DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 488

[CMS-1605-F]

RIN 0938-AS07

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2015

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

ACTION: Final rule.

SUMMARY: This final rule updates the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for fiscal year (FY) 2015. In addition, it adopts the most recent Office of Management and Budget (OMB) statistical area delineations to identify a facility's urban or rural status for the purpose of determining which set of rate tables will apply to the facility, and to determine the SNF PPS wage index including a 1-year transition with a blended wage index for all providers for FY 2015. This final rule also contains a revision to policies related to the Change of Therapy (COT) Other Medicare Required Assessment (OMRA). This final rule includes a discussion of a provision related to the Affordable Care Act involving Civil Money Penalties. Finally, this final rule discusses the SNF therapy payment research currently underway within CMS, observed trends related to therapy utilization among SNF providers, and the agency's commitment to accelerating health information exchange in SNFs.

DATES: Effective Date: This final rule is effective on October 1, 2014.

FOR FURTHER INFORMATION CONTACT:

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

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

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

Karen Tritz, (410) 786-8021, for information related to Civil Money Penalties.

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

SUPPLEMENTARY INFORMATION:

Availability of Certain Tables Exclusively Through the Internet on the CMS Website

In the past, tables setting forth the Wage Index for Urban Areas Based on CBSA Labor Market Areas and the Wage Index Based on CBSA Labor Market Areas for Rural Areas were published in the **Federal Register** as an Addendum to the annual SNF PPS rulemaking (that is, the SNF PPS proposed and final rules or, when applicable, the current update notice). However, as finalized in the FY 2014 SNF PPS final rule (78 FR 47936, 47964), beginning in FY 2015, these wage index tables are no longer published in the **Federal Register**. Instead, these tables will be available exclusively through the Internet. The wage index tables for this final rule are available exclusively through the Internet on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.

Readers who experience any problems accessing any of the tables that are posted on the CMS website identified above should contact Kia Sidbury at (410) 786-7816.

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

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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 abbreviations and their corresponding terms in alphabetical order below:

AIDS	Acquired Immune Deficiency Syndrome
ARD	Assessment reference date
BBA	Balanced Budget Act of 1997, Pub. L. 105-33
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106-113

BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106-554
CAH	Critical access hospital
CBSA	Core-based statistical area
CFR	Code of Federal Regulations
CMI	Case-mix index
CMS	Centers for Medicare & Medicaid Services
COT	Change of therapy
EHR	Electronic health record
EOT	End of therapy
FQHC	Federally qualified health center
FR	Federal Register
FY	Fiscal year
GAO	Government Accountability Office
HCPCS	Healthcare Common Procedure Coding System
HIE	Health information exchange
HOMER	Home office Medicare records
ICR	Information Collection Requirements
IGI	IHS (Information Handling Services) Global Insight, Inc.
IPPS	Inpatient Prospective Payment System
MDS	Minimum data set
MFP	Multifactor productivity
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173

MSA	Metropolitan statistical area
NAICS	North American Industrial Classification System
NF	Nursing facility
OMB	Office of Management and Budget
OMRA	Other Medicare Required Assessment
PAMA	Protecting Access to Medicare Act of 2014, Pub. L. 113-93
PPS	Prospective Payment System
RAI	Resident assessment instrument
RAVEN	Resident assessment validation entry
RFA	Regulatory Flexibility Act, Pub. L. 96-354
RHC	Rural health clinic
RIA	Regulatory impact analysis
RUG-III	Resource Utilization Groups, Version 3
RUG-IV	Resource Utilization Groups, Version 4
RUG-53	Refined 53-Group RUG-III Case-Mix Classification System
SCHIP	State Children's Health Insurance Program
SNF	Skilled nursing facility
STM	Staff time measurement
STRIVE	Staff time and resource intensity verification
UMRA	Unfunded Mandates Reform Act, Pub. L. 104-4

I. Executive Summary

A. Purpose

This final rule updates the SNF prospective payment rates for FY 2015 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, certain specified information relating to the payment update (see section II.C.).

B. Summary of Major Provisions

In accordance with sections 1888(e)(4)(E)(ii)(IV) and 1888(e)(5) of the Act, the federal rates in this final rule reflect an update to the rates that we published in the SNF PPS final rule for FY 2014 (78 FR 47936) which reflects the SNF market basket index, adjusted by the forecast error correction, if applicable, and the multifactor productivity adjustment for FY 2015.

C. Summary of Impacts

Provision Description	Total Transfers
FY 2015 SNF PPS payment rate update.	The overall economic impact of this final rule is an estimated increase of $750 million in aggregate payments to SNFs during FY 2015.

II. Background

A. Statutory Basis and Scope

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

Part B and which are furnished to Medicare beneficiaries who are residents in a SNF during a covered Part A stay. A comprehensive discussion of these provisions appears in the May 12, 1998 interim final rule (63 FR 26252). In addition, a detailed discussion of the legislative history of the SNF PPS is available online at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_07302013.pdf.

As noted in section I.F. of that legislative history, on March 23, 2010, the Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted. Then, the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted on March 30, 2010) amended certain provisions of Pub. L. 111-148 and certain sections of the Social Security Act and, in certain instances, included "freestanding" provisions. In this final rule, Pub. L. 111-148 and Pub. L. 111-152 are collectively referred to as the "Affordable Care Act." In section IV.D.4 of this final rule, we discuss one specific provision related to the Affordable Care Act involving Civil Money Penalties.

B. Initial Transition

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

C. Required Annual Rate Updates

Section 1888(e)(4)(E) of the Act requires the SNF PPS payment rates to be updated annually. The most recent annual update occurred in a final rule that set forth updates to the SNF PPS payment rates for FY 2014 (78 FR 47936, August 6, 2013). We subsequently published two correction notices (78 FR 61202, October 3, 2013, and 79 FR 63, January 2, 2014) with respect to that final rule, as well as a notice that made corrections to the January 2, 2014 correction notice (79 FR 1742, January 10, 2014).

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

- The unadjusted federal per diem rates to be applied to days of covered SNF services furnished during the upcoming FY.
- The case-mix classification system to be applied for these services during the upcoming FY.
- 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 the required annual updates to the per diem payment rates for SNFs for FY 2015.

III. Summary of the Provisions of the FY 2015 SNF PPS Proposed Rule

In the FY 2014 SNF PPS proposed rule (79 FR 25767), we proposed an update to the payment rates used under the PPS for SNFs for FY 2015. In addition, we proposed to adopt the most recent OMB statistical area delineations to identify a facility's urban or rural status for the purpose of determining which set of rate tables would apply to the facility, and to determine the SNF PPS wage index including a proposed 1-year transition with a blended wage index for all providers for FY 2015. It also included a discussion of the SNF therapy payment research currently underway within CMS. The proposed rule also proposed a revision to policies related

to the COT OMRA. The proposed rule included a discussion of a provision related to the Affordable Care Act involving Civil Money Penalties. Finally, the proposed rule included a discussion of observed trends related to therapy utilization among SNF providers and a discussion of accelerating health information exchange in SNFs.

IV. Analysis of and Responses to Public Comments on the FY 2015 SNF PPS Proposed Rule

In response to the publication of the FY 2015 SNF PPS proposed rule, we received 26 timely public comments from individuals, 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 2015 SNF PPS Proposed Rule

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

Comment: We received a few comments about the operational aspects of updating the subregulatory guidance contained in the MDS RAI manual, including the frequency of updates and process for announcing revisions. These commenters stated that CMS has made major revisions to the RAI manual with little or no notice to providers and without meaningful consultation with stakeholders. These commenters further stated that CMS should utilize a more formal process for announcing revisions and reinterpretations of the RAI manual.

Response: We appreciate the commenters' suggestions and we recognize that the MDS 3.0 is a complex assessment tool. We have provided education, clarification and training

associated with the MDS 3.0, as well as discussion of potential revisions and updates to the RAI manual, at national training conferences, and postings to the MDS 3.0 and SNF PPS website. We also provide support to and consult with stakeholders through oral and written inquiries and, most notably, through our regular and special Open Door Forums. We are committed to continuing training on the MDS 3.0 and to ensuring that the update process is predictable for providers and gives providers sufficient notice of and time to discuss, incorporate and train on any revisions to the manual which may occur. We will take the commenters' suggestions into consideration for future operational enhancements.

Comment: Several commenters raised concerns regarding the compensation for Non-Therapy Ancillaries (NTAs), specifically for hospital-based SNFs within the SNF PPS. These commenters urged CMS to expedite the research necessary to develop a new model for NTA payment and to implement such a model shortly thereafter.

Response: We appreciate the comments on this topic and the broad support for our research efforts on the development of a new NTA payment model. Furthermore, the comments we received provided a number of interesting and creative ideas for future consideration. We look forward to working with providers and stakeholders in the future as we continue to research possible refinements to address concerns with the SNF PPS, such as the SNF therapy research work discussed in section IV.D.2 of this final rule.

Comment: One commenter recommended that we address the need for CMS to broaden the categories of healthcare professionals who may order patient diets. The commenter stated that such a change will improve patient health and allows SNFs to respond more quickly to resident nutritional needs.

Response: We appreciate this comment, but note that the specific issues the commenter raised about who, within a SNF, may prescribe resident diets relate to the certification standards

for long-term care facilities, and therefore, are beyond the scope of this final rule. We have, however, shared this comment with CMS's survey and certification staff so that they can consider these suggestions as part of their ongoing review and refinement of our policies.

Comment: One commenter supported CMS's proposal to include several new outcomes measures as part of the FY 2017 Hospital Value-Based Purchasing program.

Response: We appreciate this comment, but note that this comment does not relate to the SNF PPS and involves a program that does not apply to SNFs. We have, however, shared this comment with CMS staff who work more closely with the Hospital Value-Based Purchasing program to consider as part of their ongoing review and refinement of their proposed policies.

B. SNF PPS Rate Setting Methodology and FY 2015 Update

In the FY 2015 SNF PPS proposed rule (79 FR 25770 through 25779), we outlined the basic methodology used to set the rates for the SNF PPS. We also discussed a proposal associated with our rate setting methodology, specifically a proposal to adopt the most recent Office of Management and Budget (OMB) statistical area delineations to identify a facility's urban or rural status for the purpose of determining which set of rate tables would apply to the facility. Our discussion of the rate setting methodology, our proposed changes associated with this methodology, and the comments, along with our responses, on these proposals appear below.

1. Federal Base Rates

Under section 1888(e)(4) of the Act, the SNF PPS uses per diem federal payment rates based on mean SNF costs in a base year (FY 1995) updated for inflation to the first effective period of the PPS. We developed the federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in FY 1995. The data used in developing the federal rates also incorporated a "Part B add-on," which is an estimate of

the amounts that, prior to the SNF PPS, would have been payable under Part B for covered SNF services furnished to individuals during the course of a covered Part A stay in a SNF.

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

2. SNF Market Basket Update

a. SNF Market Basket Index

Section 1888(e)(5)(A) of the Act requires us to establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered SNF services. Accordingly, we have developed a SNF market basket index that encompasses the most commonly used cost categories for SNF routine services, ancillary services, and capital-related expenses. 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 2014 (78 FR 47939 through 47946), we revised and rebased the market basket, which included updating the base year from FY 2004 to FY 2010.

For the FY 2015 final rule, the FY 2010-based SNF market basket growth rate is estimated to be 2.5 percent, which is based on the IHS Global Insight, Inc. (IGI) second quarter 2014 forecast with historical data through first quarter 2014. In section IV.B.2.e. of this final rule, we discuss the specific application of this adjustment to the forthcoming annual update of the SNF PPS payment rates.

b. Use of the SNF 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 midpoint of the previous FY to the midpoint of the current FY. For the federal rates set forth in this final rule, we use the percentage change in the SNF market basket index to compute the update factor for FY 2015. This is based on the IGI second quarter 2014 forecast (with historical data through the first quarter 2014) of the FY 2015 percentage increase in the FY 2010-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 sections IV.B.2.c. and IV.B.2.d. of this final rule, this market basket percentage change would be reduced by the forecast error correction (as described in §413.337(d)(2)) if applicable, and by the multifactor productivity adjustment as required by section 1888(e)(5)(B)(ii) of the Act. Finally, as discussed in section II.B. 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.

c. Forecast Error Adjustment

As discussed in the June 10, 2003 supplemental proposed rule (68 FR 34768) and finalized in the August 4, 2003, final rule (68 FR 46057 through 46059), the regulations at §413.337(d)(2) provide for an adjustment to account for market basket forecast error. The initial

adjustment for market basket forecast error applied to the update of the FY 2003 rate for FY 2004, and took into account the cumulative forecast error for the period from FY 2000 through FY 2002, resulting in an increase of 3.26 percent to the FY 2004 update. Subsequent adjustments in succeeding FYs take into account the forecast error from the most recently available FY for which there is final data, and apply the difference between the forecasted and actual change in the market basket when the difference exceeds a specified threshold. We originally used a 0.25 percentage point threshold for this purpose; however, for the reasons specified in the FY 2008 SNF PPS final rule (72 FR 43425, August 3, 2007), we adopted a 0.5 percentage point threshold effective for FY 2008 and subsequent fiscal years. As we stated in the final rule for FY 2004 that first issued the market basket forecast error adjustment (68 FR 46058, August 4, 2003), the adjustment will ". . . reflect both upward and downward adjustments, as appropriate."

For FY 2013 (the most recently available FY for which there is final data), the estimated increase in the market basket index was 2.5 percentage points, while the actual increase for FY 2013 was 2.2 percentage points, resulting in the actual increase being 0.3 percentage point lower than the estimated increase. Accordingly, as the difference between the estimated and actual amount of change in the market basket index does not exceed the 0.5 percentage point threshold, the payment rates for FY 2015 do not include a forecast error adjustment. Table 1 shows the forecasted and actual market basket amounts for FY 2013.

TABLE 1: Difference Between the Forecasted and Actual Market Basket Increases for FY 2013

Index	Forecasted FY 2013 Increase*	Actual FY 2013 Increase**	FY 2013 Difference
SNF	2.5	2.2	-0.3

*Published in **Federal Register**; based on second quarter 2012 IGI forecast (2004-based index).
**Based on the second quarter 2014 IHS Global Insight forecast, with historical data through the first quarter 2014 (2004-based index).

d. 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) of the Act is to be reduced annually by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act, added by section 3401(a) of the Affordable Care Act, sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to "the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost-reporting period, or other annual period)" (the MFP adjustment). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business multifactor productivity (MFP). Please see http://www.bls.gov/mfp to obtain the BLS historical published MFP data.

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

i. 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." Section 1888(e)(5)(B)(ii) of the Act, added by section 3401(b) of the Affordable Care Act, requires that for FY 2012 and each subsequent FY, after determining the market basket

percentage described in section 1888(e)(5)(B)(i) of the Act, "the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)" (which we refer to as the MFP adjustment). Section 1888(e)(5)(B)(ii) of the Act further states that the reduction of the market basket percentage by the MFP adjustment may result in the market basket percentage being less than zero for a FY, and may result in payment rates under section 1888(e) of the Act for a FY being less than such payment rates for the preceding FY. Thus, if the application of the MFP adjustment to the market basket percentage calculated under section 1888(e)(5)(B)(i) of the Act results in an MFP-adjusted market basket percentage that is less than zero, then the annual update to the unadjusted federal per diem rates under section 1888(e)(4)(E)(ii) of the Act would be negative, and such rates would decrease relative to the prior FY.

For the FY 2015 update, the MFP adjustment is calculated as the 10-year moving average of changes in MFP for the period ending September 30, 2015, which is 0.5 percent. Consistent with section 1888(e)(5)(B)(i) of the Act and §413.337(d)(2) of the regulations, the market basket percentage for FY 2015 for the SNF PPS is based on IGI's second quarter 2014 forecast of the SNF market basket update, and is estimated to be 2.5 percent. In accordance with section 1888(e)(5)(B)(ii) of the Act (as added by section 3401(b) of the Affordable Care Act) and §413.337(d)(3), this market basket percentage is then reduced by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2015) of 0.5 percentage point, which is calculated as described above and based on IGI's second quarter 2014 forecast. The resulting MFP-adjusted SNF market basket update is equal to 2.0 percent, or 2.5 percent less 0.5 percentage point.

e. Market Basket Update Factor for FY 2015

Sections 1888(e)(4)(E)(ii)(IV) and 1888(e)(5)(i) of the Act require that the update factor

used to establish the FY 2015 unadjusted federal rates be at a level equal to the market basket index percentage change. Accordingly, we determined the total growth from the average market basket level for the period of October 1, 2013 through September 30, 2014 to the average market basket level for the period of October 1, 2014 through September 30, 2015. This process yields an update factor of 2.5 percent. As further explained in section IV.B.2.c. of this final rule, as applicable, we adjust the market basket update factor 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 percentage change in the market basket exceeds a 0.5 percentage point threshold. For FY 2013 (the most recently available FY for which there is final data), the difference between the forecasted SNF market basket percentage change and the actual SNF market basket percentage change does not exceed 0.5 percentage point, so the FY 2015 market basket of 2.5 percent would not be adjusted by the applicable difference. In addition, for FY 2015, section 1888(e)(5)(B)(ii) of the Act requires us to reduce the market basket percentage by the MFP adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2015) of 0.5 percentage point, as described in section IV.B.2.d. of this final rule. The resulting MFP-adjusted SNF market basket update is equal to 2.0 percent, or 2.5 percent less 0.5 percentage point. We used the SNF market basket, adjusted as described above, to adjust each per diem component of the federal rates forward to reflect the change in the average prices for FY 2015 from average prices for FY 2014. We would 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 2015, prior to adjustment for case-mix.

