe utilization trends for a greater period of FY 2011 to confirm our preliminary assessment. We have now used 8 months of FY 2011 data as the basis for the recalibration discussed in section III.B.2 above and the data have confirmed our preliminary assessment. Therefore, as discussed in section III.B.2 of this final rule, we are implementing a recalibration of the nursing CMIs of the RUG–IV therapy groups based on eight months of FY 2011 MDS and claims data.

Both during development of the proposed rule (76 FR 26372, 26404) and in response to comments we received on the proposed rule, as discussed in section III.B.2 above, we considered various alternatives for implementing a recalibrated case-mix adjustment. Most notably, as discussed in section III.B.2 of this final rule, we considered applying the recalibration to all of the nursing CMIs, rather than just the nursing CMIs for the RUG–IV therapy groups as we have finalized in this final rule.

However, as noted in the proposed rule (76 FR 26372, 26404), we found that an across-the-board recalibration of the nursing CMIs that included the complex medical groups (approximately 8 percent of the total SNF Part A population), would affect patients in these complex medical groups disproportionately and negatively. Moreover, we are concerned that reducing payment rates for both the therapy and the complex medical patients could inadvertently create an access problem for beneficiaries with complex medical care needs. The increasing volume of therapy patients during the past several years, in combination with the increasing SNF Medicare profit margins, suggests that the care needs for therapy patients may be more predictable and less costly than those for beneficiaries with severe medical conditions. In reviewing FY 2011 MDS assessment data, we found that approximately 30 percent of the SNF Part A patients did not have a medical need that would qualify them for coverage under the SNF PPS. Reducing the rates paid for beneficiaries with complex medical conditions at the same time therapy rates are being adjusted may create access problems for patients with complex medical and rehabilitation needs. Thus, while we considered an across-the-board recalibration of the nursing CMIs, we decided it would be more prudent to keep the payment levels for the low-volume complex medical services at their present levels for 2012. We plan to reassess the adequacy of the complex medical payment rates as part of the development of the NTA component discussed in section III.C.1 of this final rule. We believe that applying the recalibration to only the nursing CMIs of the RUG–IV therapy groups will restore the system to the intended budget neutrality and ensure adequate access to quality SNF care for the important subset of Medicare beneficiaries needing complex medical care.

As described in section III.B.2 of this final rule and in sections XII.A.5 and II.B.2 of the proposed rule, we also considered how the recalibration might be implemented so as to mitigate the economic impact of the recalibration on facilities. Specifically, we considered mitigating the impact of the recalibration by phasing in the negative adjustments prospectively over multiple years until parity was achieved. However, as discussed elsewhere in this preamble, we believe that in implementing RUG–IV, it is essential that we stabilize the baseline as quickly as possible without creating a significant adverse effect on the industry or to beneficiaries. For the reasons discussed in section II.B.2 of this final rule, we do not believe that implementation of the full recalibration in FY 2012 should negatively impact facilities, beneficiaries or quality of care. Moreover, implementing the recalibration over a multi-year period would continue the significant overpayments observed in FY 2011 and could further destabilize the SNF PPS.

We received a number of comments on the impact analysis contained in the proposed rule which, along with our responses, appear below.

Comment: Several commenters believed that CMS did not consider adequately possible alternative methodologies for applying or implementing the recalibration of the case-mix indexes. Specifically, commenters believed that CMS should consider a phase-in approach for the recalibration, if it were to be finalized.

Response: We believe that the discussion of alternatives in this section above, in section III.B.2 above, as well as in the FY 2012 proposed rule (76 FR 26372, 26403 through 26404) provides sufficient consideration of alternatives as well as appropriate justification for our finalized changes. Regarding a phase-in approach, we noted in section III.B.2 above our belief that the 18.1 percent SNF profit margins for Medicare even before the FY 2011 overpayments occurred would justify a full recalibration in FY 2012. It is also important to note that this recalibration would serve to remove an unintended spike in payments rather than decreasing an otherwise appropriate payment amount; thus, we do not believe that the recalibration should negatively affect facilities, beneficiaries, or quality of care, or create an undue hardship on providers. In fact, notwithstanding the recalibration, the FY 2012 payment rates will actually be 3.4 percent higher than the rates established for FY 2010, the last period prior to the unintended spike in payment levels. We continue to believe that in implementing RUG–IV, it is essential that we stabilize the baseline as quickly as possible without creating a significant adverse effect on the industry or to beneficiaries. Utilizing a phase-in approach would only add to, rather than reduce, the cumulative excess payments.

