in the *Journal of the American Heart Association* on October 24, 2013.[3]

C. Administrator's Determination on Petition 004

The Administrator has established a methodology for evaluating whether to add non-cancer health conditions to the List of WTC-Related Health Conditions.[4] A health condition may be added to the List if published, peer-reviewed epidemiologic evidence provides substantial support for a causal relationship between 9/11 exposures and the health condition in 9/11-exposed populations.[5] If the epidemiologic evidence provides modest support for a causal relationship between 9/11 exposures and the health condition, the Administrator may then evaluate studies of associations between the health condition and 9/11 agents in similarly-exposed populations.[6] If that additional assessment establishes substantial support for a causal relationship between a 9/11 agent or agents and the health condition, the health condition may be added to the List.

In accordance with section 3312(a)(6)(B) of the PHS Act, 42 CFR 88.17, and the methodology for the addition of non-cancer health conditions, the Administrator reviewed the evidence presented in Petition 004. Although the petitioner requested the addition of ''heart attack,'' the Administrator determined that the more appropriate health condition is ''cardiovascular disease,'' which includes heart attack, acute or chronic coronary artery disease, cardiac arrhythmia, angina, and any other heart condition. The Administrator then selected a team under the direction of the WTC Health Program Associate Director for Science (ADS) to perform a systematic literature search and provide input on whether the available scientific and medical information has the potential to provide a basis for a decision on whether to add the health condition to the List. The ADS conducted a search of the existing scientific/medical literature for epidemiologic evidence of a causal relationship between 9/11 exposures and cardiovascular disease. Among the studies identified by the literature search, four were found to be published, peer-reviewed epidemiologic studies of 9/11-exposed populations.[7] However, when reviewed by the ADS for relevance, quantity, and quality, each of the four published, peer-reviewed epidemiologic studies of 9/11-exposed populations were found to have significant limitations, both individually and in combination. Limitations of the four studies included selection, recall, and confounding bias [8]; poor generalizability among all exposed groups; and lack of consistency among the associations reported between 9/11 exposures and cardiovascular disease between studies. Thus, the ADS concluded that the available information did not have the potential to form the basis for a decision on whether to propose adding cardiovascular disease to the List.

The findings described above led the Administrator to determine that insufficient evidence exists to take further action, including either proposing the addition of cardiovascular disease to the List (pursuant to PHS Act, section 3312(a)(6)(B)(ii) and 42 CFR 88.17(a)(2)(ii)) or publishing a determination not to publish a proposed rule in the **Federal Register** (pursuant to PHS Act, section 3312(a)(6)(B)(iii) and 42 CFR 88.17(a)(2)(iii)). The Administrator has also determined that requesting a recommendation from the STAC (pursuant to PHS Act, section 3312(a)(6)(B)(i) and 42 CFR 88.17(a)(2)(i)) is unwarranted.

For the reasons discussed above, the request made in Petition 004 to add cardiovascular disease to the List of WTC-Related Health Conditions is denied.

Dated: May 1, 2014.

John Howard,

Administrator, World Trade Center Health Program and Director, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention, Department of Health and Human Services.

[FR Doc. 2014–10434 Filed 5–5–14; 8:45 am]

BILLING CODE 4163–18–P

[3] Jordan HT, Stellman SD, Morabia A, Miller-Archie SA, Alper H, Laskaris Z, Brackbill RM, and Cone JE [2013] Cardiovascular disease hospitalizations in relation to exposure to the September 11, 2001 World Trade Center disaster and posttraumatic stress disorder. Journal of the American Heart Association 2(5).

[4] This methodology, ''Policy and Procedures for Adding Non-Cancer Conditions to the List of WTC-Related Health Conditions,'' is available on the WTC Health Program Web site, at *http://www.cdc.gov/wtc/policies.html*.

[5] The substantial evidence standard is met when the Program assesses all of the available, relevant information and determines with high confidence that the evidence supports its findings regarding a causal association between the 9/11 exposure(s) and the health condition.