We proposed in the FY 2015 SNF PPS proposed rule (79 FR 25772) that while we would continue to compute and apply separate federal per diem rates for SNFs located in urban and

rural areas as we have in the past, beginning on October 1, 2014 we would use the revised OMB statistical area delineations discussed in section IV.D.1 of this final rule to identify a facility's urban or rural status for the purpose of determining which set of rate tables would apply to a facility. As noted in that discussion, we believe that the most current OMB delineations more accurately reflect the contemporary urban and rural nature of areas across the country, and that use of such delineations allows us to determine more accurately the appropriate rate tables to apply under the SNF PPS. Thus, we believe it is appropriate to use the most current OMB delineations for this purpose, in order to enhance the accuracy of payments under the SNF PPS. We did not receive any comments on this proposal. Therefore, for the reasons discussed above, we are finalizing our proposal to use the revised OMB delineations discussed in section IV.D.1 of this final rule to identify a facility's urban or rural status for the purpose of determining which set of rate tables will apply to a facility beginning on October 1, 2014.

TABLE 2: FY 2015 Unadjusted Federal Rate Per Diem Urban

Rate Component	Nursing - Case-Mix	Therapy - Case-Mix	Therapy - Non-Case-mix	Non-Case-Mix
Per Diem Amount	$169.28	$127.51	$16.79	$86.39

TABLE 3: FY 2015 Unadjusted Federal Rate Per Diem Rural

Rate Component	Nursing - Case-Mix	Therapy - Case-Mix	Therapy - Non-Case-mix	Non-Case-Mix
Per Diem Amount	$161.72	$147.02	$17.94	$87.99

3. Case-Mix Adjustment

Under section 1888(e)(4)(G)(i) of the Act, the federal rate also incorporates an adjustment to account for facility case-mix, using a classification system that accounts for the relative resource utilization of different patient types. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the

relative resource use of different patient types, as well as resident assessment data and other data that the Secretary considers appropriate. In the interim final rule with comment period that initially implemented 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). 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), we subsequently conducted a multi-year data collection and analysis under the Staff Time and Resource Intensity Verification (STRIVE) project to update the case-mix classification system for FY 2011. The resulting Resource Utilization Groups, Version 4 (RUG-IV) case-mix classification system reflected the data collected in 2006-2007 during the STRIVE project, and was finalized in the FY 2010 SNF PPS final rule (74 FR 40288) to take effect in FY 2011 concurrently with an updated new resident assessment instrument, version 3.0 of the Minimum Data Set (MDS 3.0), which collects the clinical data used for case-mix classification under RUG-IV.

We note that case-mix classification is based, in part, on the beneficiary's need for skilled nursing care and therapy services. The case-mix classification system uses clinical data from the MDS to assign a case-mix group to each patient that is then used to calculate a per diem payment under the SNF PPS. As discussed in section IV.C.1. of this final rule, the clinical orientation of the case-mix classification system supports the SNF PPS's use of an administrative presumption that considers a beneficiary's initial case-mix classification to assist in making certain SNF level of care determinations. Further, because the MDS is used as a basis for payment, as well as a

clinical assessment, we have provided extensive training on proper coding and the time frames for MDS completion in 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 website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.

In addition, we note that section 511 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Pub. L. 108-173) 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 add-on for SNF residents with AIDS 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 add-on for SNF residents with AIDS is also discussed in Program Transmittal #160 (Change Request #3291), issued on April 30, 2004, which is available online at www.cms.gov/transmittals/downloads/r160cp.pdf. In the SNF PPS final rule for FY 2010 (74 FR 40288), we did not address the certification of the add-on for SNF residents with AIDS in that final rule's implementation of the case-mix refinements for RUG-IV, thus allowing the add-on payment required by section 511 of the MMA to remain in effect. For the limited number of SNF residents that qualify for this add-on, there is a significant increase in payments. For example, using FY 2012 data, we identified fewer than 4,355 SNF residents with a diagnosis code of 042 (Human Immunodeficiency Virus (HIV) Infection). For FY 2015, an urban facility

with a resident with AIDS in RUG-IV group "HC2" would have a case-mix adjusted per diem payment of $423.12 (see Table 4) before the application of the MMA adjustment. After an increase of 128 percent, this urban facility would receive a case-mix adjusted per diem payment of approximately $964.71.

Currently, we use the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) code 042 to identify those residents for whom it is appropriate to apply the AIDS add-on established by section 511 of the MMA. In this context, we note that the Department published a final rule in the September 5, 2012 **Federal Register** (77 FR 54664) which requires us to stop using ICD-9-CM on September 30, 2014, and begin using the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM), on October 1, 2014. Regarding the above-referenced ICD-9-CM diagnosis code of 042, in the FY 2014 SNF PPS proposed rule (78 FR 26444, May 6, 2013), we proposed to transition to the equivalent ICD-10-CM diagnosis code of B20 upon the overall conversion to ICD-10-CM on October 1, 2014, and we subsequently finalized that proposal in the FY 2014 SNF PPS final rule (78 FR 47951 through 47952).

However, on April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted. Section 212 of PAMA, titled "Delay in Transition from ICD-9 to ICD-10 Code Sets," provides that "[t]he Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD-10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d-2(c)) and section 162.1002 of title 45, Code of Federal Regulations." In light of PAMA, in the FY 2015 SNF PPS proposed rule, we stated that the effective date of the change from ICD-9-CM code 042 to ICD-10-CM code B20 for purposes of applying the AIDS add-on would be the date when ICD-10-CM becomes the required medical data code set for use on Medicare SNF claims and that, until that time, we

would continue to use ICD-9-CM code 042 for this purpose. On May 1, 2014, the Department announced that, in light of section 212 of PAMA, "the U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015." The Department has not yet published the interim final rule, however, we are proceeding in accordance with the announcement. Therefore, the effective date of the change from ICD-9-CM code 042 to ICD-10-CM code B20 for purposes of applying the AIDS add-on is October 1, 2015. Until that time, we will continue to use ICD-9-CM code 042 for this purpose.

Under section 1888(e)(4)(H), each update of the payment rates must include the case-mix classification methodology applicable for the upcoming FY. The payment rates set forth in this final rule reflect the use of the RUG-IV case-mix classification system from October 1, 2014, through September 30, 2015. We list the case-mix adjusted RUG-IV payment rates, provided separately for urban and rural SNFs, in Tables 4 and 5 with corresponding case-mix values. As discussed above, we will use the revised OMB delineations in order to identify a facility's urban or rural status for the purpose of determining which set of rate tables will apply to the facility beginning on October 1, 2014. These tables do not reflect the add-on for SNF residents with AIDS enacted by section 511 of the MMA, which we apply only after making all other adjustments (such as wage index and case-mix).

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 Comp	Non-case Mix Component	Total Rate
RUX	2.67	1.87	$451.98	$238.44		$86.39	$776.81
RUL	2.57	1.87	$435.05	$238.44		$86.39	$759.88
RVX	2.61	1.28	$441.82	$163.21		$86.39	$691.42
RVL	2.19	1.28	$370.72	$163.21		$86.39	$620.32

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RHX	2.55	0.85	$431.66	$108.38		$86.39	$626.43
RHL	2.15	0.85	$363.95	$108.38		$86.39	$558.72
RMX	2.47	0.55	$418.12	$70.13		$86.39	$574.64
RML	2.19	0.55	$370.72	$70.13		$86.39	$527.24
RLX	2.26	0.28	$382.57	$35.70		$86.39	$504.66
RUC	1.56	1.87	$264.08	$238.44		$86.39	$588.91
RUB	1.56	1.87	$264.08	$238.44		$86.39	$588.91
RUA	0.99	1.87	$167.59	$238.44		$86.39	$492.42
RVC	1.51	1.28	$255.61	$163.21		$86.39	$505.21
RVB	1.11	1.28	$187.90	$163.21		$86.39	$437.50
RVA	1.10	1.28	$186.21	$163.21		$86.39	$435.81
RHC	1.45	0.85	$245.46	$108.38		$86.39	$440.23
RHB	1.19	0.85	$201.44	$108.38		$86.39	$396.21
RHA	0.91	0.85	$154.04	$108.38		$86.39	$348.81
RMC	1.36	0.55	$230.22	$70.13		$86.39	$386.74
RMB	1.22	0.55	$206.52	$70.13		$86.39	$363.04
RMA	0.84	0.55	$142.20	$70.13		$86.39	$298.72
RLB	1.50	0.28	$253.92	$35.70		$86.39	$376.01
RLA	0.71	0.28	$120.19	$35.70		$86.39	$242.28
ES3	3.58		$606.02		$16.79	$86.39	$709.20
ES2	2.67		$451.98		$16.79	$86.39	$555.16
ES1	2.32		$392.73		$16.79	$86.39	$495.91
HE2	2.22		$375.80		$16.79	$86.39	$478.98
HE1	1.74		$294.55		$16.79	$86.39	$397.73
HD2	2.04		$345.33		$16.79	$86.39	$448.51
HD1	1.60		$270.85		$16.79	$86.39	$374.03
HC2	1.89		$319.94		$16.79	$86.39	$423.12
HC1	1.48		$250.53		$16.79	$86.39	$353.71
HB2	1.86		$314.86		$16.79	$86.39	$418.04
HB1	1.46		$247.15		$16.79	$86.39	$350.33
LE2	1.96		$331.79		$16.79	$86.39	$434.97
LE1	1.54		$260.69		$16.79	$86.39	$363.87
LD2	1.86		$314.86		$16.79	$86.39	$418.04
LD1	1.46		$247.15		$16.79	$86.39	$350.33
LC2	1.56		$264.08		$16.79	$86.39	$367.26
LC1	1.22		$206.52		$16.79	$86.39	$309.70
LB2	1.45		$245.46		$16.79	$86.39	$348.64
LB1	1.14		$192.98		$16.79	$86.39	$296.16
CE2	1.68		$284.39		$16.79	$86.39	$387.57
CE1	1.50		$253.92		$16.79	$86.39	$357.10
CD2	1.56		$264.08		$16.79	$86.39	$367.26
CD1	1.38		$233.61		$16.79	$86.39	$336.79
CC2	1.29		$218.37		$16.79	$86.39	$321.55
CC1	1.15		$194.67		$16.79	$86.39	$297.85
CB2	1.15		$194.67		$16.79	$86.39	$297.85

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
CB1	1.02		$172.67		$16.79	$86.39	$275.85
CA2	0.88		$148.97		$16.79	$86.39	$252.15
CA1	0.78		$132.04		$16.79	$86.39	$235.22
BB2	0.97		$164.20		$16.79	$86.39	$267.38
BB1	0.90		$152.35		$16.79	$86.39	$255.53
BA2	0.70		$118.50		$16.79	$86.39	$221.68
BA1	0.64		$108.34		$16.79	$86.39	$211.52
PE2	1.50		$253.92		$16.79	$86.39	$357.10
PE1	1.40		$236.99		$16.79	$86.39	$340.17
PD2	1.38		$233.61		$16.79	$86.39	$336.79
PD1	1.28		$216.68		$16.79	$86.39	$319.86
PC2	1.10		$186.21		$16.79	$86.39	$289.39
PC1	1.02		$172.67		$16.79	$86.39	$275.85
PB2	0.84		$142.20		$16.79	$86.39	$245.38
PB1	0.78		$132.04		$16.79	$86.39	$235.22
PA2	0.59		$99.88		$16.79	$86.39	$203.06
PA1	0.54		$91.41		$16.79	$86.39	$194.59

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 Comp	Non-case Mix Component	Total Rate
RUX	2.67	1.87	$431.79	$274.93		$87.99	$794.71
RUL	2.57	1.87	$415.62	$274.93		$87.99	$778.54
RVX	2.61	1.28	$422.09	$188.19		$87.99	$698.27
RVL	2.19	1.28	$354.17	$188.19		$87.99	$630.35
RHX	2.55	0.85	$412.39	$124.97		$87.99	$625.35
RHL	2.15	0.85	$347.70	$124.97		$87.99	$560.66
RMX	2.47	0.55	$399.45	$80.86		$87.99	$568.30
RML	2.19	0.55	$354.17	$80.86		$87.99	$523.02
RLX	2.26	0.28	$365.49	$41.17		$87.99	$494.65
RUC	1.56	1.87	$252.28	$274.93		$87.99	$615.20
RUB	1.56	1.87	$252.28	$274.93		$87.99	$615.20
RUA	0.99	1.87	$160.10	$274.93		$87.99	$523.02
RVC	1.51	1.28	$244.20	$188.19		$87.99	$520.38
RVB	1.11	1.28	$179.51	$188.19		$87.99	$455.69
RVA	1.10	1.28	$177.89	$188.19		$87.99	$454.07
RHC	1.45	0.85	$234.49	$124.97		$87.99	$447.45
RHB	1.19	0.85	$192.45	$124.97		$87.99	$405.41
RHA	0.91	0.85	$147.17	$124.97		$87.99	$360.13
RMC	1.36	0.55	$219.94	$80.86		$87.99	$388.79

RUG-IV Category	Nursing Index	Therapy Index	Nursing Component	Therapy Component	Non-case Mix Therapy Comp	Non-case Mix Component	Total Rate
RMB	1.22	0.55	$197.30	$80.86		$87.99	$366.15
RMA	0.84	0.55	$135.84	$80.86		$87.99	$304.69
RLB	1.50	0.28	$242.58	$41.17		$87.99	$371.74
RLA	0.71	0.28	$114.82	$41.17		$87.99	$243.98
ES3	3.58		$578.96		$17.94	$87.99	$684.89
ES2	2.67		$431.79		$17.94	$87.99	$537.72
ES1	2.32		$375.19		$17.94	$87.99	$481.12
HE2	2.22		$359.02		$17.94	$87.99	$464.95
HE1	1.74		$281.39		$17.94	$87.99	$387.32
HD2	2.04		$329.91		$17.94	$87.99	$435.84
HD1	1.60		$258.75		$17.94	$87.99	$364.68
HC2	1.89		$305.65		$17.94	$87.99	$411.58
HC1	1.48		$239.35		$17.94	$87.99	$345.28
HB2	1.86		$300.80		$17.94	$87.99	$406.73
HB1	1.46		$236.11		$17.94	$87.99	$342.04
LE2	1.96		$316.97		$17.94	$87.99	$422.90
LE1	1.54		$249.05		$17.94	$87.99	$354.98
LD2	1.86		$300.80		$17.94	$87.99	$406.73
LD1	1.46		$236.11		$17.94	$87.99	$342.04
LC2	1.56		$252.28		$17.94	$87.99	$358.21
LC1	1.22		$197.30		$17.94	$87.99	$303.23
LB2	1.45		$234.49		$17.94	$87.99	$340.42
LB1	1.14		$184.36		$17.94	$87.99	$290.29
CE2	1.68		$271.69		$17.94	$87.99	$377.62
CE1	1.50		$242.58		$17.94	$87.99	$348.51
CD2	1.56		$252.28		$17.94	$87.99	$358.21
CD1	1.38		$223.17		$17.94	$87.99	$329.10
CC2	1.29		$208.62		$17.94	$87.99	$314.55
CC1	1.15		$185.98		$17.94	$87.99	$291.91
CB2	1.15		$185.98		$17.94	$87.99	$291.91
CB1	1.02		$164.95		$17.94	$87.99	$270.88
CA2	0.88		$142.31		$17.94	$87.99	$248.24
CA1	0.78		$126.14		$17.94	$87.99	$232.07
BB2	0.97		$156.87		$17.94	$87.99	$262.80
BB1	0.90		$145.55		$17.94	$87.99	$251.48
BA2	0.70		$113.20		$17.94	$87.99	$219.13
BA1	0.64		$103.50		$17.94	$87.99	$209.43
PE2	1.50		$242.58		$17.94	$87.99	$348.51
PE1	1.40		$226.41		$17.94	$87.99	$332.34
PD2	1.38		$223.17		$17.94	$87.99	$329.10
PD1	1.28		$207.00		$17.94	$87.99	$312.93
PC2	1.10		$177.89		$17.94	$87.99	$283.82
PC1	1.02		$164.95		$17.94	$87.99	$270.88
PB2	0.84		$135.84		$17.94	$87.99	$241.77
PB1	0.78		$126.14		$17.94	$87.99	$232.07
PA2	0.59		$95.41		$17.94	$87.99	$201.34
PA1	0.54		$87.33		$17.94	$87.99	$193.26

4. Wage Index Adjustment

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 the Secretary determines appropriate. Since the inception of the SNF PPS, we have used hospital inpatient wage data in developing a wage index to be applied to SNFs. In the FY 2015 SNF PPS proposed rule (79 FR 25775), we proposed to continue this practice for FY 2015, as we continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index data is appropriate and reasonable for the SNF PPS. As explained in the update notice for FY 2005 (69 FR 45786), 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 hospital inpatient wage data exclusive of the occupational mix adjustment continues to be appropriate for SNF payments. For FY 2015, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2010 and before October 1, 2011 (FY 2011 cost report data).

We note that section 315 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554, enacted on December 21, 2000) authorized us to establish a geographic reclassification procedure that is specific to SNFs, but only after collecting the data necessary to establish a SNF wage index that is based on wage data from nursing homes. However, to date, this has proven to be unfeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data.