Comment: Several commenters expressed concern that the impact analysis presented in the proposed rule did not account adequately for the total

economic impact of the policy changes discussed in the FY 2012 proposed rule. One commenter stated specifically that the implementation of the proposed changes could lead the U.S. economy back into a deep recession.

Response: As indicated in Table 11 above, the changes due to the recalibration of the CMIs (which is arguably the only proposed change which would have a definitive negative impact on current facility payments) are expected to result in a decrease in Medicare payments to SNFs of 12.6 percent. We note that the recalibration is only intended to restore budget neutrality between the RUG–53 and RUG–IV case-mix systems, which effectively will align overall payments under RUG–IV in FY 2012 with those under RUG–III, not accounting for subsequent increases associated with the annual market basket increase.

Based on a comparative analysis of the actual payment amounts reflected on claims paid in FY 2010 and in FY 2011, payments to facilities increased in FY 2011 by an average of approximately $66 per day per resident for all providers. Furthermore, as noted in section III.B.2 of this final rule, the aggregate Medicare margin for freestanding SNFs in FY 2009, prior to the implementation of the parity adjustment in FY 2011 and the resulting overpayments, was 18.1 percent, up from 16.6 percent in 2008. Therefore, given these high Medicare margins coupled with the fact that Medicare payments represent a small percentage of aggregate facility revenues (considering all payers), we do not believe it can be concluded that a return to the intended payment levels after the FY 2011 short-term spike in payments will result in a direct and significant negative macroeconomic effect on the U.S. economy. For these reasons, we believe that the regulatory impact analysis both in this final rule and in the proposed rule adequately assesses the economic impact of the changes to the RUG–IV system.

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 12, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. Tables 12 provides our best estimate of the possible changes in Medicare payments under the SNF PPS as a result of the policies in this final rule, based on the data for 14,706 SNFs in our database. All expenditures are classified as transfers to Medicare providers (that is, SNFs).

TABLE 12—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2011 SNF PPS FISCAL YEAR TO THE 2012 SNF PPS FISCAL YEAR

Category	Transfers
Annualized Monetized Transfers	−$3.87 billion.*
From Whom To Whom?	Federal Government to SNF Medicare Providers.

*The net decrease of $3.87 billion in transfer payments is a result of the decrease of $4.47 billion due to the recalibration of the case mix adjustment, together with the increase of $600 million due to the MFP-adjusted market basket update.

7. Conclusion

The overall estimated payments for SNFs in FY 2012 are projected to decrease by $3.87 billion, or 11.1 percent, compared with those in FY 2011. We estimate that under RUG–IV, SNFs in urban and rural areas would experience, on average, an 11.3 and 10.3 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 11.8 percent. In order to have achieved parity between the RUG–53 and RUG–IV case-mix systems in FY 2011, aggregated payments would have had to have been 11.1 percent lower. It should also be noted that the FY 2012 payment rates, which remove the unanticipated excess payments resulting from the FY 2011 parity adjustment, are still 3.4 percent higher than the FY 2010 rates, the last fiscal year before the introduction of RUG–IV.

B. Regulatory Flexibility Act Analysis

The Regulatory Flexibility Act (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.

This final 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 discussed in section II.B.2 above would result in a net decrease of $3.87 billion in payments to SNFs for FY 2012. This reflects a $600 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 11, the estimated effect of the recalibration on facilities for FY 2012 would be an aggregate negative impact of 11.1 percent. While it is projected in Table 11 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.

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 11. Therefore, the Secretary has determined that this final rule may have a significant impact on a substantial number of small entities.

We offer an analysis of the alternatives considered in section VII.A.4 of this final rule. The analysis above, together with the remainder of this preamble, constitutes the final regulatory flexibility analysis.

In addition, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis (RIA) 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. This final rule will affect small rural hospitals that (a) furnish SNF services under a swing-bed agreement or (b) have a hospital-based SNF. We anticipate that the impact on small rural hospitals would be similar to the impact on SNF providers overall. Therefore, the Secretary has determined that this final rule may have a significant impact on the operations of a substantial number of small rural hospitals.