[6] The modest evidence standard is met when the Program assesses all of the available, relevant information and determines with moderate confidence that the evidence supports its findings regarding a causal association between the 9/11 exposure(s) and the health condition.

[7] Jordan HT, Brackbill RM, Cone JE, Debchoudhury I, Farfel MR, Greene CM, Hadler JL, Kennedy J, Li J, Liff J, Stayner L, Stellman SD [2011]. Mortality among survivors of the Sept 11, 2001, World Trade Center disaster: results from the World Trade Center Health Registry cohort. The Lancet 378: 879–87; Jordan HT, Miller-Archie SA, Cone JE, Morabia A, Stellman SD [2011]. Heart disease among adults exposed to the September 11, 2001 World Trade Center disaster: Results from the World Trade Center Health Registry. Preventive Medicine 53:370–376; Jordan HT, Stellman SD, Morabia A, Miller-Archie SA, Alper H, Laskaris Z, Brackbill RM, Cone JE [2013]. Cardiovascular Disease Hospitalizations in Relation to Exposure to the September 11, 2001 World Trade Center Disaster and Posttraumatic Stress Disorder. J Am Heart Assoc; Brackbill RM, Cone JE, Farfel MR, Stellman SD [2014]. Chronic Physical Health Consequences of Being Injured During the Terrorist Attacks on World Trade Center on September 11, 2001. American Journal of Epidemiology. Advance Access published February 20, 2014.

[8] In this case, ''selection bias'' refers to study populations that include individuals who were self-identified as heart patients but whose reported illness was not independently verified; ''recall bias'' refers to the inaccuracies or incompleteness inherent in the self-reporting of 9/11-related health conditions years after the event; and ''confounding bias'' refers to the existence of risk factors for cardiovascular disease that have not been accounted for by study authors.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 488

[CMS–1605–P]

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: Proposed rule.

SUMMARY: This proposed rule would update the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for fiscal year (FY) 2015. In addition, it includes 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 and to determine the SNF PPS wage index including a proposed one-year transition with a blended wage index for all providers for FY 2015. It also includes a discussion of the SNF therapy payment research currently underway within CMS. This proposed rule also proposes a revision to policies related to the Change of Therapy (COT) Other Medicare Required Assessment (OMRA). This proposed rule includes a discussion of a provision related to the

Affordable Care Act involving Civil Money Penalties. Finally, this proposed rule includes a discussion of observed trends related to therapy utilization among SNF providers and a discussion of accelerating health information exchange in SNFs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 30, 2014.

ADDRESSES: In commenting, please refer to file code CMS–1605–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Within the search bar, enter the Regulation Identifier Number associated with this regulation, 0938–AS07, and then click on the ''Comment Now'' box.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1605–P, P.O. Box 8016, Baltimore, MD 21244–8016.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1605–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

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

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

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

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

FOR FURTHER INFORMATION CONTACT:

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:

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

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

Availability of Certain Tables Exclusively Through the Internet on the CMS Web Site

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 proposed rule are available exclusively through the Internet on the CMS Web site 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 Web sites 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.

Table of Contents

Acronyms

In addition, because of the many terms to which we refer by acronym in this proposed 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
CMP Civil money penalties
CMS Centers for Medicare & Medicaid Services
COT Change of therapy
ECI Employment Cost Index
eCQM Electronically specified clinical quality measures
EHR Electronic health record
EOT End of therapy
EOT–R End of therapy—resumption
FQHC Federally qualified health center
FR Federal Register
FY Fiscal year
GAO Government Accountability Office
HCPCS Healthcare Common Procedure Coding System
HIE Health information exchange
HIT Health information technology
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 proposed rule would update the SNF prospective payment rates for FY 2015 as required under section 1888(e)(4)(E) of the Act. It would also respond 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 proposed rule would 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 Cost and Benefits

Provision description	Total transfers
Proposed FY 2015 SNF PPS payment rate update.	The overall economic impact of this proposed rule would be 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 proposed rule, Public Law 111–148 and Public Law 111–152 are collectively referred to as the ''Affordable Care Act.'' In section V. of this proposed rule, we include discussions of one specific provision related to the Affordable Care Act involving Civil Money Penalties (as discussed in section V.D.).