In the FY 2015 SNF PPS proposed rule (79 FR 25775 through 25776), we also proposed to continue to use the same methodology discussed in the SNF PPS final rule for FY 2008

(72 FR 43423) to address those geographic areas in which there are no hospitals, and thus, no hospital wage index data on which to base the calculation of the FY 2015 SNF PPS wage index. For rural geographic areas that do not have hospitals and, therefore, lack hospital wage data on which to base an area wage adjustment, we would use the average wage index from all contiguous Core-Based Statistical Areas (CBSAs) as a reasonable proxy. For FY 2015, there are no rural geographic areas without hospitals for which we would apply this policy. For rural Puerto Rico, we would not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity to one another of almost all of Puerto Rico's various urban and non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we would continue to use the most recent wage index previously available for that area. For urban areas without specific hospital wage index data, we would use the average wage indexes of all of the urban areas within the state to serve as a reasonable proxy for the wage index of that urban CBSA. For FY 2015, the only urban area without wage index data available is CBSA 25980, Hinesville-Fort Stewart, GA. We did not receive any comments on these proposals, and thus we will continue to use the same methodology discussed in the SNF PPS final rule for FY 2008 (72 FR 43423) to address those geographic areas in which there are no hospitals, and thus, no hospital wage index data on which to base the calculation of the FY 2015 SNF PPS wage index.

A discussion of the general comments that we received on the wage index adjustment to the federal rates, and our responses to those comments, appears below. Comments on the specific proposal to use revised OMB delineations as part of the wage index are discussed in section IV.D.1. of this final rule.

Comment: Several commenters stated that hospital cost data may not be the most reliable resource when determining geographical differences in salary structure for skilled nursing

facilities. These commenters also stated that, if CMS plans to continue using hospital cost data as the basis of SNF wage index adjustments, then CMS should consider adopting certain wage index policies in use under the IPPS, such as reclassification, because SNFs compete in a similar labor pool as acute care hospitals. Commenters stated that even if reclassification is not permissible, CMS should consider using the post-reclassification hospital wage data to influence SNF PPS wage index policy decisions. In addition, a few commenters recommended that CMS develop a SNF-specific wage index. Finally, a few commenters recommended that CMS attempt to smooth out the perceived volatility of annual wage index changes by implementing a floor and ceiling for annual changes to the wage index that are above or below a certain level.

Response: Consistent with our previous responses to these recurring comments (most recently published in the FY 2014 SNF PPS final rule (78 FR 47952)), developing a wage index that utilizes data specific to SNFs would require us to engage in a resource-intensive audit process. Also, we note that section 315 of 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-specific wage index that is based on wage data from nursing homes. However, to date, this has proven to be unfeasible due to the volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of that data. Furthermore, we believe the collection of SNF-specific wage data would place a significant amount of additional burden on SNFs. As discussed above, we continue to believe that in the absence of SNF-specific wage data, using the pre-reclassified hospital inpatient wage data (without the occupational mix adjustment) is appropriate and reasonable for the SNF PPS. Additionally, we believe that using post-reclassification inpatient hospital wage data to influence SNF PPS wage index policy decisions, as suggested by commenters, would not be appropriate as such reclassification data are specific to those hospitals making that request, which may or may

not apply to a given SNF in a given instance.

Furthermore, we do not believe it would be appropriate to establish a floor and ceiling for annual wage index changes which are above or below a given level. Any perceived volatility in the wage index would be based upon volatility in actual wages in that area, which is something outside of CMS's control. As stated above, under section 1888(e)(4)(G)(ii) of the Act and §413.337(a)(1)(ii) of the regulations, we adjust the SNF PPS rates to account for differences in area wage levels. We believe that applying a ceiling or floor to annual wage index changes would make the area wage index less reflective of the area wage levels. Additionally, we note that establishing an artificial ceiling for annual changes in the wage index could not only result in a wage index that does not accurately reflect the wage levels in the area, but would also have an adverse impact on those providers that would otherwise experience a larger increase in their wage index absent a ceiling.

After considering the comments received, for the reasons discussed above and in the FY 2015 SNF PPS proposed rule (79 FR 25775), we are finalizing our proposal to continue to use the updated hospital inpatient wage data , exclusive of the occupational mix adjustment, to develop the SNF PPS wage index. For FY 2015, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2010 and before October 1, 2011 (FY 2011 cost report data).

Once calculated, we apply the wage index adjustment to the labor-related portion of the federal rate, which is 69.180 percent of the total rate. This percentage reflects the labor-related relative importance for FY 2015, using the FY 2010-based SNF market basket. Each year, we calculate a revised labor-related share, based on the relative importance of labor-related cost categories (that is, those cost categories that are sensitive to local area wage costs) in the input price index. As discussed in section IV.B.2 of this final rule, for the FY 2014 SNF PPS update,

we revised the labor-related share to reflect the relative importance of the revised FY 2010-based SNF market basket cost weights for the following cost categories: wages and salaries; employee benefits; the labor-related portion of nonmedical professional fees; administrative and facilities support services; all other: labor-related services (previously referred to in the FY 2004-based SNF market basket as labor-intensive); and a proportion of capital-related expenses.

We calculate the labor-related relative importance from the SNF market basket, and it approximates the labor-related portion of the total costs after taking into account historical and projected price changes between the base year and FY 2015. 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 2015 than the base year weights from the SNF market basket.

We calculate the labor-related relative importance for FY 2015 in four steps. First, we compute the FY 2015 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 2015 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2015 relative importance for each cost category by multiplying this ratio by the base year (FY 2010) weight. Finally, we add the FY 2015 relative importance for each of the labor-related cost categories (wages and salaries, employee benefits, the labor-related portion of non-medical professional fees, administrative and facilities support services, all other: labor-related services, and a portion of capital-related expenses) to produce the FY 2015 labor-related relative importance. Tables 6 and 7 show the RUG-IV case-mix adjusted federal rates by labor-related and non-labor-related components. As discussed previously, the new OMB delineations will be used to identify a facility's urban or rural status for the purpose of determining which set

of rate tables will apply to them beginning on October 1, 2014. Table 12 in section IV.D.1.c provides the FY 2015 labor-related share components based on the SNF market basket.

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	776.81	$537.40	$239.41
RUL	759.88	$525.68	$234.20
RVX	691.42	$478.32	$213.10
RVL	620.32	$429.14	$191.18
RHX	626.43	$433.36	$193.07
RHL	558.72	$386.52	$172.20
RMX	574.64	$397.54	$177.10
RML	527.24	$364.74	$162.50
RLX	504.66	$349.12	$155.54
RUC	588.91	$407.41	$181.50
RUB	588.91	$407.41	$181.50
RUA	492.42	$340.66	$151.76
RVC	505.21	$349.50	$155.71
RVB	437.50	$302.66	$134.84
RVA	435.81	$301.49	$134.32
RHC	440.23	$304.55	$135.68
RHB	396.21	$274.10	$122.11
RHA	348.81	$241.31	$107.50
RMC	386.74	$267.55	$119.19
RMB	363.04	$251.15	$111.89
RMA	298.72	$206.65	$92.07
RLB	376.01	$260.12	$115.89
RLA	242.28	$167.61	$74.67
ES3	709.20	$490.62	$218.58
ES2	555.16	$384.06	$171.10
ES1	495.91	$343.07	$152.84
HE2	478.98	$331.36	$147.62
HE1	397.73	$275.15	$122.58
HD2	448.51	$310.28	$138.23
HD1	374.03	$258.75	$115.28
HC2	423.12	$292.71	$130.41
HC1	353.71	$244.70	$109.01
HB2	418.04	$289.20	$128.84
HB1	350.33	$242.36	$107.97
LE2	434.97	$300.91	$134.06
LE1	363.87	$251.73	$112.14
LD2	418.04	$289.20	$128.84
LD1	350.33	$242.36	$107.97
LC2	367.26	$254.07	$113.19
LC1	309.70	$214.25	$95.45
LB2	348.64	$241.19	$107.45
LB1	296.16	$204.88	$91.28

RUG-IV Category	Total Rate	Labor Portion	Non-Labor Portion
CE2	387.57	$268.12	$119.45
CE1	357.10	$247.04	$110.06
CD2	367.26	$254.07	$113.19
CD1	336.79	$232.99	$103.80
CC2	321.55	$222.45	$99.10
CC1	297.85	$206.05	$91.80
CB2	297.85	$206.05	$91.80
CB1	275.85	$190.83	$85.02
CA2	252.15	$174.44	$77.71
CA1	235.22	$162.73	$72.49
BB2	267.38	$184.97	$82.41
BB1	255.53	$176.78	$78.75
BA2	221.68	$153.36	$68.32
BA1	211.52	$146.33	$65.19
PE2	357.10	$247.04	$110.06
PE1	340.17	$235.33	$104.84
PD2	336.79	$232.99	$103.80
PD1	319.86	$221.28	$98.58
PC2	289.39	$200.20	$89.19
PC1	275.85	$190.83	$85.02
PB2	245.38	$169.75	$75.63
PB1	235.22	$162.73	$72.49
PA2	203.06	$140.48	$62.58
PA1	194.59	$134.62	$59.97

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	794.71	$549.78	$244.93
RUL	778.54	$538.59	$239.95
RVX	698.27	$483.06	$215.21
RVL	630.35	$436.08	$194.27
RHX	625.35	$432.62	$192.73
RHL	560.66	$387.86	$172.80
RMX	568.30	$393.15	$175.15
RML	523.02	$361.83	$161.19
RLX	494.65	$342.20	$152.45
RUC	615.20	$425.60	$189.60
RUB	615.20	$425.60	$189.60
RUA	523.02	$361.83	$161.19
RVC	520.38	$360.00	$160.38
RVB	455.69	$315.25	$140.44
RVA	454.07	$314.13	$139.94
RHC	447.45	$309.55	$137.90
RHB	405.41	$280.46	$124.95

RUG-IV Category	Total Rate	Labor Portion	Non-Labor Portion
RHA	360.13	$249.14	$110.99
RMC	388.79	$268.96	$119.83
RMB	366.15	$253.30	$112.85
RMA	304.69	$210.78	$93.91
RLB	371.74	$257.17	$114.57
RLA	243.98	$168.79	$75.19
ES3	684.89	$473.81	$211.08
ES2	537.72	$371.99	$165.73
ES1	481.12	$332.84	$148.28
HE2	464.95	$321.65	$143.30
HE1	387.32	$267.95	$119.37
HD2	435.84	$301.51	$134.33
HD1	364.68	$252.29	$112.39
HC2	411.58	$284.73	$126.85
HC1	345.28	$238.86	$106.42
HB2	406.73	$281.38	$125.35
HB1	342.04	$236.62	$105.42
LE2	422.90	$292.56	$130.34
LE1	354.98	$245.58	$109.40
LD2	406.73	$281.38	$125.35
LD1	342.04	$236.62	$105.42
LC2	358.21	$247.81	$110.40
LC1	303.23	$209.77	$93.46
LB2	340.42	$235.50	$104.92
LB1	290.29	$200.82	$89.47
CE2	377.62	$261.24	$116.38
CE1	348.51	$241.10	$107.41
CD2	358.21	$247.81	$110.40
CD1	329.10	$227.67	$101.43
CC2	314.55	$217.61	$96.94
CC1	291.91	$201.94	$89.97
CB2	291.91	$201.94	$89.97
CB1	270.88	$187.39	$83.49
CA2	248.24	$171.73	$76.51
CA1	232.07	$160.55	$71.52
BB2	262.80	$181.81	$80.99
BB1	251.48	$173.97	$77.51
BA2	219.13	$151.59	$67.54
BA1	209.43	$144.88	$64.55
PE2	348.51	$241.10	$107.41
PE1	332.34	$229.91	$102.43
PD2	329.10	$227.67	$101.43
PD1	312.93	$216.48	$96.45
PC2	283.82	$196.35	$87.47
PC1	270.88	$187.39	$83.49
PB2	241.77	$167.26	$74.51
PB1	232.07	$160.55	$71.52
PA2	201.34	$139.29	$62.05

RUG-IV Category	Total Rate	Labor Portion	Non-Labor Portion
PA1	193.26	$133.70	$59.56

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 under the SNF PPS that are greater or less than what would otherwise be made if the wage adjustment had not been made. For FY 2015 (federal rates effective October 1, 2014), 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 2014 to the weighted average wage adjustment factor for FY 2015, based on the blended wage index for FY 2015 as discussed later in this final rule. For this calculation, we use the same FY 2013 claims utilization data for both the numerator and denominator of this ratio. We define the wage adjustment factor used in this calculation as the labor share of the rate component multiplied by the wage index plus the non-labor share of the rate component. The budget neutrality factor for FY 2015 is 1.0009.

In the SNF PPS final rule for FY 2006 (70 FR 45026, August 4, 2005), we adopted the changes discussed in the OMB Bulletin No. 03-04 (June 6, 2003), available online at www.whitehouse.gov/omb/bulletins/b03-04.html, which announced revised definitions for MSAs, and the creation of micropolitan statistical areas and combined statistical areas.

In adopting the CBSA geographic designations, we provided for a 1-year transition in FY 2006 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), since the expiration of this 1-year transition on September 30, 2006, we have used the full CBSA-based wage index values.

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

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

As discussed in the SNF PPS proposed rule for FY 2014 (78 FR 26448), the changes made by the bulletin and their ramifications required extensive review by CMS before using them for the SNF PPS wage index. Having completed our assessment, in the FY 2015 SNF PPS proposed rule (79 FR 25779 through 25786), we proposed changes to the SNF PPS wage index based on the newest OMB delineations, as described in OMB Bulletin No. 13-01, beginning in FY 2015, including a proposed 1-year transition with a blended wage index for FY 2015. These changes, and associated comments, are discussed further in section IV.D.1. of this final rule. The wage index applicable to FY 2015 is set forth in Table A available on the CMS website at http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html. Table

A provides a crosswalk between the FY 2015 wage index for a provider using the current OMB delineations in effect in FY 2014 and the FY 2015 wage index using the revised OMB delineations, as well as the transition wage index values that will be in effect in FY 2015.

5. Adjusted Rate Computation Example

Using the hypothetical SNF XYZ described below, Table 8 shows the adjustments made to the federal per diem rates to compute the provider's actual per diem PPS payment. We derive the Labor and Non-labor columns from Table 6. The wage index used in this example is based on the transition wage index, which may be found in Table A as referenced above. As illustrated in Table 8, SNF XYZ's total PPS payment would equal $42,299.26.

TABLE 8: Adjusted Rate Computation Example
SNF XYZ: Located in Cedar Rapids, IA (Urban CBSA 16300)
Wage Index: 0.8850
(See Transition Wage Index in Table A)[1]

RUG-IV Group	Labor	Wage Index	Adjusted Labor	Non-Labor	Adjusted Rate	Percent Adjustment	Medicare Days	Payment
RVX	$478.32	0.885	$423.31	$213.10	$636.41	$636.41	14	$8,909.74
ES2	$384.06	0.885	$339.89	$171.10	$510.99	$510.99	30	$15,329.70
RHA	$241.31	0.885	$213.56	$107.50	$321.06	$321.06	16	$5,136.96
CC2*	$222.45	0.885	$196.87	$99.10	$295.97	$674.81	10	$6,748.10
BA2	$153.36	0.885	$135.72	$68.32	$204.04	$204.04	30	$6,121.20
							100	$42,245.70

*Reflects a 128 percent adjustment from section 511 of the MMA.
[1] Available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html.

C. Additional Aspects of the SNF PPS

1. SNF Level of Care--Administrative Presumption

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 discussed in section IV.B.3 of this final rule. This approach includes an

administrative presumption that utilizes a beneficiary's initial classification in one of the upper 52 RUGs of the 66-group RUG-IV case-mix classification system to assist in making certain SNF level of care determinations.

In accordance with section 1888(e)(4)(H)(ii) of the Act and the regulations at §413.345, we include in each update of the federal payment rates in the **Federal Register** the designation of those specific RUGs under the classification system that represent the required SNF level of care, as provided in §409.30. As set forth in the FY 2010 SNF PPS final rule (74 FR 40341), 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 five-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 five-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 the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to modifications in the case-mix classification structure. In this final rule, we would continue to designate the upper 52 RUG-IV groups for purposes of this administrative presumption, consisting of all groups encompassed by the following RUG-IV categories:

- Rehabilitation plus Extensive Services;

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

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

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

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

2. Consolidated Billing

Sections 1842(b)(6)(E) and 1862(a)(18) of the Act (as added by section 4432(b) of the BBA) require a SNF to submit consolidated Medicare bills to its Medicare Administrative Contractor for almost all of the services that its residents receive during the course of a covered Part A stay. In addition, section 1862(a)(18) places the responsibility with the SNF for billing Medicare for physical therapy, occupational therapy, and speech-language pathology services that the resident receives during a noncovered stay. Section 1888(e)(2)(A) of the Act excludes a small list of services from the consolidated billing provision (primarily those services furnished by physicians and certain other types of practitioners), which remain separately billable under Part B when furnished to a SNF's Part A resident. These excluded service categories are discussed in greater detail in section V.B.2. of the May 12, 1998 interim final rule (63 FR 26295 through 26297).

A detailed discussion of the legislative history of the consolidated billing provision is available on the SNF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Legislative_History_07302013.pdf. In particular, section 103 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113, enacted on November 29, 1999) amended section 1888(e)(2)(A) of the Act by further excluding a number of individual "high-cost, low probability" services, identified by Healthcare Common Procedure Coding System (HCPCS) codes, within several broader categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. We discuss this BBRA amendment in greater detail in the SNF PPS 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 www.cms.gov/transmittals/downloads/ab001860.pdf.