Comment: One commenter believed that the RFA analysis and RIA discussed in the proposed rule did not sufficiently account for the impact of the proposed changes, specifically the recalibration of the case-mix indexes, on small entities. Also, the commenter pointed out that the portion of SNFs which may be characterized properly as small entities may, in fact, be higher than our estimates. The commenter asserted that in evaluating the effect of the proposed changes on small entities ''as a whole,'' the analysis must necessarily consider their effect on the entity's overall margins. This commenter also asserted that CMS failed to provide sufficient discussion of possible alternatives. The commenter further suggested that the RIA cannot also serve to meet the requirements of the RFA.

Response: We do not agree with the commenter's assertion that the RFA or RIA discussions in the proposed rule were insufficient. First, we would note that, as discussed above, approximately 91 percent of all SNFs may be classified as small entities. As the commenter pointed out, the portion of SNFs which may be characterized properly as small entities may, in fact, be higher than our estimates. Therefore, any discussion of impacts throughout the proposed rule, as well as in this final rule, may be directly characterized as an analysis of the impact of the FY 2012 changes to the SNF PPS on small entities. Moreover, the focus on small entities in this instance (a category that would include the small rural hospitals that are the subject of a RIA) also means that the analyses required under the RIA and the RFA are, in fact, directly interlinked in this situation, as essentially the same factors are being examined in both contexts. Also, guidance issued by the Department of Health and Human Services on the proper assessment of the impact on small entities in rulemakings, utilizes a total cost or revenue impact of 3 to 5 percent as a significance threshold under the RFA analysis and not overall margins. As a result, the addition of other (non-Medicare) revenue streams effectively dilutes the impact of any Medicare changes, as we noted previously in this discussion as well as in the proposed rule: ''* * * for most facilities, when all payers are included in the revenue stream, the overall impact effect [of the Medicare changes] to total revenues should be substantially less * * *'' (76 FR 26405).

Furthermore, we would note that we provided additional data on our Web site on therapy utilization trends for the different types of SNF providers (profit, non-profit, and government), which are available online at *http://www.cms.gov/SNFPPS/02_Spotlight.asp.* This additional data, as well as our impact analysis in the proposed rule, illustrated that all SNFs, including small entities and non-profits, have experienced a significant increase in payments in FY 2011. We do not believe that the recalibration constitutes a rate cut but instead represents a return to the appropriate level of SNF payments, which have been found to be more than adequate for SNFs and small entities within the SNF industry. This information, as well as the discussion of alternatives in section XII.A.5 of the proposed rule, is sufficient to fulfill our obligations under the RFA.

Finally, given our discussion of alternatives in section VIII.D of this final rule and elsewhere in this preamble, and our analysis of the potential impacts on the SNF industry as a whole, we believe that the requirements under the RFA for providing this final RFA analysis have been properly addressed.

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 final 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 final rule would have no substantial direct effect on State and local governments, preempt State law, or otherwise have Federalism implications.

List of Subjects in 42 CFR Part 413

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

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as 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 1.0 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 1.0 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 index percentage change by the MFP adjustment may result in the market basket index 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.

* * * * *

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

Dated: July 21, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: July 27, 2011.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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 final 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	0.8444
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	0.3611
10420	Akron, OH Portage County, OH Summit County, OH	0.8814
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.8687
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8680
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9550
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8026
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9260
11020	Altoona, PA Blair County, PA	0.8917
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8714
11180	Ames, IA Story County, IA	1.0009
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2133
11300	Anderson, IN Madison County, IN	0.9266
11340	Anderson, SC Anderson County, SC	0.8524
11460	Ann Arbor, MI Washtenaw County, MI	1.0128
11500	Anniston-Oxford, AL Calhoun County, AL	0.7979

11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9226
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.8918
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9642
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	0.9575
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1033
12220	Auburn-Opelika, AL Lee County, AL	0.7877
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9529
12420	Austin-Round Rock-San Marcos, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9535
12540	Bakersfield-Delano, CA Kern County, CA	1.1817
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	1.0151
12620	Bangor, ME Penobscot County, ME	0.9979
12700	Barnstable Town, MA Barnstable County, MA	1.2838
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	0.8523
12980	Battle Creek, MI Calhoun County, MI	0.9935