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 proposed rule would provide the required annual updates to the per diem payment rates for SNFs for FY 2015.

III. SNF PPS Rate Setting Methodology and FY 2015 Update

A. 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.

B. SNF Market Basket Update

1. 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 proposed rule, the FY 2010-based SNF market basket growth rate is estimated to be 2.4 percent, which is based on the IHS Global Insight, Inc. (IGI) first quarter 2014 forecast with historical data through fourth quarter 2013. In section III.B.5. of this proposed rule, we discuss the specific application of this adjustment to the forthcoming annual update of the SNF PPS payment rates.

2. 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 proposed 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 first quarter 2014 forecast (with historical data through the fourth quarter 2013) 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 proposed rule. As discussed in sections III.B.3. and III.B.4. of this proposed 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 proposed rule, we no longer compute update factors to adjust a facility-specific portion of the SNF PPS rates, because the initial three-phase transition period from facility-specific to full federal rates that started with cost reporting periods beginning in July 1998 has expired.

3. Forecast Error Adjustment

As discussed in the June 10, 2003 supplemental proposed rule (68 FR 34768) and finalized in the August 4, 2003, final rule (68 FR 46057 through 46059), the regulations at § 413.337(d)(2) provide for an adjustment to account for market basket forecast error. The initial adjustment for market basket forecast error applied to the update of the FY 2003 rate for FY 2004, and took into account the cumulative forecast error for the period from FY 2000 through FY 2002, resulting in an increase of 3.26 percent to the FY 2004 update. Subsequent adjustments in succeeding FYs take into account the forecast error from the most recently available FY for which there is final data, and apply the difference between the forecasted and actual change in the market basket when the difference exceeds a specified threshold. We originally used a 0.25 percentage point threshold for this purpose; however, for the reasons specified in the FY 2008 SNF PPS final rule (72 FR 43425, August 3, 2007), we adopted a 0.5 percentage point threshold effective for FY 2008 and subsequent fiscal years. As we stated in the 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 first quarter 2014 IHS Global Insight forecast, with historical data through the fourth quarter 2013 (2004-based index).

4. 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).

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

According to section 1888(e)(5)(A) of the Act, the Secretary ''shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.'' 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 0.4 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 first quarter 2014 forecast of the SNF market basket update, and is estimated to be 2.4 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 0.4 percent, which is calculated as described above and based on IGI's first quarter 2014 forecast. The resulting MFP-adjusted SNF market basket update is equal to 2.0 percent, or 2.4 percent less 0.4 percentage point.

5. 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 2.4 percent. As further explained in section III.B.3. of this proposed 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. Since the difference between the forecasted FY 2013 SNF market basket percentage change and the actual FY 2013 SNF market basket percentage change (FY 2013 is the most recently available FY for which there is final data) does not exceed 0.5 percentage point, the FY 2015 market basket of 2.4 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 0.4 percent, as described in section III.B.4. of this proposed rule.

The resulting MFP-adjusted SNF market basket update would be equal to 2.0 percent, or 2.4 percent less 0.4 percentage point. We note that if more recent data become available (for example, a more recent estimate of the SNF market basket, MFP adjustment, and/or FY 2004-based SNF market basket used for the forecast error calculation), we would use such data, if appropriate, to determine the FY 2015 SNF market basket update, FY 2015 labor-related share relative importance, and MFP adjustment in the FY 2015 SNF PPS final rule. 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.

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, we propose to use the revised OMB statistical area delineations discussed in Section V.A below to identify a facility's urban or rural status for the purpose of determining which set of rate tables would apply to a facility beginning on October 1, 2014. 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 would allow us to more accurately determine 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 invite comments on this proposal.