As explained in the FY 2001 proposed rule (65 FR 19232), the amendments enacted in section 103 of the BBRA not only identified for exclusion from this provision a number of particular service codes within four specified categories (that is, chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices), but also gave the Secretary ". . . the authority to designate additional, individual services for exclusion within each of the specified service categories." In the 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) of the BBRA "is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs . . . ." By contrast, we noted that the Congress declined to designate for exclusion any of the remaining services within those four categories (thus, leaving all of those services subject to SNF consolidated billing), because they are relatively inexpensive and are furnished routinely in SNFs.

As we further explained in the final rule for FY 2001 (65 FR 46790), and as our longstanding policy, any additional service codes that we might designate for exclusion under our discretionary authority must meet the same statutory criteria used in identifying the original codes excluded from consolidated billing under section 103(a) of the BBRA: 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), and since that time, we have periodically invited the public to submit comments identifying codes that might meet the criteria for exclusion. In the FY 2015 SNF PPS proposed rule (79 FR 25779), we specifically invited public comments identifying HCPCS codes in any of these four service categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) representing recent medical advances that might meet our criteria for exclusion from SNF consolidated billing, and we requested commenters to identify in their comments the specific HCPCS code that is associated with the service in question, as well as their rationale for requesting that the identified HCPCS code(s) be excluded. A discussion of the public comments received on this topic, along with our responses, appears below.

Comment: One commenter recommended four particular chemotherapy drugs for exclusion. As described by Healthcare Common Procedure Coding System (HCPCS) code J8562, the first drug (fludarabine phosphate, 10 mg) is administered orally, but this same drug is already excluded under code J9185 when administered in a 50 mg dosage via intravenous injection. The commenter incorrectly characterized the second recommended drug, Revlimid (lenalidomide), as being assigned to code J3590 (whose descriptor is actually "unclassified biologic"); in fact, that drug, along with the commenter's third recommended drug, Zytiga (Abiraterone acetate), is not assigned a specific code of its own, but instead comes under the heading of one of the broader, "not otherwise specified" (NOS) codes, J8999 ("Prescription drug, oral, chemotherapeutic, NOS"). The fourth chemotherapy drug that the commenter recommended for exclusion was code J9219 (Leuprolide acetate implant, 65 mg).

Response: Regarding the first drug that the commenter cited (code J8562), the only oral

fludarabine product is Oforta®, which was withdrawn from the market in September 2011. In addition, Oforta® is marked as discontinued on the drugs@FDA website (see http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm?fuseaction=Search.Set_Current_Drug&ApplNo=022273&DrugName=OFORTA&ActiveIngred=FLUDARABINE%20PHOSPHATE&SponsorApplicant=SANOFI%20AVENTIS%20US&ProductMktStatus=3&goto=Search.DrugDetails), and there are no generics listed for the oral form.

Regarding the comment involving two chemotherapy drugs that have not been assigned their own specific HCPCS codes, we note that the assignment of such a code has been an essential element of identifying certain chemotherapy drugs for exclusion ever since the BBRA first created the statutory exclusion list in 1999, as reflected in the drafting of the statutory provision itself as well as in our periodic solicitation of "codes" that might meet the criteria for exclusion. When the Congress previously enacted the original consolidated billing legislation in section 4432(b) of the BBA, chemotherapy drugs did not appear in the initial set of exclusions from this provision. Accordingly, all chemotherapy drugs were originally subject to consolidated billing, and none were separately billable under Part B when furnished to an SNF's Part A resident. Then, in section 103 of the BBRA, the Congress excluded certain items and services involving chemotherapy and its administration from the SNF consolidated billing requirement, effective with items and services furnished on or after April 1, 2000. However, this legislation did not categorically exclude all chemotherapy drugs from SNF consolidated billing; rather, as explained in the BBRA's Conference Report, it specifically targeted those "high-cost, low probability" drugs that ". . . are not typically administered in a SNF, or are exceptionally expensive, or are given as infusions, thus requiring special staff expertise to administer" (H.R. Conf. Rep. No. 106-479 at 854). By contrast, other types of chemotherapy drugs that ". . . are relatively inexpensive and are administered routinely in SNFs" were to remain subject to SNF

consolidated billing. The approach that the Congress adopted to identify the individual chemotherapy drugs being designated for exclusion consisted of listing them by HCPCS code in the statute itself. Thus, a chemotherapy drug's assignment to its own specific code has always served as the mechanism of designating that drug for exclusion, as well as the means by which the claims processing system is able to recognize that exclusion. This means that an NOS code such as J8999, which is broadly comprised of miscellaneous chemotherapy drugs "not otherwise specified" in the coding system, would be unsuitable for this function, as such a code would not allow for distinguishing the particular chemotherapy drug that is intended for exclusion from the various other, non-excluded chemotherapy drugs also encompassed by that same code.

Regarding code J9219 (Leuprolide acetate implant, 65 mg), we have noted previously in the FY 2008 SNF PPS final rule (72 FR 43431, August 3, 2007) that this drug

> . . . is a hormonal agent which is clinically analogous to other existing codes that have not been designated for exclusion; moreover, as this drug is used in treating the commonly-occurring condition of prostate cancer, we believe that it is unlikely to meet the criterion of "low probability" specified in the BBRA.

Comment: One commenter reiterated recommendations that commenters had repeatedly urged us to adopt in previous years, by expanding the existing chemotherapy exclusion to encompass related drugs that are commonly administered in conjunction with chemotherapy to ameliorate the side effects of the chemotherapy drugs, and by excluding certain additional categories of services beyond those specified in the BBRA, such as the antibiotic drug, Vancomycin. Another commenter cited previously-expressed objections from numerous prior public comment periods regarding the limited scope of the existing administrative exclusion for certain specified types of high-intensity outpatient services (which applies only when such services are furnished in the outpatient hospital setting and not when furnished in other,

freestanding settings), and stated that this exclusion should focus on the nature of the excluded service itself rather than on the location in which the service is furnished.

Response: Regarding the exclusion of chemotherapy-related drugs, we have noted repeatedly in this and previous final rules--such as the FY 2014 SNF PPS final rule (78 FR 47958-59, August 6, 2013)--that the BBRA authorizes us to identify additional service codes for exclusion only within those particular service categories (chemotherapy items; chemotherapy administration services; radioisotope services; and, customized prosthetic devices) that it has designated for this purpose, and does not give us the authority to exclude additional services which, though they may be related to one of the categories designated for exclusion, fall outside of the specified service categories themselves. Thus, while such drugs as anti-emetics (anti-nausea drugs) and drugs that stimulate the body's production of blood cells to replace those destroyed by chemotherapy are commonly administered in conjunction with chemotherapy, they are not inherently chemotherapeutic in nature (that is, they do not actively destroy cancer cells) and, consequently, do not fall within the excluded chemotherapy category designated in the BBRA. Regarding the exclusion of the antibiotic drug Vancomycin, we noted in the FY 2012 SNF PPS final rule that ". . . we decline to add to the exclusion list those services submitted by commenters that have already been considered and not excluded in previous years based on their being outside the particular service categories that the statute authorizes for exclusion" (76 FR 48531, August 8, 2011). Such services would include antibiotics, as discussed previously in the FY 2004 SNF PPS final rule (68 FR 46060, August 4, 2003). The statute does not provide the Secretary the authority to create additional categories of excluded services beyond those specified in the law. Finally, we note that the administrative exclusion for certain designated types of outpatient services does indeed consider the exceptionally intensive nature of the excluded services themselves, and in fact, as we have explained on numerous occasions

(including, most recently, in the FY 2014 SNF PPS final rule (78 FR 47957-58, August 6, 2013)), this is precisely the reason for limiting this exclusion to the outpatient hospital setting:

> . . . as we initially noted in the FY 2009 SNF PPS final rule (73 FR 46436, August 8, 2008) and then reiterated in a number of subsequent final rules, the repeated calls to expand the administrative exclusion for high-intensity outpatient services in this manner would appear to reflect. . . a continued misunderstanding of the underlying purpose of this provision. As we have consistently noted in response to comments on this issue in previous years . . . and as also explained in MLN Matters article SE0432 . . . the rationale for establishing this exclusion was to address those types of services that are so far beyond the normal scope of SNF care that they require the intensity of the hospital setting in order to be furnished safely and effectively.

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

<u>Comment</u>: One commenter reiterated the recurring objections to excluding certain high-intensity outpatient services only when furnished in the hospital setting, specifically in the context of radiation therapy. However, in addition to restating the same positions on this point that had already been advanced and addressed repeatedly in prior rules--most recently, in the FY

2014 SNF PPS final rule (78 FR 47957-58, August 6, 2013)--the commenter also presented a new line of reasoning, stating that radiation therapy is, in fact, already encompassed by the existing exclusion for radioisotope services at section 1888(e)(2)(A)(iii)(IV) of the Act (which, as a statutory exclusion, is not restricted to only those services furnished in the outpatient hospital setting). The commenter explained that, of the three types of radiation treatment, two can involve the use of radioisotopes: systemic radioisotopes administered through infusion or oral ingestion (which are already addressed in the 79000-series codes currently set forth in the statutory exclusion) and brachytherapy (sealed source radiation placed precisely in the area under treatment, as identified in a number of 77000-series codes). (The commenter noted in passing that the third type, external beam radiation therapy, at one time also utilized a radioisotope (Cobalt 60) as well, but added that this particular application is now "very rarely used," as it ". . . poses increased radiation risk, decreased accuracy, and unfavorable treatment beam characteristics"). In addition to the relatively narrow range of 79000-series codes that the statute currently excludes as radioisotope services, the commenter recommended excluding a substantially broader range of radiation oncology codes (primarily in the 77000 series), including a number of supplemental clinical treatment and planning codes that can be furnished not only in connection with a radioisotope procedure, but also more generally with various other forms of radiation treatment as well. In this context, the commenter cited our own characterization of the BBRA legislation as conferring on the Secretary ". . . the authority to designate additional, individual services for exclusion within each of the specified service categories" (emphasis added), and stated that the particular "specified service category" at issue here is actually the Part B benefit category at section 1861(s)(4) of the Act, which encompasses "X-ray, radium, and radioactive isotope therapy, including materials and services of technicians." As a consequence, the commenter asserted that the existing statutory exclusion of "radioisotope services" should be

considered to encompass every type of radiation treatment described in section 1861(s)(4) of the Act, even in those instances where no actual use of radioisotopes is involved.

Response: We note that two of the specific codes (79300 and 79403) that the commenter recommended adding to the list of excluded radioisotope services already appear as such in Major Category III.C ("Radioisotopes and their Administration") of the online exclusion list, which is available in the 2014 Part A MAC Update at http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2014-Part-A-MAC-Update.html. Beyond that, we agree that the statutory exclusion of radioisotope services at section 1888(e)(2)(A)(iii)(IV) of the Act is not confined to the fairly narrow range of 79000-series codes specified in the law itself (identifying systemic radioisotopes administered through infusion or oral ingestion), but rather, is intended to encompass all of the "high-cost, low probability" forms of radiation treatment that actually involve the use of radioisotope services (which can include brachytherapy as well). Accordingly, we will make appropriate revisions in Major Category III.C to reflect this, by adding the brachytherapy-related code 77014 (computed tomography guidance for placement of radiation therapy fields for brachytherapy), as well as the clinical brachytherapy code range of 77750 to 77799. However, we are not adding external beam radiation therapy to this category of the exclusion list (even when it involves the use of the radioisotope Cobalt 60) in view of the commenter's characterization of this particular radioisotope application in terms that would raise questions about whether it continues to be used as well as inherent questions about its safety and efficacy in this context. In our discussion of the statutory exclusion for chemotherapy services in the FY 2014 SNF PPS final rule, we noted that ". . . when an otherwise excluded chemotherapy drug is prescribed for a use that does not involve treating cancer, the drug would not qualify as an excluded 'chemotherapy' drug in that instance" (78 FR 47958). Similarly, we note that to the extent any of the additional brachytherapy codes

we now specify for exclusion as "radioisotope services" under section 1888(e)(2)(A)(iii)(IV) of the Act could serve to identify non-radioisotope, as well as radioisotope procedures, the radioisotope exclusion under Major Category III.C would apply only in those particular instances that actually involve the use of radioisotopes. (Of course, even when associated with a non-radioisotope procedure, a particular code that also appears in Major Category I.D ("Radiation Therapy") of the online exclusion list could still qualify for exclusion on that basis when furnished in the outpatient hospital setting.)

We are also not adopting the commenter's recommendation to exclude a number of supplemental but more generic clinical treatment and planning codes beyond those that specifically identify the actual performance of the radioisotope procedure itself. We decline to exclude such codes, not because these supplemental activities would never occur in connection with a radioisotope procedure (as this is indeed possible in certain instances), but rather, because they are unlikely in themselves to meet the "high-cost, low probability" threshold which determines those specific radioisotope services that qualify for exclusion under this provision. We believe that for treatments involving the use of radioisotope services, it is the actual performance of the radioisotope procedure itself (rather than any associated preparatory and planning activities) that would account for the preponderance of the cost, so that those separate, supplemental codes would be unlikely in themselves to meet the "high-cost" threshold for exclusion. Similarly, we do not believe that these supplemental codes would meet the "low probability" criterion, as they are associated not just with radioisotope procedures alone, but also more generally with various other, more commonly used forms of radiation treatment.

Moreover, we do not share the commenter's view that the "specified service category" at issue here is the Part B benefit category at section 1861(s)(4) of the Act, which provides for broader coverage of radiation treatment beyond just that involving the use of radioisotope

services. We note that the statutory exclusion for "radioisotope services" at section 1888(e)(2)(A)(iii)(IV) of the Act stands in marked contrast, for example, to the ones for dialysis and erythropoietin (EPO) at section 1888(e)(2)(A)(ii) of the Act, which consist of--and, in fact, are defined by--explicit cross-references to the corresponding Part B benefit categories appearing in sections 1861(s)(2)(F) and 1861(s)(2)(O) of the Act, respectively. Conversely, the statutory exclusion at section 1888(e)(2)(A)(iii)(IV) of the Act does not contain such a cross-reference to the Part B benefit category at section 1861(s)(4) of the Act for general coverage of radiation treatments, and thus, applies specifically to "radioisotope services" alone.

3. Payment for SNF-Level Swing-Bed Services

Section 1883 of the Act permits certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute- or SNF-level care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF-level 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. As explained in the FY 2002 final rule (66 FR 39562), this effective date is consistent with the statutory provision to integrate swing-bed rural hospitals into the SNF PPS by the end of the transition period, June 30, 2002.

Accordingly, all non-CAH swing-bed rural hospitals have now come under the SNF PPS. Therefore, all rates and wage indexes outlined in this final rule for the SNF PPS also apply to all non-CAH swing-bed rural hospitals. A complete discussion of assessment schedules, the MDS, and the transmission software (RAVEN-SB for Swing Beds) appears in the FY 2002 final rule (66 FR 39562) and in the FY 2010 final rule (74 FR 40288). As finalized in the FY 2010 SNF PPS final rule (74 FR 40356 through 40357), 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 website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html. We received no comments on this aspect of the proposed rule.

D. Other Issues

1. Proposed Changes to the SNF PPS Wage Index

a. Background

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 the Secretary determines appropriate. Since the inception of the SNF PPS, we have used hospital inpatient wage data, exclusive of the occupational mix adjustment, in developing a wage index to be applied to SNFs. As noted previously in section IV.B.4. of this final rule, we will continue that practice for FY 2015. The wage index used for the SNF PPS is calculated using the Inpatient Prospective Payment System (IPPS) wage index data on the basis of the labor market area in which the acute care hospital is located, but without taking into account geographic reclassifications under section 1886(d)(8) and (d)(10) of the Act, and without applying the IPPS rural floor under section 4410 of the BBA, the IPPS imputed rural floor under 42 CFR 412.64(h), the frontier state floor under section 1886(d)(3)(E)(iii) of the Act, and the outmigration adjustment under section 1886(d)(13) (see the FY 2006 SNF PPS proposed rule (70 FR 29090 through 29095)). The applicable SNF wage index value is assigned to a SNF on the basis of the labor market area in which the SNF is geographically located. Under section 1888(e)(4)(G)(ii) of the Act, beginning with FY 2006, we delineate labor market areas based on the Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget (OMB). The current statistical areas used in FY 2014 are

based on OMB standards published on December 27, 2000 (65 FR 82228) and Census 2000 data and Census Bureau population estimates for 2007 and 2008 (OMB Bulletin No. 10-02). For a discussion of OMB's delineations of CBSAs and our implementation of the CBSA definitions, we refer readers to the preambles of the FY 2006 SNF PPS proposed rule (70 FR 29090 through 29096) and final rule (70 FR 45040 through 45041). As stated in the FY 2014 SNF PPS proposed rule (78 FR 26448) and final rule (78 FR 47952), on February 28, 2013, OMB issued OMB Bulletin No. 13-01, which established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. A copy of this bulletin may be obtained at http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf. According to OMB, "[t]his bulletin provides the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on June 28, 2010, in the **Federal Register** (75 FR 37246 - 37252) and Census Bureau data."