13020	Bay City, MI Bay County, MI	0.8927
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8723
13380	Bellingham, WA Whatcom County, WA	1.1748
13460	Bend, OR Deschutes County, OR	1.1395
13644	Bethesda-Rockville-Frederick, MD Frederick County, MD Montgomery County, MD	1.0305
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8576
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8731
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	0.8436
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7232
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8281
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8725
14060	Bloomington-Normal, IL McLean County, IL	0.9477
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9279
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2283
14500	Boulder, CO Boulder County, CO	1.0086
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8599
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.1288
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2914
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9183
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9068
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9750
15500	Burlington, NC Alamance County, NC	0.8665
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0021
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1210
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0202

15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8939
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9341
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.8672
16180	Carson City, NV Carson City, NV	1.0597
16220	Casper, WY Natrona County, WY	1.0117
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8831
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9890
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8144
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9063
16740	Charlotte-Gastonia-Rock Hill, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9321
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9188
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.8740
16940	Cheyenne, WY Laramie County, WY	0.9844
16974	Chicago-Joilet-Naperville, 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	1.0600
17020	Chico, CA Butte County, CA	1.1094
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	0.9430

17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8193
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.7674
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.8941
17660	Coeur d'Alene, ID Kootenai County, ID	0.9367
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9690
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9846
17860	Columbia, MO Boone County, MO Howard County, MO	0.8105
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8758
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.9040
18020	Columbus, IN Bartholomew County, IN	0.9723
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	0.9994
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8677
18700	Corvallis, OR Benton County, OR	1.0898
18880	Crestview-Fort Walton Beach-Destin, FL Okaloosa County, FL	0.8961
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.7825
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	0.9844
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8374
19180	Danville, IL Vermilion County, IL	0.9832
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.7896
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.9056

19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9281
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7334
19500	Decatur, IL Macon County, IL	0.8008
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8865
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	1.0647
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9801
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9511
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7130
20100	Dover, DE Kent County, DE	0.9909
20220	Dubuque, IA Dubuque County, IA	0.8698
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0335
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9699
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9597
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.0868
20940	El Centro, CA Imperial County, CA	0.9601
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8719
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9405
21300	Elmira, NY Chemung County, NY	0.8522
21340	El Paso, TX El Paso County, TX	0.8515
21500	Erie, PA Erie County, PA	0.8147
21660	Eugene-Springfield, OR Lane County, OR	1.1587
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8679

21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1322
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.3823
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8136
22140	Farmington, NM San Juan County, NM	0.9795
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9213
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9263
22380	Flagstaff, AZ Coconino County, AZ	1.2427
22420	Flint, MI Genesee County, MI	1.1137
22500	Florence, SC Darlington County, SC Florence County, SC	0.8217
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.7738
22540	Fond du Lac, WI Fond du Lac County, WI	0.9291
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9876
22744	Fort Lauderdale-Pompano Beach-Deerfield, FL Broward County, FL	1.0160
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7620
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9368
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9525
23420	Fresno, CA Fresno County, CA	1.1281
23460	Gadsden, AL Etowah County, AL	0.7934
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9375
23580	Gainesville, GA Hall County, GA	0.9010
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9193
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8504
24140	Goldsboro, NC Wayne County, NC	0.8690
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7573
24300	Grand Junction, CO Mesa County, CO	0.9394

24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9145
24500	Great Falls, MT Cascade County, MT	0.8462
24540	Greeley, CO Weld County, CO	0.9553
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9824
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.8798
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9637
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9620
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3730
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.8505
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9168
25260	Hanford-Corcoran, CA Kings County, CA	1.0700
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9400
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.8773
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.0700
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7940
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.8859
25980	Hinesville-Fort Stewart, GA[1] Liberty County, GA Long County, GA	0.8926
26100	Holland-Grand Haven, MI Ottawa County, MI	0.8523
26180	Honolulu, HI Honolulu County, HI	1.1698
26300	Hot Springs, AR Garland County, AR	0.9076
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7841
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	0.9945

26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.8893
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.8996
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9336
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	0.9662
26980	Iowa City, IA Johnson County, IA Washington County, IA	1.0070
27060	Ithaca, NY Tompkins County, NY	0.8819
27100	Jackson, MI Jackson County, MI	0.8938
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8172
27180	Jackson, TN Chester County, TN Madison County, TN	0.8149
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.8882
27340	Jacksonville, NC Onslow County, NC	0.8074
27500	Janesville, WI Rock County, WI	0.9234
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8222
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7796
27780	Johnstown, PA Cambria County, PA	0.8715
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7718
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8227
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	0.9939
28100	Kankakee-Bradley, IL Kankakee County, IL	0.9807