While the revisions OMB published on February 28, 2013 are not as sweeping as the changes made when we adopted the CBSA geographic designations for FY 2006, the February 28, 2013 OMB bulletin does contain a number of significant changes. For example, there are new CBSAs, urban counties that have become rural, rural counties that have become urban, and existing CBSAs that have been split apart. However, because the bulletin was not issued until February 28, 2013, with supporting data not available until later, and because the changes made by the bulletin and their ramifications needed to be extensively reviewed and verified, we were unable to undertake such a lengthy process before publication of the FY 2014 SNF PPS proposed rule and, thus, did not implement changes to the wage index for FY 2014 based on these new

OMB delineations. In the FY 2014 SNF PPS final rule (78 FR 47952), we stated that we intended to propose changes to the wage index based on the most current OMB delineations in the FY 2015 SNF PPS proposed rule. As discussed in the FY 2015 SNF PPS proposed rule (79 FR 25779 through 25786), we proposed to implement the new OMB delineations as described in the February 28, 2013 OMB Bulletin No. 13-01, for the SNF PPS wage index beginning in FY 2015, because we believe it is important for the SNF PPS to use the latest OMB delineations available in order to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. While CMS and other stakeholders have explored potential alternatives to the current CBSA-based labor market system (we refer readers to the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Reform.html), no consensus has been achieved regarding how best to implement a replacement system. As discussed in the FY 2005 IPPS final rule (69 FR 49027), "While we recognize that MSAs are not designed specifically to define labor market areas, we believe they do represent a useful proxy for this purpose." We further believe that using the most current OMB delineations would increase the integrity of the SNF PPS wage index by creating a more accurate representation of geographic variation in wage levels. As noted in the FY 2015 SNF PPS proposed rule, we have reviewed our findings and impacts relating to the new OMB delineations, and have concluded that there is no compelling reason to further delay implementation (79 FR 25780). Because we believe that we have broad authority under section 1888(e)(4)(G)(ii) to determine the labor market areas used for the SNF PPS wage index, and because we also believe that the most current OMB delineations accurately reflect the local economies and wage levels of the areas in which hospitals are currently located, we proposed to implement the new OMB delineations as described in the February 28, 2013 OMB Bulletin No. 13-01, for the SNF PPS wage index beginning in FY 2015. Further, we proposed a

transition period of 1 year, during which a 50/50 blended wage index would be used for all providers in FY 2015, in order to mitigate the resulting short-term instability and negative impacts on certain providers and to provide time for providers to adjust to their new labor market delineations. Under this proposal, providers would receive 50 percent of their FY 2015 wage index based on the new OMB delineations and 50 percent of their FY 2015 wage index based on the labor market delineations for FY 2014 (both using FY 2011 hospital wage data). In addition, we proposed to continue to treat Micropolitan Statistical Areas (referred to here as Micropolitan Areas) as rural and to include such areas in the calculation of the state's rural wage index. As we explained in the FY 2015 SNF PPS proposed rule (79 FR 25780), because Micropolitan Areas tend to encompass smaller population centers and contain fewer hospitals than MSAs, if Micropolitan Areas were to be treated as separate labor market areas, the SNF PPS wage index would include significantly more single-provider labor market areas. We further explained that recognizing Micropolitan Areas as independent labor markets would generally increase the potential for dramatic shifts in year-to-year wage index values because a single hospital (or group of hospitals) could have a disproportionate effect on the wage index of an area. Dramatic shifts in an area's wage index from year to year are problematic and create instability in the payment levels from year to year, which could make fiscal planning for SNFs difficult if we adopted this approach. For a full discussion of our proposals and associated rationale related to the implementation of the new OMB delineations, we refer readers to the FY 2015 SNF PPS proposed rule (79 FR 25779 through 25786). The comments we received on the proposed changes to the wage index, including those comments on our proposed transition methodology, as well as responses to these comments, appear below.

Comment: We received a few comments on the proposed implementation of the new OMB delineations for the SNF PPS wage index, primarily focused on how such changes would

be implemented. Specifically, one commenter requested a 2-year phase-in (rather than our proposed 1-year transition) for the proposed wage index changes. Other commenters stated that CMS should utilize similar implementation policies for the SNF wage index changes as were proposed for hospital providers in the FY 2015 Inpatient Prospective Payment System (IPPS) proposed rule (79 FR 27978). More specifically, these commenters urged CMS to establish a three-year transition policy (similar to that proposed under IPPS) for urban SNFs that would become rural under the new OMB delineations.

Response: As noted in the FY 2015 SNF PPS proposed rule (79 FR 25785), we considered proposing a multi-year transition approach, whether it be 2, 3, or some other number of years, in order minimize the impact of the proposed wage index changes in a given year. However, we also believe this must be balanced against the need to ensure the most accurate payments possible based on the most current geographic delineations, which supports the use of a shorter transition to the revised OMB delineations. As discussed in the FY 2015 SNF PPS proposed rule (79 FR 25785), we believe that using the most current OMB delineations would increase the integrity of the SNF PPS wage index by creating a more accurate representation of geographic variation in wage levels. As such, we believe that utilizing a 1-year (rather than a multiple-year) transition with a blended wage index in FY 2015 would strike the best balance.

It should also be noted that the implementation of the revised OMB delineations, which we are finalizing in this rule, sets SNF payments at a level that more accurately reflects the costs of labor in a SNF's geographic area. Accordingly, under this policy, SNFs will experience a decrease from their current wage index value only to the extent that their current wage index value actually exceeds what the latest area wage data warrants using the revised OMB delineations, and they will experience an increase from their current wage index value to the extent that their current wage index value is less than what the latest area wage data warrants

using the revised OMB delineations. We believe that pursuing a longer transition period would advantage the former group by delaying implementation of the full decrease in their wage index values under the new OMB delineations, at the further expense of the latter group which would experience an extended delay in implementation of the full increase in their wage index values. We believe that utilizing a 1-year (rather than a multiple-year) transition with a blended wage index in FY 2015 strikes an appropriate balance between the interests of these two groups of providers.

Commenters also suggested that CMS consider a 3-year transition methodology similar to that proposed in the FY 2015 IPPS proposed rule. In the FY 2015 IPPS proposed rule, CMS proposed a 3-year transition for those hospitals that are currently in urban areas that would become rural under the new OMB delineations, under which such hospitals would receive the urban wage index of the CBSA in which they are currently located for FY 2014 for a period of three fiscal years (see the FY 2015 IPPS proposed rule, 79 FR 28060). However, there are important differences between the IPPS and SNF PPS which give rise to different implementation and impact considerations. Most notably, IPPS hospital providers are subject to the rural floor, which requires that the wage index applicable to any hospital located in an urban area of a state not be less than the rural wage index of the state (see the FY 2015 IPPS proposed rule, 79 FR 28068). This guarantees that the wage index for rural hospitals is not greater than the wage index of any urban hospitals in the same state. As a result, hospitals moving from urban to rural status under the new OMB delineations are more likely to experience a decrease in their wage index, while hospitals moving from rural to urban status under the new OMB delineations are more likely to experience an increase in their wage index. This is not the case in the SNF PPS, where the rural floor is not applied and such differential impacts on urban and rural providers do not exist. Under the SNF PPS, the subsets of providers that will experience

increases and decreases in wage index due to implementation of the new OMB delineations are quite varied. For example, 22 SNFs changing from urban to rural status under the new OMB delineations will have a higher wage index than they had in their urban CBSA. This would be less likely to occur if the rural floor were applied under the SNF PPS. Given the impacts discussed above, we believe that the 3-year transition policy proposed in the FY 2015 IPPS proposed rule and discussed above is not necessary or appropriate to address the impacts on SNF providers. By contrast, under the IPPS, hospitals currently located in urban areas that would become rural under the revised OMB delineations are more likely to experience a wage index decrease as discussed above, raising concerns over the potential adverse impact of the new OMB delineations on those hospitals that are specific to the IPPS. Therefore, we do not agree with the commenter that a 3-year transition policy, similar to that proposed under the IPPS, should be applied to those SNFs changing from urban to rural status under the new OMB delineations.

To further address commenters' general suggestion that we utilize similar implementation policies as were proposed for hospital providers in the FY 2015 IPPS proposed rule, we also considered whether it would appropriate to apply a variation of the 3-year transition discussed above, pursuant to which SNFs that would experience a decrease in their wage index under the new OMB delineations would receive the wage index of the CBSA in which they are currently located for FY 2014 for a period of three fiscal years. This would involve applying a different transition policy for this subset of SNFs (allowing them to maintain the wage index of the CBSA in which they are currently located for three fiscal years) than would be applied to other SNFs. However, because revisions in the SNF PPS wage index must be made in a budget neutral manner, as required by section 1888(e)(4)(G)(ii) of the Act, if such a 3-year transition policy were to be applied to this subset of providers, the resulting budget neutrality adjustment would reduce the base payment rates for all SNFs in FY 2015, as well as potentially reduce base rates

for each of the two additional years during which this transition policy would be in effect. In terms of the overall impact on SNFs, pursuing this type of transition policy would, in effect, aid the 21 percent of SNFs experiencing a decrease in their wage index due to the new OMB delineations (who would nevertheless also experience a decrease in their base rates under this alternative) at the expense the remaining 79 percent of SNFs, all of which would experience a decrease in their base rates due to the budget neutrality adjustment (including those SNFs experiencing either no change or an increase in their wage index under the new OMB delineations). As we stated in the FY 2015 SNF PPS proposed rule (79 FR 25785), we looked for a transition approach that would provide relief to the largest percentage of adversely affected SNFs with the least impact to the rest of facilities. As discussed in the FY 2015 SNF PPS proposed rule (79 FR 25785-25786), we believe that the application of a one-year transition blended wage index for all providers best achieves this goal, as it mitigates the negative payment impacts of the new OMB delineations for adversely affected SNFs, without reducing the base rates for all providers. Furthermore, as discussed above, we do not believe a multi-year transition approach would be appropriate, given the need to ensure the most accurate payments possible based on the most current geographic delineations.

While we understand the concern raised by these commenters regarding the potential impact on the subset of SNFs that would experience a decrease in their wage index, we believe this must be weighed against the interests of and impact on all SNFs. As discussed above, and in the SNF PPS proposed rule (79 FR 25785), we believe that our proposed 1-year transition policy with a 50/50 blended wage index for all SNFs appropriately mitigates the negative payment impacts on SNFs that will experience a wage index decrease due to implementation of the new OMB delineations, while having the least impact on the rest of the facilities.

Accordingly, for the reasons specified in this final rule and in the FY 2015 SNF PPS

proposed rule (79 FR 25779 through 25786), we are finalizing, without modification, our proposal to implement the new OMB delineations as described in the February 28, 2013 OMB Bulletin No. 13-01, for the SNF PPS wage index beginning in FY 2015. Under this policy, as proposed, we will continue to treat Micropolitan Areas as rural and to include such areas in the calculation of the state's rural wage index. Further, as proposed in the FY 2015 SNF PPS proposed rule, we are finalizing a transition period of 1 year, during which a 50/50 blended wage index will be used for all providers in FY 2015. In FY 2015, SNFs will receive 50 percent of their FY 2015 wage index based on the new OMB delineations and 50 percent of their FY 2015 wage index based on the OMB delineations in effect for FY 2014 (both using FY 2011 hospital wage data). Beginning October 1, 2015, the wage index for all SNFs will be fully based on the new OMB delineations.

The wage index applicable to FY 2015 is set forth in Table A available on the CMS website at http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/WageIndex.html. Table A provides a crosswalk between the FY 2015 wage index for a provider using the current OMB delineations in effect in FY 2014 and the FY 2015 wage index using the revised OMB delineations, as well as the transition wage index values that will be in effect in FY 2015.

a. Labor-Related Share

Each year, we calculate a revised labor-related share based on the relative importance of labor-related cost categories in the SNF market basket as discussed in section IV.B.4 of this final rule. Table 12 summarizes the updated labor-related share for FY 2015, compared to the labor-related share that was used for the FY 2014 SNF PPS final rule.

TABLE 12: Labor-related Relative Importance, FY 2014 and FY 2015

	Relative importance, labor-related, FY 2014 13:2 forecast[1]	Relative importance, labor-related, FY 2015 14:2 forecast[2]
Wages and salaries	49.118	48.816
Employee benefits	11.423	11.365
Nonmedical Professional fees: labor-related	3.446	3.450
Administrative and facilities support services	0.499	0.502
All Other: Labor-related services	2.287	2.276
Capital-related (.391)	2.772	2.771
Total	69.545	69.180

[1] Published in the **Federal Register**; based on second quarter 2013 IGI forecast
[2] Based on second quarter 2014 IGI forecast, with historical data through first quarter 2014.

2. SNF Therapy Research Project

As discussed in the FY 2014 SNF PPS proposed rule (78 FR 26466, May 6, 2013), CMS contracted with Acumen, LLC and the Brookings Institution to identify potential alternatives to the existing methodology used to pay for therapy services received under the SNF PPS. Under the current payment model, the therapy payment rate component of the SNF PPS is based solely on the amount of therapy provided to a patient during the 7-day look-back period, regardless of the specific patient characteristics. The amount of therapy a patient receives is used to classify the resident into a RUG category, which then determines the per diem payment for that resident. In the FY 2014 SNF PPS proposed rule (78 FR 26466, May 6, 2013), we invited public comment on this project. In the FY 2014 SNF PPS final rule (78 FR 47963, August 6, 2013), we discussed the comments we received on this project, all of which supported the overall goals and objective of the project, and a few highlighted the importance of maintaining contact with the stakeholder community.

In the FY 2015 SNF PPS proposed rule (79 FR 25786), we provided an update on the current state of this project and invited public comments on this project. The comments we received on this topic, with their responses, appear below.

Comment: All of the comments we received on this work supported CMS's research effort in developing a new methodology for paying for therapy services received in the SNF. Most commenters urged CMS to expedite the research necessary to develop a new therapy payment model, with one commenter expressing disappointment that CMS has not implemented a model to date. A few commenters stated that CMS should seek input from stakeholders on how best to revise the current therapy payment model.

Response: We appreciate the broad support for this research initiative and understand the importance of completing this work in both a timely and efficient manner. We also recognize the importance of seeking input from stakeholders on how best to revise the current therapy payment model, which is why one of our central focuses in leading this research effort has been to solicit stakeholder feedback through listening sessions and through the creation of a SNF therapy research email box at SNFTherapyPayments@cms.hhs.gov. Stakeholders can send input on a revised therapy payment model to this email box at any time, and every email is read and considered by both CMS staff and contractors. We also plan to solicit feedback through more formal avenues such as a technical expert panel in the near future.

Currently, we are closely examining all of the models that have been suggested for improving SNF therapy payment, including but not limited to models developed by MedPAC and the Urban Institute. We will carefully consider suggested models such as these by using their best attributes, combined with all of the stakeholder feedback and ideas we are receiving, and intend to develop a payment model that will pay accurately and appropriately for SNF therapy services, while also incentivizing the most appropriate treatment for the individual

patient's care needs. Additional considerations for a revised SNF therapy payment approach go beyond existing research and will also need to include implementation strategies for the revised therapy payment methodology, along with the incorporation of the revised therapy payment approach into a single payment system that also includes payment for nursing services.

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

Comments on this topic may still be provided outside the rulemaking process, and these comments should be sent via email to SNFTherapyPayments@cms.hhs.gov. Information regarding this project can be found on the project website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html.

3. Proposed Revisions to Policies Related to the Change of Therapy (COT) Other Medicare Required Assessment (OMRA)

In the FY 2015 SNF PPS proposed rule (79 FR 25786 through 25788), we discussed proposed changes to the existing COT OMRA policy which would permit providers to complete a COT OMRA for a resident who is not currently classified into a RUG-IV therapy group or receiving a level of therapy sufficient for classification into a RUG-IV therapy group, but only in those rare cases where the resident had qualified for a RUG-IV therapy group on a prior assessment during the resident's current Medicare Part A stay, and had no discontinuation of

therapy services between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the patient into a RUG-IV therapy group. The comments we received on this proposal, along with our responses, appear below.

Comment: All of the comments we received on this topic supported the proposed revision to the existing COT OMRA policies. One commenter stated that this proposal is not necessary, stating that the current COT OMRA policy already allows for providers to complete a COT OMRA in the circumstances proposed in the FY 2015 SNF PPS proposed rule.

Response: We appreciate the broad support we received on this proposal. With regard to the comment that this proposal is not necessary, we would note that the FY 2012 SNF PPS final rule (78 FR 48525 through 48526) and section 2.9 of the MDS RAI manual (available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html) clearly state that the COT OMRA is to be used in those cases where the patient is classified into a RUG-IV therapy category, or where the patient is receiving a level of therapy sufficient for classification into a therapy RUG (but is classified into a nursing RUG because of index maximization). That providers may have misinterpreted the rules and are currently using the COT OMRA in a manner that is inconsistent with these guidelines does not affect how the policy was finalized and implemented. We would encourage providers to examine their current COT OMRA completion protocols to ensure they are aligned with existing COT OMRA guidelines, as provided in the aforementioned references, and immediately address any assessments that were completed inappropriately.

Comment: Several commenters highlighted an issue in the second example that begins on page 25787 of the FY 2015 SNF PPS proposed rule. Specifically, these commenters pointed

out that because the resident is no longer in a RUG-IV therapy group, an End of Therapy (EOT) OMRA would not be completed on this resident when the discontinuation of therapy occurs as this would violate the rules associated with the EOT OMRA, which require that the resident be in a RUG-IV therapy group for this assessment to be completed. These commenters requested that an additional example be added here to clarify this second example and the scope of this proposed revision. Finally, a few commenters requested that CMS provide as much detail as possible in this final rule regarding how this policy will be implemented and how this revision to the COT OMRA policy may affect other OMRAs.

Response: We agree with the commenters that the reference to completing an EOT OMRA in the second example on page 25787 of the FY 2015 SNF PPS proposed rule is incorrect. To address this issue, below we provide a new example that is intended to clarify the scope of this proposed revision to the COT OMRA policy.

Assume Mr. A is classified into the RUG group RUA on his 30-day assessment with an ARD set for Day 30 of his stay. On Day 37, the facility checks the amount of therapy that was provided to Mr. A and finds that while Mr. A did receive the requisite number of therapy minutes to qualify for this RUG category, he only received therapy on 4 distinct calendar days, which would make it impossible for him to qualify for an Ultra-High Rehabilitation RUG group. Moreover, due to the lack of 5 distinct calendar days of therapy and the lack of any restorative nursing services, Mr. A does not qualify for any therapy RUG group. As a result, the facility must complete a COT OMRA for Mr. A, on which he may only classify for a non-therapy RUG group. However, as opposed to the first example found on page 25787 of the FY 2015 SNF PPS proposed rule, where the resident's therapy continued during the week following the COT OMRA, let us assume the facility decides to discontinue his therapy services, with Day 39 representing the last day that Mr. A is provided therapy. The facility subsequently decides to

provide Mr. A with therapy services due to observing Mr. A's deteriorating condition, with the first day of new therapy services being Day 48. On Day 54 (7 days following the day therapy began on Day 48, including Day 48) the facility reviews the therapy services provided to Mr. A during the prior week and finds that Mr. A would qualify for the RUG group RUA.

As intended in the second example in the FY 2015 SNF PPS proposed rule (79 FR 25787), this example represents a scenario where, under both the current and proposed COT OMRA policies, a COT OMRA may not be completed. This is because a discontinuation of therapy services occurred. To clarify our example and the scope of the proposed revision to the COT OMRA policy, we note that "discontinuation of therapy services" is defined in a manner consistent with how this phrase is described in the FY 2010 SNF PPS final rule (76 FR 40346 through 40349), the FY 2012 SNF PPS final rule (78 FR 48517 through 48522), and Chapter 2, Section 2.9, of the MDS RAI manual. Consistent with what constitutes a discontinuation of therapy more globally within the SNF PPS, a "discontinuation of therapy" here refers to the planned or unplanned discontinuation of all rehabilitation therapies for 3 or more consecutive days. This was the actual intent of the erroneous reference to the EOT OMRA in the FY 2015 SNF PPS proposed rule, as noted by these commenters. In essence, the same criteria used to determine the need for an EOT OMRA (which is that the resident does not receive therapy services for 3 consecutive calendar days) will be used under our revised COT OMRA policy to determine whether there has been a discontinuation of therapy services and thus whether a COT OMRA may be completed for a given resident. In the above example, since the resident did not receive therapy services for 8 days, this would represent a discontinuation of therapy services as defined above and the COT OMRA that was planned with an ARD of Day 54 would not be permissible, both under our current policy and under our proposed revised COT OMRA policy.

With regard to comments on how this revision would affect other OMRAs, the answer is

that it does not have any impact on the other OMRAs within the SNF PPS. The rules and policies associated with all other assessment types remain the same. We also plan to provide additional details on the operation of this revised policy in a forthcoming MDS RAI manual revision, which would be effective October 1, 2014.

Accordingly, for the reasons specified in this final rule and in the FY 2015 SNF PPS proposed rule (79 FR 25786 through 25788), we are finalizing our proposal to permit providers, in certain circumstances (discussed below), to complete a COT OMRA for a resident who is not currently classified into a RUG-IV therapy group, or receiving a level of therapy sufficient for classification into a RUG-IV therapy group. As discussed above, this would be allowed only in those rare cases where the resident had qualified for a RUG-IV therapy group on a prior assessment during the resident's current Medicare Part A stay, and had no discontinuation of therapy services between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the patient into a RUG-IV therapy group. This change in policy will be effective October 1, 2014, with further details on how this policy will be implemented to be provided in a forthcoming MDS RAI manual revision and other guidance, consistent with the way we have provided implementation details for other MDS RAI policy revisions (for example, see Transition for Implementation of FY 2014 SNF PPS MDS 3.0 Policy Changes, available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Spotlight.html)

4. Civil Money Penalties (section 6111 of the Affordable Care Act)

In the FY 2015 SNF PPS proposed rule (79 FR 25788 through 25789), we discussed clarifications related to statutory requirements as specified in section 6111 of the Affordable Care Act regarding the approval and use of civil money penalties imposed by CMS. Further, we proposed changes to the CMS enforcement regulations at §488.433 to clarify and strengthen

these provisions to provide more specific instructions to states regarding the use of civil money penalties and the approval process, and to permit an opportunity for greater transparency and accountability of civil money penalty monies utilized by states. Finally, we invited public comment on our proposed changes as well as on CMS's proposed methods to ensure compliance with these requirements. The comments received on this topic, along with our responses, appear below.

Comment: A few commenters requested that we specify the requirements and CMS's expectations for soliciting civil money penalty funds and tracking approved civil money penalty projects. One commenter suggested that we establish a formula to determine how much is appropriate for a state to keep in reserve each year. Several commenters suggested that CMS should specify how information should be made public by the state, including the availability of grants, approved projects funded to date and the outcomes of previously funded projects. One commenter states that the proposed rule lacks clarity regarding what constitutes an "acceptable" state plan and how CMS would make such a determination.

Response: Specific operational details regarding our expectations for the state are not appropriate for inclusion in regulation. We plan to issue subsequent guidance regarding these operational details and publish this guidance in the State Operations manual.

Comment: One commenter asked if states will be required to share their acceptable plan for the effective use of civil money penalty funds with CMS. One commenter recommends formal CMS approval of all plans and public disclosure once the plan is approved. One commenter asked if CMS will require the acceptable plan be posted on some website.

Response: We will require states to submit their plans to their respective CMS Regional Offices for formal approval. We have revised §488.433(e) to specify that the plan must be approved by CMS. Public reporting of particular information related to survey and certification

information is addressed specifically in Sections 1819(g)(5) and 1819(i) of the Act (as amended by section 6103 of the Affordable Care Act) and directs CMS to publish relevant enforcement information.

Comment: One commenter asked if CMS has any plans to publicly report the amount of civil money penalty funds collected and returned to the states. Another commenter stated that CMS should publish a link to information on state's civil money penalty account balances on Nursing Home Compare. One commenter asked if the solicitation, acceptance and monitoring information of approved projects utilizing civil money penalty funds would be required to be posted on some website for transparency purposes. Several commenters suggested that CMS require information regarding state's use of civil money penalties to be posted online and updated annually. One commenter recommended that we include in the regulatory language at §488.433(e)(2) that the information be publicly available at all times and updated, at least annually. One commenter requested that a link to information on state's use of civil money penalties be included on the Nursing Home Compare website. One commenter asked CMS to specify what the reporting timeframe would be. This commenter also asked if State Medicaid websites would be an acceptable place to post civil money penalty information on, what the duration of the posting would be, and finally, if states would be required to post previously approved civil money penalty projects prior to the effective date of this ruling.

Response: We will make key information publicly available regarding approved projects, CMP grant awards, and CMP funds disbursed to states. We will explore appropriate methods to present information in a manner that will be accessible and meaningful to the public. Currently, all projects that a state is recommending for approval are submitted to the CMS Regional Office for final approval. The CMS Regional Office is tracking all approved projects and submits this information to the CMS Central Office at least annually. Additionally, we will prepare an annual

transparency report on approved civil money penalty projects. We will be posting this annual report on the CMS website. We expect the states to provide information in their plans for utilizing CMP funds to CMS on an annual basis to permit CMS to make a national report available on an annual basis; preferably aligning with the current civil money penalty uses transparency report which is compiled on a calendar year basis. The additional information required as a result of this rule would apply to all projects approved after the rule's effective date.

In response to these comments, we will consider issuing guidance to states regarding making the information about their state plans for civil money penalties as well as approved civil money penalty projects publicly available, as required in this final rule, by posting on a state website and making sure that this information is updated on an annual basis. As to the length of time of the posting, we would anticipate that states would post a new report about the use of penalty funds on an annual basis that would include currently funded projects as well as information, or links to the information, for projects funded after this regulation even if the projects have ended.

Comment: One commenter asked us to clarify what the terms "results of projects" and "other key information" would involve when we proposed that states "make information about the use of civil money penalty funds publicly available, including about the dollar amount awarded for approved projects, the grantee or contract recipients, the results of projects, and other key information."

Response: We expect that states track the results of approved projects. Projects funded with civil money penalty monies should have clear goals and methodologies to achieve those goals. States will be required to make information available about the outcome or results of completed projects. These results should include the grant recipient, amount and duration of the grant, purpose and goals of the project, results of the project (for example, whether or not the

project was successful), lessons learned, and similar key information, such as whether improvements have been institutionalized as a result of the project. Most importantly, we hope that the publicly-shared information would help others to gain insight into the methodologies to achieve important quality of care or quality of life goals, even if the project was not successful in achieving such goals within the time period of the civil money penalty grant.

Comment: One state asked that if there is a year when a state does not receive civil money penalty proposals that meet the CMS criteria, what would be the required next steps for a state to take.

Response: If there is a year that a state has actively solicited for proposals and still receives no proposals that meet the CMS criteria for approval, then we would work with the state to explore opportunities to fund worthwhile projects that would benefit nursing home residents. We would do this by looking at the state's solicitation process, using successful projects that have been funded by other states as a model, and offering any guidance necessary to ensure that civil money penalty funds are being utilized for their intended purpose.

Comment: We received several comments regarding the language at §488.433(b)(4), specifically on the potential that civil money penalty funds could be used for technical assistance for facilities implementing quality assurance and performance improvement (QAPI) programs. Commenters stated that quality assurance and performance improvement is a facility's responsibility and it will also soon be a requirement of participation. They stressed that civil money penalty funds should not be given to facilities to perform activities that they are already required and paid to perform under federal law. They noted that while language at §6111 of the Affordable Care Act authorizes the use of civil money penalties for "technical assistance for facilities implementing quality assurance programs;" general language about quality assurance should not be interpreted to include QAPI.

Response: We agree that civil money penalty funds should not be used to pay for activities, functions, or products that nursing homes are required to provide. At the same time, we believe there is a tremendous need for knowledge and sharing of important ways to provide care and achieve results that may transcend the basic requirements in our regulations. Because there is a challenge to providing technical assistance while avoiding any supplanting of nursing home responsibilities, we require that proposed projects be approved by CMS and publicly reported. We expect, over time, that we will learn more about the projects that achieve the appropriate balance between providing effective technical assistance that advances the quality of care and quality of life for residents without supplanting what nursing homes are already required to do. At the present time we have already identified in CMS published guidance a variety of uses that are prohibited, and believe that the identified prohibitions are sufficient for now. With regard to QAPI in particular, section 1128I(c) of the Act directs CMS to provide technical assistance to facilities on the development of best practices in order to meet CMS' established QAPI standards. We expect most of the technical assistance will be done by the Quality Improvement Organizations (QIOs), but do not rule out the use of CMP funds for very targeted purposes that the QIOs are not able to accomplish, especially for nursing homes that have a high reliance on Medicaid funding or are among the lowest-performing facilities. Further, at the present time there is no federal requirement for nursing homes to have a QAPI system, so there is little potential for supplanting facility compliance with a current expectation. Under section 1128I(c), following promulgation of regulations, all facilities will be required to develop and implement a QAPI program in the future, and we plan to administer the CMP funds in a manner that avoids supplanting of facility responsibilities when those rules become effective.

Comment: While the proposed language at §488.433(b)(5) addresses and expands the appropriate use of civil money penalties for the infrastructure of the temporary management

remedy, one commenter does not feel this provision will help as facilities cannot afford the temporary manager salary. This commenter urges CMS to allow facilities to use civil money penalties to pay the salaries of temporary managers when the alternative is decertification of the facility.

Response: At §488.433(b)(5), we proposed to clarify in a new paragraph that in extraordinary situations involving closure of a facility, civil money penalty funds may be used to pay the salary of a temporary manager. Such a circumstance is very narrowly construed to situations where CMS concludes that it is otherwise infeasible to ensure timely payment for such a manager by the facility and CMS determines that extraordinary action is necessary in order to protect the residents until relocation efforts are successful. However, as specified in §488.415(c), in all other circumstances a temporary manager's salary must be paid by the facility. We do not propose to change this basic responsibility of a nursing home to pay the salary of the temporary manager.

Comment: One commenter stated that they did not support the use of civil money penalty funds for the joint training of facility staff and surveyors and suggested that this use be a low level priority, be limited, and include other interested parties, such as consumers, ombudsman and advocates. This commenter also urged CMS to restore the language at the end of proposed §488.433(b)(4) which is included in current regulations, "…when such facilities have been cited by CMS for deficiencies in the applicable requirements."

Response: We believe that there are benefits for joint training between State survey agencies and nursing home providers to improve understanding of federal requirements and to communicate specific policies and procedures. In fact, we have sponsored such joint trainings on a national basis dating back to the implementation of the nursing home reform provisions of Omnibus Budget Reconciliation Act of 1987 (OBRA '87) to train both states and providers in the

new health and safety requirements and enforcement rules. To provide optimum flexibility of such training, we do not propose to limit or to require other stakeholders in joint trainings nor do we propose to limit the facilities that may utilize civil money penalty funds for joint training to only those facilities that have been cited by CMS for deficiencies under the applicable requirements. However, we do agree that this is a lower-priority use of CMP funds and ought to be limited to special situations. We will further address this issue in CMS guidance.

Comment: One commenter suggested that CMS should not limit itself to only withholding future civil money penalty disbursements in cases where states routinely failed to comply with the acceptable use of civil money penalty funds. They suggested referral to the Office of the Inspector General, or the recoupment of such funds. Another commenter recommended that we require states that failed to comply to submit an acceptable plan of correction within 30 days. They further suggested that, until an acceptable plan of correction had been submitted and approved by CMS, that CMS continue to award these civil money penalty funds to entities whose applications for use of such funds met CMS criteria. It was also suggested that a statement that CMS is withholding funds due to a state's non-compliance be posted clearly and visibly on the state survey agency's website. Additionally, it was urged that CMS monitor a withheld state's civil money penalty activity on a quarterly basis for at least one year after funds are once again distributed.

Response: Specific operational details regarding the withholding of future civil money penalty disbursements to a state are not appropriate for inclusion in regulation. We plan to issue subsequent guidance regarding these operational details and publish this guidance in the State Operations Manual. While we appreciate the suggestions offered for further enforcement action when states are not complying with the acceptable uses of civil money penalty funds as specified in §488.433, we are optimistic that the possibility of funds being withheld will be incentive

enough for states to comply with this regulation. While we do not rule out the idea of posting public information about a state that has had funds withheld, we expect that any withholding would be short-lived. We will take under advisement the additional suggestions offered by commenters for future consideration.

Comment: Several commenters suggested that CMS develop a standardized application for use of civil money penalty funds. This application should clearly articulate how the proposed use is not duplicative of statutorily mandated services, including those related to quality of care or quality of life, and how residents, families, long term care ombudsman and consumer representatives were included in the development of the proposed use and how they will be engaged in the project activities.

Response: We agree, and will develop a standardized application that states may make available to any entities seeking to submit proposals for projects to be funded with civil money penalties. We expect that such a template should be completed by early CY 2015.

Comment: One commenter suggested that CMS allow states more autonomy to award civil money penalty funds to applicants consistent with CMS-prescribed guidelines. They further noted that because states vary in their specific needs, they are more knowledgeable about how to best meet their needs in order to best serve the beneficiaries and residents/patients of nursing centers within the state.

Response: We will consider ways in which states may gain more autonomy over time, as we learn more about projects that are successful, are able to fully implement the additional processes in this regulation, and work with stakeholders. We recognize the critical role that states play and wish to bolster state ability to use civil money penalty funds effectively. Under the arrangements already in place, proposals for projects utilizing civil money penalty funds are submitted directly to the state survey agency. The state conducts the initial review of all

proposals and forwards those that meet CMS criteria and that they are recommending for final approval to the CMS regional office. We believe the regulations we are finalizing here will make the entire state civil money penalty program more coherent, more transparent, and more effective.

Comment: One commenter recommends that states be allowed to align their civil money penalty grant process with their fiscal year in order to coordinate existing state grant process timeframes.

Response: We have no objections to states aligning their civil money penalty grant process with their fiscal year.

5. Observations on Therapy Utilization Trends

In the FY 2015 SNF PPS proposed rule, we discussed recent observed trends related to therapy service provision under the SNF Part A benefit, specifically with regard to overall therapy case-mix distribution trending toward more residents classifying into the Ultra-High Rehabilitation groups, and therapy being reported on the MDS in amounts that are just enough to surpass the relevant therapy minute threshold for a given therapy RUG category. We also posted a memo on the SNF PPS website (available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Spotlight.html) which discussed these trends in greater depth. Finally, we invited comment on the data presented in the proposed rule (and associated memo) and the discussion of observed trends. The comments we received on this topic, as well as our responses, appear below.

Comment: We received a number of comments on the discussion of observed therapy trends. All of the commenters supported CMS in monitoring these trends, with a few offering their own data analytics surrounding the same issues raised in the memo referenced above. A few commenters highlighted the lack of current medical evidence related to how much therapy a

given resident should receive. One commenter recommended that CMS ensure that access to specialty populations be accounted for in our monitoring efforts. Another commenter highlighted that the trends memo provides evidence of concerns and issues of which they have become aware related to therapy minute demands on practitioners, shortened evaluation times, and pressure to reduce services inappropriately. This commenter also noted that the minimum minutes for a RUG level are often perceived as maximum minutes and that some providers may implement internal rules that prohibit clinicians, against their own professional judgment from providing therapy above the RUG levels.

Response: We appreciate the support for our continued monitoring efforts. As always, we appreciate any assistance that stakeholders may wish to provide in terms of understanding existing trends and data.