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	0.9637
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	0.9582
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.9501
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.7399
28740	Kingston, NY Ulster County, NY	0.9170
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.7838
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9186
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9685
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9507
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8319
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7998
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0311
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	0.9967
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8432
29540	Lancaster, PA Lancaster County, PA	0.9439
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0477
29700	Laredo, TX Webb County, TX	0.7730
29740	Las Cruces, NM Dona Ana County, NM	0.9106
29820	Las Vegas-Paradise, NV Clark County, NV	1.2050
29940	Lawrence, KS Douglas County, KS	0.8853
30020	Lawton, OK Comanche County, OK	0.8545
30140	Lebanon, PA Lebanon County, PA	0.8042
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9067

30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9038
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.8833
30620	Lima, OH Allen County, OH	0.9371
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9612
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	0.8558
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8592
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8530
31020	Longview, WA Cowlitz County, WA	0.9989
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2287
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	0.8900
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8794
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8768
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9122
31460	Madera-Chowchilla, CA Madera County, CA	0.8114
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1234
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0083
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS	0.7912

31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9346
31900	Mansfield, OH Richland County, OH	0.9215
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3676
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.8878
32780	Medford, OR Jackson County, OR	1.0318
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	0.9275
32900	Merced, CA Merced County, CA	1.2424
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0085
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9358
33260	Midland, TX Midland County, TX	1.0514
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	0.9961
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	1.1105
33540	Missoula, MT Missoula County, MT	0.9154
33660	Mobile, AL Mobile County, AL	0.8002
33700	Modesto, CA Stanislaus County, CA	1.2670
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7915
33780	Monroe, MI Monroe County, MI	0.8727
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8103
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8197
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7031
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0235
34620	Muncie, IN Delaware County, IN	0.7817

34740	Muskegon-Norton Shores, MI Muskegon County, MI	0.9967
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.8653
34900	Napa, CA Napa County, CA	1.4511
34940	Naples-Marco Island, FL Collier County, FL	0.9740
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	0.9340
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2416
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1322
35300	New Haven-Milford, CT New Haven County, CT	1.1556
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	0.9026
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	1.3052
35660	Niles-Benton Harbor, MI Berrien County, MI	0.8653
35840	North Port-Bradenton-Sarasota, FL Manatee County, FL Sarasota County, FL	0.9435
35980	Norwich-New London, CT New London County, CT	1.1227
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6080
36100	Ocala, FL Marion County, FL	0.8449
36140	Ocean City, NJ Cape May County, NJ	1.0641
36220	Odessa, TX Ector County, TX	0.9809
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9220
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	0.8934

36500	Olympia, WA Thurston County, WA	1.1339
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	0.9864
36740	Orlando-Kissimmee-Sanford, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9128
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9319
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8202
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.2830
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9042
37380	Palm Coast, FL Flagler County, FL	0.9373
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL	0.8388
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7647
37700	Pascagoula, MS George County, MS Jackson County, MS	0.7885
37764	Peabody, MA Essex County, MA	1.0698
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8013
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.8830
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0760
38060	Phoenix-Mesa-Glendale, AZ Maricopa County, AZ Pinal County, AZ	1.0566
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.7700
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8669
38340	Pittsfield, MA Berkshire County, MA	1.0616
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9426
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4185
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	0.9661

38900	Portland-Vancouver-Hillsboro, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.1454
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	0.9784
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1339
39140	Prescott, AZ Yavapai County, AZ	1.2261
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	1.0639
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9404
39380	Pueblo, CO Pueblo County, CO	0.8668
39460	Punta Gorda, FL Charlotte County, FL	0.8801
39540	Racine, WI Racine County, WI	0.8630
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9648
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0203
39740	Reading, PA Berks County, PA	0.9212
39820	Redding, CA Shasta County, CA	1.5584
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0596
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	0.9791
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1463
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.9166
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.0802