With regard to the comments which highlight the lack of existing medical evidence for how much therapy a given resident should receive, we would note that the trends memo was not intended to address such an issue. The memo was merely intended to highlight a trend indicating that, the current state of medical evidence on this point notwithstanding, the number of therapy minutes provided to SNF residents within certain therapy RUG categories is, in fact, clustered around the minimum thresholds for a given therapy RUG category. However, given the comments highlighting the lack of medical evidence related to the appropriate amount of therapy in a given situation, it is all the more concerning that practice patterns would appear to be as homogenized as the data would suggest.

With regard to the comment on specialty populations, we agree with the commenter that access must be preserved for all categories of SNF residents, particularly those with complex medical and nursing needs. As appropriate, we will examine our current monitoring efforts to identify any revisions which may be necessary to account appropriately for these populations.

With regard to the comment which highlighted potential explanatory factors for the observed trends, such as internal pressure within SNFs that would override clinical judgment, we find these potential explanatory factors troubling and entirely inconsistent with the intended use of the SNF benefit. Specifically, the minimum therapy minute thresholds for each therapy RUG category are certainly not intended as ceilings or targets for therapy provision. As discussed in Chapter 8, Section 30 of the Medicare Benefit Policy Manual (Pub. 100-02), to be covered, the services provided to a SNF resident must be "reasonable and necessary for the treatment of a patient's illness or injury, that is, are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice." (emphasis added) Therefore, services which are not specifically tailored to meet the individualized needs and goals of the resident, based on the resident's condition and the evaluation and judgment of the resident's clinicians, may not meet this aspect of the definition for covered SNF care, and we believe that internal provider rules should not seek to circumvent the Medicare statute, regulations and policies, or the professional judgment of clinicians.

6. Accelerating Health Information Exchange in SNFs

In the FY 2015 SNF PPS proposed rule, we included a discussion of our commitment to accelerating Health Information Exchange (HIE) in SNFs. Specifically, we noted that the Department is committed to accelerating HIE through the use of electronic health records (EHRs) and other types of health information technology across the broader care continuum through a number of initiatives including: (1) alignment of incentives and payment adjustments to encourage provider adoption and optimization of health information technology and HIE services through Medicare and Medicaid payment policies; (2) adoption of common standards and certification requirements for interoperable health information technology; (3) support for privacy and security of patient information across all HIE-focused initiatives; and (4) governance

of health information networks. A discussion of the comments received on this topic, with our response, appears below.

Comment: All of the comments received on this topic supported the overall agency goal to accelerate HIE within SNFs, and among post-acute care providers generally. A few commenters urged CMS to consider potential barriers to HIE for certain providers, such as those within mountainous or rural areas where connectivity may be an issue. Other commenters also asked that CMS continue to coordinate with the Office of the National Coordinator for Health Information Technology. One commenter asked CMS to consider providing a financial incentive for providers to adopt health information technology.

Response: We appreciate the broad support for this initiative and the helpful suggestions provided by the commenters. We will share these comments with the appropriate CMS staff and other governmental agencies to ensure they are taken into account as we continue to encourage adoption of health information technology.

7. SNF Value Based Purchasing

As noted above, on April 1, 2014, PAMA (Pub. L. No. 113-93) was enacted. Section 215 of PAMA, titled "Skilled nursing facility value-based purchasing," amended section 1888 of the Social Security Act (42 U.S.C. 1395yy) to create new subsections (g) and (h). The provisions of PAMA, including section 215, may be viewed at http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf. We will engage in future rulemaking, as appropriate, to implement this section of PAMA.

V. Provisions of the Final Rule; Regulations Text

As discussed in section IV.B. of this final rule, we are updating the payment rates under the SNF PPS for FY 2015 as required by section 1888(e)(4)(E)(ii) of the Act. In addition, we will use the most current OMB delineations (discussed in section IV.D.1) to identify a facility's

urban or rural status for the purpose of determining which set of rate tables will apply to the facility. Also, effective October 1, 2015, we will use ICD-10-CM code B20 (in place of ICD-9-CM code 042) to identify those residents for whom it is appropriate to apply the AIDS add-on. Further, as discussed in section IV.D.1 of this final rule, we are finalizing changes to the wage index based on the most current OMB delineations, including a 1-year transition with a blended wage index for all SNFs for FY 2015; revising the policy governing use of the COT OMRA (section IV.D.3); and finalizing changes to the enforcement regulations related to civil money penalties utilized by states (section IV.D.4.).

With reference to the civil money penalty provisions discussed in section IV.D.4. of this final rule, as proposed we are modifying current CMS regulations to provide further clarification to states and the public regarding prior approval and appropriate use of these federally-imposed civil money penalty funds.

At §488.433, civil money penalties: uses and approval of civil money penalties imposed by CMS, we will amend the regulation to specify that civil money penalties may not be used for state management operations except for the reasonable costs that are consistent with managing the projects utilizing civil money penalty funds; specify that all activities utilizing civil money penalty funds must be approved in advance by CMS; outline specific requirements that must be included in proposals submitted for CMS approval; specify that CMP funds may not be used for projects that have not been approved by CMS; specify that states are responsible for soliciting, accepting, monitoring and tracking the results of all approved activities utilizing civil money penalties and making this information publicly available on at least an annual basis; specify that state plans must ensure that a core amount of civil money penalty funds will be held in reserve for emergencies, such as relocation of residents in the event of involuntary termination from Medicare and Medicaid; and, specify steps CMS will take if civil money penalty funds are being

used for disapproved purposes or not being used at all, in other words, that CMS has authority to take appropriate steps to ensure that these funds are used for their intended purpose, such as withholding future disbursements of CMP amounts.

The revised CMS regulations will explicitly clarify the intended use of these civil money penalty funds (including the processes for prior approval of all activities using civil money penalty funds by CMS) and how CMS will address a state's use of civil money penalty funds for activities that have been disapproved by CMS or used by states for activities other than those explicitly specified in statute or regulations.

At §488.433(a), we clarify that approved projects may work to improve residents' quality of life and not just quality of care. We also clarify that while states may not use funds for survey and certification operations or state expenses, they may use a reasonable amount of civil money penalty funds for the actual administration of grant awards, including the tracking, monitoring, and evaluating of approved projects. Some states have maintained that effective use and management of the civil money penalty funds requires more state oversight and planning than they are able to provide currently, and that an allowance for such management would remove a barrier to the effective use of these funds. We did not propose a monetary or numeric limit on what might be considered reasonable, although one to three percent of available funds might be considered reasonable for an established fund.

At §488.433(b)(5), we clarify in a new paragraph that in extraordinary situations involving closure of a facility, civil money penalty funds may be used to pay the salary of a temporary manager when CMS concludes that it is infeasible to ensure timely payment for such a manager by the facility. We have encountered situations, for example, in which a facility is in bankruptcy and the court has frozen all funds at the very time that residents are being relocated and closure is proceeding. In another situation involving involuntary termination from Medicare and

impending closure of the facility, the facility was not making payments for staff or for its utilities, and residents were at risk due to the imminent departure of staff and the absence of a manager. While §489.55 permits Medicare and Medicaid payments to a facility to continue for up to 30 days after the effective date of a facility's termination or possibly longer (or shorter) if a facility has submitted a notification of closure under §483.75(r) in order to promote the orderly and safe relocation of residents, if the continued Medicare and Medicaid payments are being used to pay for facility operations during the relocation period but are being diverted elsewhere by the facility, then residents may be placed at increased risk. The change at §488.433(b)(5) clarifies not only that CMS places a priority on resident protection and protection of the Trust Fund and allows such emergency use of civil money funds, but that CMS also intends to stop or suspend the payments to the facility under §489.55 when such a situation occurs.

At new §488.433(c), we specify the requirements for all civil money penalty fund proposals being submitted to CMS for approval.

At new §488.433(d), we provide that civil money penalty funds may not be used for activities that have been disapproved by CMS.

At new §488.433(e), we provide that states must maintain an acceptable plan (approved by CMS) for the effective use of civil money penalty funds, including a description of methods by which the state will solicit, accept, monitor, and track approved projects funded by civil money penalty amounts and make key information publicly available. Examples of information that must be publicly available would include information on the projects that have been approved by CMS, the grantee and project recipients, the dollar amounts of projects approved, and the results of the projects. We also clarify that these plans provide for a core amount of funds that will generally be held in reserve for emergencies such as unplanned relocation of residents pursuant to an involuntary termination from Medicare and Medicaid, unless the state's plan demonstrates

the availability of other funds to cover emergency situations, and a reasonable aggregate amount of civil money penalty funds, beyond the emergency reserve amount, that the state expects to disburse each year for grants or contracts of projects that benefit residents and are consistent with the statute and CMS regulations. We appreciate that states may wish to develop a multi-year plan and provide an approximate range of total amount that the state plans to disburse. The intent is to ensure there is an acceptable plan, and that a state is prepared to respond to emergencies while at the same time is not maintaining a large unused amount of civil money penalty funds.

In §488.433(f), we provide that CMS may withhold future disbursement of collected civil money penalty funds to a state if CMS finds that the state has not spent such funds in accordance with the statute and regulations, fails to make use of funds to benefit the quality of care or life of residents, or fails to maintain an acceptable plan approved by CMS.

VI. Collection of Information Requirements

In the May 6, 2014, proposed rule (79 FR 25767) we solicited public comment on that rule's information collection requirements. While PRA-related comments were received, the proposed rule (and this final rule) does not contain any new or revised recordkeeping, reporting, or third-party disclosure requirements. Consequently, this rule does not require additional OMB review/approval under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.). A summary of the comments and our response can be found in section IV.D.4. of this preamble under, "Civil Money Penalties (section 6111 of the Affordable Care Act)."

VII. Economic Analyses

A. Regulatory Impact Analysis

1. Introduction

We have examined the impacts of this final rule as required by Executive Order 12866 on

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

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

2. Statement of Need

This final rule updates the SNF prospective payment rates for FY 2015 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. In addition, this final rule clarifies statutory requirements and intent as specified in section 6111 of

the Affordable Care Act regarding the approval and use of civil money penalties imposed by CMS.

3. Overall Impacts

This final rule sets forth updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2014 (78 FR 47936). Based on the above, we estimate that the aggregate impact would be an increase of $750 million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as adjusted by the MFP adjustment. The impact analysis of this final rule represents the projected effects of the changes in the SNF PPS from FY 2014 to FY 2015. 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 such that the changes may interact and, thus, the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon SNFs.

In accordance with sections 1888(e)(4)(E) and 1888(e)(5) of the Act, we update the FY 2014 payment rates by a factor equal to the market basket index percentage change adjusted by the FY 2013 forecast error adjustment (if applicable) and the MFP adjustment to determine the payment rates for FY 2015. As discussed previously, for FY 2012 and each subsequent FY,

as required by section 1888(e)(5)(B) of the Act as amended by section 3401(b) of the Affordable Care Act, the market basket percentage is reduced by the MFP adjustment. The special AIDS add-on established by section 511 of the MMA remains in effect until ". . . such date as the Secretary certifies that there is an appropriate adjustment in the case mix . . . ." We have not provided a separate impact analysis for the MMA provision. Our latest estimates indicate that there are fewer than 4,355 beneficiaries who qualify for the add-on payment for residents with AIDS. The impact to Medicare is included in the "total" column of Table 13. In updating the SNF PPS rates for FY 2015, we made a number of standard annual revisions and clarifications mentioned elsewhere in this final rule (for example, the update to the wage and market basket indexes used for adjusting the federal rates).

The annual update set forth in this final rule applies to SNF PPS payments in FY 2015. Accordingly, the analysis that follows only describes the impact of this single year. In accordance with the requirements of the Act, we will publish a notice or rule for each subsequent FY that will provide for an update to the SNF PPS payment rates and include an associated impact analysis.

As discussed in section IV.D.4 of this final rule, we also clarify statutory requirements and intent as specified in section 6111 of the Affordable Care Act regarding the approval and use of civil money penalties imposed by CMS. There would be no impact to states unless they failed to follow the new regulations regarding the approval and use of civil money penalty funds. In FY 2011, the approximate total amount of civil money penalties returned to the states was $28 million. In FY 2012, the approximate total amount of civil money penalties returned to the states was $32 million. In FY 2013, the approximate total amount of civil money penalties returned to the states was $35 million. The estimated amount that we expect to be returned to the states in FY2015, based on data from previous years, is approximately $33 million. These payments to

the states would only be withheld in the event that states did not spend civil money penalty funds in accordance with the statute and this regulation, or failed to make use of funds to benefit the quality of care or life of residents, or failed to maintain an acceptable plan for the use of these funds. Even if civil money penalty funds are withheld from a state, we expect that the state would eventually come into compliance and that the state would later again be eligible to receive civil money penalty funds.

4. Detailed Economic Analysis

The FY 2015 impacts appear in Table 13. Using the most recently available data, in this case FY 2013, we apply the current FY 2014 wage index and labor-related share value to the number of payment days to simulate FY 2014 payments. Then, using the same FY 2013 data, we apply the FY 2015 wage index, as discussed in section IV.D.1 of this final rule, and labor-related share value to simulate FY 2015 payments. We tabulate the resulting payments according to the classifications in Table 13 (for example, facility type, geographic region, facility ownership), and compare the difference between current and proposed payments to determine the overall impact. The breakdown of the various categories of data in the table follows.

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

The first row of figures describes the estimated effects of the various changes on all facilities. The next six rows show the effects on facilities split by hospital-based, freestanding, urban, and rural categories. The urban and rural designations are based on the location of the facility under the new OMB delineations that we are implementing beginning in FY 2015. Facilities should use these OMB delineations to identify their urban or rural status for purposes of identifying what areas of the impact table would apply to them beginning on October 1, 2014. The next nineteen rows show the effects on facilities by urban versus rural status by census

region. The last three rows show the effects on facilities by ownership (that is, government, profit, and non-profit status).

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

The third column shows the effect of the annual update to the wage index. This represents the effect of using the most recent wage data available, without taking into account the revised OMB delineations. That is, the impact represented in this column is solely that of updating from the FY 2014 wage index to the FY 2015 wage index without any changes to the OMB delineations. The total impact of this change is zero percent; however, there are distributional effects of the change.

The fourth column shows the effect of adopting the updated OMB delineations (as set forth in OMB Bulletin No. 13-01) for wage index purposes for FY 2015, independent of the effect of using the most recent wage data available, captured in Column 3. That is, the impact represented in this column is that of using the revised OMB delineations, and utilizing the blended wage index finalized in section IV.D.1.b.v above. The total impact of this change is zero percent; however, there are distributional effects of the change.

The fifth column shows the effect of all of the changes on the FY 2015 payments. The update of 2.0 percent (consisting of the market basket increase of 2.5 percentage points, reduced by the 0.5 percentage point MFP adjustment) is constant for all providers and, though not shown individually, is included in the total column. It is projected that aggregate payments will increase by 2.0 percent, assuming facilities do not change their care delivery and billing practices in response.

As illustrated in Table 13, the combined effects of all of the changes vary by specific types of providers and by location. For example, due to changes in this rule, providers in the rural Pacific region would experience a 4.8 percent increase in FY 2015 total payments.

TABLE 13: RUG-IV Projected Impact to the SNF PPS for FY 2015

	Number of Facilities FY 2015	Update Wage Data	Update OMB Delineations	Total Change
Group				
Total	15,399	0.0%	0.0%	2.0%
Urban	10,862	0.0%	0.0%	2.0%
Rural	4,537	0.2%	-0.2%	1.9%
Hospital based urban	574	0.1%	0.0%	2.1%
Freestanding urban	10,288	0.0%	0.0%	2.0%
Hospital based rural	640	0.2%	-0.3%	1.9%
Freestanding rural	3,897	0.2%	-0.2%	1.9%
Urban by region				
New England	803	0.7%	0.0%	2.7%
Middle Atlantic	1,490	0.0%	0.2%	2.1%
South Atlantic	1,853	-0.3%	0.0%	1.7%
East North Central	2,054	0.0%	0.0%	2.0%
East South Central	544	-0.7%	0.1%	1.3%
West North Central	889	-0.1%	0.1%	2.0%
West South Central	1,293	-0.7%	0.0%	1.3%
Mountain	501	0.2%	0.0%	2.2%
Pacific	1,429	0.5%	0.0%	2.5%
Outlying	6	0.8%	-0.1%	2.6%
Rural by region				
New England	144	0.5%	0.1%	2.6%
Middle Atlantic	228	1.6%	-1.6%	2.0%
South Atlantic	504	-0.2%	-0.2%	1.6%
East North Central	925	-0.1%	0.0%	2.0%
East South Central	533	-0.3%	-0.2%	1.5%
West North Central	1,093	0.2%	-0.1%	2.1%
West South Central	770	0.2%	-0.4%	1.8%
Mountain	235	-0.6%	0.0%	1.4%
Pacific	105	2.8%	-0.1%	4.8%
Outlying	0	0.0%	0.0%	2.1%
Ownership				
Government	852	0.1%	-0.1%	2.0%
Profit	10,784	0.0%	-0.1%	1.9%

	Number of Facilities FY 2015	Update Wage Data	Update OMB Delineations	Total Change
Non-profit	3,763	0.1%	-0.1%	1.9%

Note: The Total column includes the 2.5 percent market basket increase, reduced by the 0.5 percentage point MFP adjustment. Additionally, we found no SNFs in rural outlying areas.

5. Alternatives Considered

As described above, we estimate that the aggregate impact for FY 2015 would be an increase of $750 million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as adjusted by the MFP adjustment.

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, a market basket index, a wage index, and the urban and rural distinction used in the development or adjustment of the federal rates). Further, section 1888(e)(4)(H) of the Act specifically requires us to disseminate the payment rates for each new FY through the **Federal Register**, and to do so before the August 1 that precedes the start of the new FY. Accordingly, we are not pursuing alternatives with respect to the payment methodology as discussed above.

With regard to our implementation of the revised OMB delineations discussed in section IV.D.1 above, we considered a number of potential alternatives in the FY 2015 SNF PPS proposed rule (79 FR 25793 through 25795), which we also address here.

We considered having no transition period and fully implementing the new OMB

delineations beginning in FY 2015. This would mean that we would adopt the revised OMB delineations for all providers on October 1, 2014. However, this would not provide any time for providers to adapt to the new OMB delineations. As discussed above, more providers will experience a decrease in wage index due to implementation of the new OMB delineations than will experience an increase. Thus, we believe that it is appropriate to provide for a transition period to mitigate the resulting short-term instability and negative impact on these providers, and to provide time for providers to adjust to their new labor market area delineations. Furthermore, in light of the comments received during the FY 2006 rulemaking cycle on our proposal in the FY 2006 SNF PPS proposed rule (70 FR 29094 through 29095) to adopt the new CBSA definitions without a transition period, we anticipated that providers would have similar concerns with not having a transition period for the new OMB delineations. Therefore, similar to the policy adopted in the FY 2006 SNF PPS final rule (70 FR 45041) when we first adopted OMB's CBSA definitions for purposes of the SNF PPS wage index, we are implementing a 1-year transition blended wage index for all SNFs to assist providers in adapting to the new OMB delineations. In determining an appropriate transition methodology, consistent with the objectives set forth in the FY 2006 SNF PPS final rule (70 FR 45041), we looked for approaches that would provide relief to the largest percentage of adversely-affected SNFs with the least impact to the rest of the facilities

First, we considered transitioning the wage index to the revised OMB delineations over a number of years in order minimize the impact of the wage index changes in a given year. However, we also believe this must be balanced against the need to ensure the most accurate payments possible, which supports the use of a shorter transition to the revised OMB delineations. As discussed above in section IV.D.1 of this final rule, we believe that using the most current OMB delineations will increase the integrity of the SNF PPS wage index by

creating a more accurate representation of geographic variation in wage levels. As such, we believe that utilizing a 1-year (rather than a multiple year) transition with a blended wage index in FY 2015 strikes the best balance.

Second, we considered what type of blend would be appropriate for purposes of the transition wage index. We proposed that providers would receive a 1-year blended wage index using 50 percent of their FY 2015 wage index based on the proposed new OMB delineations and 50 percent of their FY 2015 wage index based on the FY 2014 OMB delineations. We believe that a 50/50 blend best mitigates the negative payment impacts associated with the implementation of the new OMB delineations. While we considered alternatives to the 50/50 blend, we believe this type of split balances the increases and decreases in wage index values associated with the transition, as well as provides a readily understandable calculation for providers.

Next, we considered whether or not the blended wage index should be used for all providers or for only a subset of providers, such as those providers that would experience a decrease in their respective wage index values due to implementation of the revised OMB delineations. As required in Section 1888(e)(4)(G)(ii) of the Act, the wage index adjustment must be implemented in a budget neutral manner. As such, as discussed in the FY 2015 SNF PPS proposed rule (79 FR 25785), if we were to apply the blended wage index only to those providers that would experience a decrease in their respective wage index values due to the implementation of the revised OMB delineations, the budget neutrality factor calculated based on this approach would reduce the base rates for all providers. Pursuing this type of transition policy would, in effect, aid the 21 percent of SNFs experiencing a decrease in their wage index due to the new OMB delineations (who would nevertheless also experience a decrease in their base rates under this alternative) at the expense the remaining 79 percent of SNFs, all of which

would experience a decrease in their base rates due to the budget neutrality adjustment (including those SNFs experiencing either no change or an increase in their wage index under the new OMB delineations). However, as discussed in the FY 2015 SNF PPS proposed rule (79 FR 25785), if we apply the blended wage index to all providers, the resulting budget neutrality factor would not reduce the base rates for any provider. As discussed in the FY 2015 SNF PPS proposed rule, our goal in implementing a transition is to provide relief to the largest percentage of adversely affected SNFs with the least impact to the rest of facilities. We believe that the application of a one-year transition blended wage index for all providers best achieves this goal, as it mitigates the negative payment impacts of the new OMB delineations for adversely affected SNFs, without reducing the base rates for all providers.

As discussed in section IV.D.1 above, some commenters also suggested that CMS consider a 3-year transition methodology similar to that proposed in the FY 2015 IPPS proposed rule. In the FY 2015 IPPS proposed rule, CMS proposed a 3-year transition for those hospitals that are currently in urban areas that would become rural under the new OMB delineations, under which such hospitals would receive the urban wage index of the CBSA in which they are currently located for FY 2014 for a period of three fiscal years (see the FY 2015 IPPS proposed rule, 79 FR 28060). However, there are important differences between the IPPS and SNF PPS which give rise to different implementation and impact considerations. Most notably, IPPS hospital providers are subject to the rural floor, which requires that the wage index applicable to any hospital located in an urban area of a state not be less than the rural wage index of the state (see the FY 2015 IPPS proposed rule, 79 FR 28068). This guarantees that the wage index for rural hospitals is not greater than the wage index of any urban hospitals in the same state. As a result, hospitals moving from urban to rural status under the new OMB delineations are more likely to experience a decrease in their wage index, while hospitals moving from rural to urban

status under the new OMB delineations are more likely to experience an increase in their wage index. This is not the case in the SNF PPS, where the rural floor is not applied and such differential impacts on urban and rural providers do not exist. Under the SNF PPS, the subsets of providers that will experience increases and decreases in wage index due to implementation of the new OMB delineations are quite varied. For example, 22 SNFs changing from urban to rural status under the new OMB delineations will have a higher wage index than they had in their urban CBSA. This would be less likely to occur if the rural floor were applied under the SNF PPS. Given the impacts discussed above, we believe that the 3-year transition policy proposed in the FY 2015 IPPS proposed rule and discussed above is not necessary or appropriate to address the impacts on SNF providers. By contrast, under the IPPS, hospitals currently located in urban areas that would become rural under the revised OMB delineations are more likely to experience a wage index decrease as discussed above, raising concerns over the potential adverse impact of the new OMB delineations on those hospitals that are specific to the IPPS. Therefore, we do not agree with the commenter that a 3-year transition policy, similar to that proposed under the IPPS, should be applied to those SNFs changing from urban to rural status under the new OMB delineations.

To further address commenters' general suggestion that we utilize similar implementation policies as were proposed for hospital providers in the FY 2015 IPPS proposed rule, we also considered whether it would appropriate to apply a variation of the 3-year transition discussed above, pursuant to which all SNFs that would experience a decrease in their wage index under the new OMB delineations would receive the wage index of the CBSA in which they are currently located for FY 2014 for a period of three fiscal years. This would involve applying a different transition policy for this subset of SNFs (allowing them to maintain the wage index of the CBSA in which they are currently located for three fiscal years) than would be applied to

other SNFs. However, because revisions in the SNF PPS wage index must be made in a budget neutral manner, as required by section 1888(e)(4)(G)(ii) of the Act, if such a 3-year transition policy were to be applied to this subset of providers, the resulting budget neutrality adjustment would reduce the base payment rates for all SNFs in FY 2015, as well as potentially reduce base rates for each of the two additional years during which this transition policy would be in effect. In terms of the overall impact on SNFs, pursuing this type of transition policy would, in effect, aid the 21 percent of SNFs experiencing a decrease in their wage index due to the new OMB delineations (who would nevertheless also experience a decrease in their base rates under this alternative) at the expense the remaining 79 percent of SNFs, all of which would experience a decrease in their base rates due to the budget neutrality adjustment (including those SNFs experiencing either no change or an increase in their wage index under the new OMB delineations). As we stated in the FY 2015 SNF PPS proposed rule (79 FR 25785), we looked for a transition approach that would provide relief to the largest percentage of adversely affected SNFs with the least impact to the rest of facilities. As discussed above, we believe that the application of a one-year transition blended wage index for all providers best achieves this goal, as it mitigates the negative payment impacts of the new OMB delineations for adversely affected SNFs, without reducing the base rates for all providers. Furthermore, as discussed above, we do not believe a multi-year transition approach would be appropriate, given the need to ensure the most accurate payments possible based on the most current geographic delineations.

While we understand the concern raised by these commenters regarding the potential impact on the subset of SNFs that would experience a decrease in their wage index, we believe this must be weighed against the interests of and impact on all SNFs. As discussed above, and in the SNF PPS proposed rule (79 FR 25785), we believe that our proposed 1-year transition policy with a 50/50 blended wage index for all SNFs appropriately mitigates the negative payment

impacts on SNFs that will experience a wage index decrease due to implementation of the new OMB delineations, while having the least impact on the rest of the facilities.

We received a comment on the potential impact of finalizing the proposals in the FY 2015 SNF PPS proposed rule, which is not otherwise addressed in prior sections of this final rule. A discussion of this comment, and our response, appears below.

Comment: In their March 2014 report (available at: http://www.medpac.gov/documents/Mar14_entirereport.pdf), and in their comment on this proposed rule, MedPAC recommended that CMS eliminate the market basket update for SNFs and rebase payments for the SNF PPS, beginning with a 4 percent reduction in the base payment rates.

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

6. Accounting Statement

As required by OMB Circular A-4 (available online at www.whitehouse.gov/sites/default/files/omb/assets/regulatory_matters_pdf/a-4.pdf), in Table 14, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. Table 14 provides our best estimate of the possible changes in Medicare payments under the SNF PPS as a result of the policies in this final rule, based on the data for 15,399 SNFs in our database. All expenditures are classified as transfers to Medicare providers (that is, SNFs).

TABLE 14: Accounting Statement: Classification of Estimated Expenditures, from the 2014 SNF PPS Fiscal Year to the 2015 SNF PPS Fiscal Year

Category	Transfers
Annualized Monetized Transfers	$750 million*
From Whom To Whom?	Federal Government to SNF Medicare Providers

* The net increase of $750 million in transfer payments is a result of the MFP-adjusted market basket increase of $750 million.

7. Conclusion

This final rule sets forth updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2014 (78 FR 47936). Based on the above, we estimate the overall estimated payments for SNFs in FY 2015 are projected to increase by $750 million, or 2.0 percent, compared with those in FY 2014. We estimate that in FY 2015 under RUG-IV, SNFs in urban and rural areas would experience, on average, a 2.0 and 1.9 percent increase, respectively, in estimated payments compared with FY 2014. Providers in the rural Pacific region would experience the largest estimated increase in payments of approximately 4.8 percent. Providers in the urban East South Central and West South Central regions would experience the smallest increase in payments of 1.3 percent.

B. Regulatory Flexibility Act Analysis

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most SNFs and most other providers and suppliers are small entities, either by their non-profit status or by having revenues of $25.5 million or less in any 1 year. We utilized the revenues of individual SNF providers (from recent Medicare Cost Reports) to classify a small business, and not the revenue of a larger firm with which they may be affiliated. As a result, we estimate approximately 91 percent of SNFs are considered small businesses according to the Small Business Administration's latest size standards (NAICS 623110), with total revenues of $25.5 million or less in any 1 year. (For details, see the Small Business Administration's website at http://www.sba.gov/category/navigation-structure/contracting/contracting-officials/eligibility-size-standards). In addition, approximately 25 percent of SNFs classified as small entities are

non-profit organizations. Finally, individuals and states are not included in the definition of a small entity.

This final rule sets forth updates of the SNF PPS rates contained in the SNF PPS final rule for FY 2014 (78 FR 47936). Based on the above, we estimate that the aggregate impact would be an increase of $750 million in payments to SNFs, resulting from the SNF market basket update to the payment rates, as adjusted by the MFP adjustment. While it is projected in Table 13 that all providers would experience a net increase in payments, we note that some individual providers within the same region or group may experience different impacts on payments than others due to the distributional impact of the FY 2015 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 11 percent of total patient days in freestanding facilities and 22 percent of facility revenue (Report to the Congress: Medicare Payment Policy, March 2014, available at http://www.medpac.gov/documents/Mar14_EntireReport.pdf). 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 (Report to the Congress: Medicare Payment Policy, March 2014, available at http://www.medpac.gov/documents/Mar14_EntireReport.pdf). As a result, for most facilities, when all payers are included in the revenue stream, the overall impact on total revenues should be substantially less than those impacts presented in Table 13. As indicated in Table 13, the effect on facilities is projected to be an aggregate positive impact of 2.0 percent. As the overall impact on the industry as a whole, and thus on small entities specifically, is less than the 3 to 5 percent threshold discussed above, the Secretary has

determined that this final rule would not have a significant impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. This final rule would affect small rural hospitals that (1) furnish SNF services under a swing-bed agreement or (2) have a hospital-based SNF. We anticipate that the impact on small rural hospitals would be similar to the impact on SNF providers overall. Moreover, as noted in previous SNF PPS final rules (most recently the one for FY 2014 (78 FR 47968)), the category of small rural hospitals would be included within the analysis of the impact of this final rule on small entities in general. As indicated in Table 13, the effect on facilities is projected to be an aggregate positive impact of 2.0 percent. As the overall impact on the industry as a whole is less than the 3 to 5 percent threshold discussed above, the Secretary has determined that this final rule would not have a significant impact on a substantial number of small rural hospitals.

C. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2014, that threshold is approximately $141 million. This final rule would not impose spending costs on state, local, or tribal governments in the aggregate, or by the private sector, of $141 million.

D. Federalism Analysis

Executive Order 13132 establishes certain requirements that an agency must meet when it

promulgates a proposed rule (and subsequent final rule) that impose substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. This final rule would have no substantial direct effect on state and local governments, preempt state law, or otherwise have federalism implications.

List of Subjects in 42 CFR Part 488

Administrative practice and procedure, Health facilities, 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 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

1. The authority citation for part 488 continues to read as follows:

Authority: Secs. 1102, 1128I and 1871 of the Social Security Act, unless otherwise noted (42 U.S.C. 1302, 1320a-7j, and 1395hh); Pub. L. 110-149, 121 Stat. 1819.

2. Section 488.433 is revised to read as follows:

§488.433 Civil money penalties: Uses and approval of civil money penalties imposed by CMS.

(a) Ten percent of the collected civil money penalty funds that are required to be held in escrow pursuant to §488.431 and that remain after a final administrative decision will be deposited with the Department of the Treasury in accordance with §488.442(f). The remaining ninety percent of the collected civil money penalty funds that are required to be held in escrow pursuant to §488.431 and that remain after a final administrative decision must be used entirely for activities that protect or improve the quality of care or quality of life for residents consistent with paragraph (b) of this section and may not be used for survey and certification operations or

State expenses, except that reasonable expenses necessary to administer, monitor, or evaluate the effectiveness of projects utilizing civil money penalty funds may be permitted.

(b) All activities and plans for utilizing civil money penalty funds, including any expense used to administer grants utilizing civil money penalty funds, must be approved in advance by CMS and may include, but are not limited to:

(1) Support and protection of residents of a facility that closes (voluntarily or involuntarily).

(2) Time-limited expenses incurred in the process of relocating residents to home and community-based settings or another facility when a facility is closed (voluntarily or involuntarily) or downsized pursuant to an agreement with the State Medicaid agency.

(3) Projects that support resident and family councils and other consumer involvement in assuring quality care in facilities.

(4) Facility improvement initiatives, such as joint training of facility staff and surveyors or technical assistance for facilities implementing quality assurance and performance improvement programs.

(5) Development and maintenance of temporary management or receivership capability such as but not limited to, recruitment, training, retention or other system infrastructure expenses. However, as specified in §488.415(c), a temporary manager's salary must be paid by the facility. In rare situations, if the facility is closing, CMS plans to stop or suspend continued payments to the facility under §489.55 of this chapter during the temporary manager's duty period, and CMS determines that extraordinary action is necessary to protect the residents until relocation efforts are successful, civil money penalty funds may be used to pay the manager's salary.

(c) At a minimum, proposed activities submitted to CMS for prior approval must include a description of the intended outcomes, deliverables, and sustainability; and a description of the methods by which the activity results will be assessed, including specific measures.

(d) Civil money penalty funds may not be used for activities that have been disapproved by CMS.

(e) The State must maintain an acceptable plan, approved by CMS, for the effective use of civil money funds, including a description of methods by which the State will:

(1) Solicit, accept, monitor, and track projects utilizing civil money penalty funds including any funds used for state administration.

(2) Make information about the use of civil money penalty funds publicly available, including about the dollar amount awarded for approved projects, the grantee or contract recipients, the results of projects, and other key information.

(3) Ensure that:

(i) A core amount of civil money penalty funds will be held in reserve for emergencies, such as relocation of residents pursuant to an involuntary termination from Medicare and Medicaid.

(ii) A reasonable amount of funds, beyond those held in reserve under paragraph (e)(3)(i) of this section, will be awarded or contracted each year for the purposes specified in this section.

(f) If CMS finds that a State has not spent civil money penalty funds in accordance with this section, or fails to make use of funds to benefit the quality of care or life of residents, or fails to maintain an acceptable plan for the use of funds that is approved by CMS, then CMS may withhold future disbursements of civil money penalty funds to the State until the State has submitted an acceptable plan to comply with this section.

Dated: July 24, 2014.

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Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: July 30, 2014

_____

Sylvia M. Burwell,

Secretary,

Department of Health and Human Services.

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