40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8602
40420	Rockford, IL Boone County, IL Winnebago County, IL	0.9938
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH	1.0185
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9018
40660	Rome, GA Floyd County, GA	0.8838
40900	Sacramento-Arden-Arcade-Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.3777
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.8512
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.0724
41100	St. George, UT Washington County, UT	0.9070
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0255
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	0.9165
41420	Salem, OR Marion County, OR Polk County, OR	1.1224
41500	Salinas, CA Monterey County, CA	1.5604
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9227
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9415
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8273
41700	San Antonio-New Braunfels, 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	0.9006

41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1950
41780	Sandusky, OH Erie County, OH	0.8167
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.5904
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.4612
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.6878
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	0.4340
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.3072

42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2042
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.2246
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.7111
42140	Santa Fe, NM Santa Fe County, NM	1.0660
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.6102
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9095
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8328
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1541
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9032
43100	Sheboygan, WI Sheboygan County, WI	0.9303
43300	Sherman-Denison, TX Grayson County, TX	0.8011
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8505
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9538
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9153
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9426
43900	Spartanburg, SC Spartanburg County, SC	0.9325
44060	Spokane, WA Spokane County, WA	1.0504
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.8958
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0247
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8680
44220	Springfield, OH Clark County, OH	0.8981
44300	State College, PA Centre County, PA	0.9251
44600	Steubenville-Weirton, OH-WV Jefferson County, OH Brooke County, WV Hancock County, WV	0.7054
44700	Stockton, CA San Joaquin County, CA	1.3052
44940	Sumter, SC Sumter County, SC	0.7551
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9776

45104	Tacoma, WA Pierce County, WA	1.1384
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8593
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9072
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9209
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.7937
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9148
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8818
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0062
46060	Tucson, AZ Pima County, AZ	0.9318
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8362
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8664
46340	Tyler, TX Smith County, TX	0.8335
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8441
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.7997
46700	Vallejo-Fairfield, CA Solano County, CA	1.4636
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8434
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0222

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	0.9001
47300	Visalia-Porterville, CA Tulare County, CA	1.0343
47380	Waco, TX McLennan County, TX	0.8559
47580	Warner Robins, GA Houston County, GA	0.8245
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9625
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	1.0807
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8372
48140	Wausau, WI Marathon County, WI	0.8962
48300	Wenatchee-East Wenatchee, WA Chelan County, WA Douglas County, WA	1.0168
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9823
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6735
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.8696

48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	1.0097
48700	Williamsport, PA Lycoming County, PA	0.8084
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0662
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9107
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	0.9106
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.8343
49340	Worcester, MA Worcester County, MA	1.1076
49420	Yakima, WA Yakima County, WA	1.0433
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3757
49620	York-Hanover, PA York County, PA	0.9675
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8328
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1808
49740	Yuma, AZ Yuma County, AZ	0.9350

[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	0.7260
2	Alaska	1.2846
3	Arizona	0.8826
4	Arkansas	0.7194
5	California	1.2194
6	Colorado	1.0126
7	Connecticut	1.1287
8	Delaware	1.0008
10	Florida	0.8361
11	Georgia	0.7547
12	Hawaii	1.1200
13	Idaho	0.7531
14	Illinois	0.8426
15	Indiana	0.8551
16	Iowa	0.8618
17	Kansas	0.8041
18	Kentucky	0.7825
19	Louisiana	0.7769
20	Maine	0.8581
21	Maryland	0.9291
22	Massachusetts	1.3962
23	Michigan	0.8295
24	Minnesota	0.9107
25	Mississippi	0.7539
26	Missouri	0.7673
27	Montana	0.8615

State Code	Nonurban Area	Wage Index
28	Nebraska	0.8872
29	Nevada	0.9637
30	New Hampshire	1.0441
31	New Jersey[1]	-----
32	New Mexico	0.8878
33	New York	0.8152
34	North Carolina	0.8288
35	North Dakota	0.7295
36	Ohio	0.8455
37	Oklahoma	0.7848
38	Oregon	1.0337
39	Pennsylvania	0.8450
40	Puerto Rico[1]	0.4047
41	Rhode Island[1]	-----
42	South Carolina	0.8277
43	South Dakota	0.8300
44	Tennessee	0.7734
45	Texas	0.7934
46	Utah	0.8719
47	Vermont	0.9709
48	Virgin Islands	0.7505
49	Virginia	0.7817
50	Washington	1.0231
51	West Virginia	0.7371
52	Wisconsin	0.8977
53	Wyoming	0.9433
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.

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