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	$169.14	$127.41	$16.78	$86.32

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	$161.59	$146.90	$17.92	$87.92

C. 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.A. of this proposed 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 Web site 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 $422.77 (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 $963.92.

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.'' As of now, the Secretary has not implemented this provision under HIPAA. In light of PAMA, 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 becomes the required medical data code set for use on Medicare SNF claims. Until that time, we would 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 proposed rule reflect the use of the RUG–IV case-mix classification system from October 1, 2014, through September 30, 2015. We list the proposed 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, facilities would use the proposed revised OMB delineations in order to identify their urban or rural status for the purpose of determining which set of rate tables would apply to them 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	$451.60	$238.26	.....	$86.32	$776.18
RUL	2.57	1.87	434.69	238.26	.....	86.32	759.27
RVX	2.61	1.28	441.46	163.08	.....	86.32	690.86
RVL	2.19	1.28	370.42	163.08	.....	86.32	619.82
RHX	2.55	0.85	431.31	108.30	.....	86.32	625.93
RHL	2.15	0.85	363.65	108.30	.....	86.32	558.27
RMX	2.47	0.55	417.78	70.08	.....	86.32	574.18
RML	2.19	0.55	370.42	70.08	.....	86.32	526.82
RLX	2.26	0.28	382.26	35.67	.....	86.32	504.25
RUC	1.56	1.87	263.86	238.26	.....	86.32	588.44
RUB	1.56	1.87	263.86	238.26	.....	86.32	588.44
RUA	0.99	1.87	167.45	238.26	.....	86.32	492.03
RVC	1.51	1.28	255.40	163.08	.....	86.32	504.80
RVB	1.11	1.28	187.75	163.08	.....	86.32	437.15
RVA	1.10	1.28	186.05	163.08	.....	86.32	435.45
RHC	1.45	0.85	245.25	108.30	.....	86.32	439.87
RHB	1.19	0.85	201.28	108.30	.....	86.32	395.90
RHA	0.91	0.85	153.92	108.30	.....	86.32	348.54
RMC	1.36	0.55	230.03	70.08	.....	86.32	386.43
RMB	1.22	0.55	206.35	70.08	.....	86.32	362.75
RMA	0.84	0.55	142.08	70.08	.....	86.32	298.48
RLB	1.50	0.28	253.71	35.67	.....	86.32	375.70
RLA	0.71	0.28	120.09	35.67	.....	86.32	242.08
ES3	3.58	.....	605.52	.....	16.78	86.32	708.62
ES2	2.67	.....	451.60	.....	16.78	86.32	554.70
ES1	2.32	.....	392.40	.....	16.78	86.32	495.50
HE2	2.22	.....	375.49	.....	16.78	86.32	478.59
HE1	1.74	.....	294.30	.....	16.78	86.32	397.40
HD2	2.04	.....	345.05	.....	16.78	86.32	448.15
HD1	1.60	.....	270.62	.....	16.78	86.32	373.72
HC2	1.89	.....	319.67	.....	16.78	86.32	422.77
HC1	1.48	.....	250.33	.....	16.78	86.32	353.43

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

RUG–IV Category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
HB2	1.86		314.60		16.78	86.32	417.70
HB1	1.46		246.94		16.78	86.32	350.04
LE2	1.96		331.51		16.78	86.32	434.61
LE1	1.54		260.48		16.78	86.32	363.58
LD2	1.86		314.60		16.78	86.32	417.70
LD1	1.46		246.94		16.78	86.32	350.04
LC2	1.56		263.86		16.78	86.32	366.96
LC1	1.22		206.35		16.78	86.32	309.45
LB2	1.45		245.25		16.78	86.32	348.35
LB1	1.14		192.82		16.78	86.32	295.92
CE2	1.68		284.16		16.78	86.32	387.26
CE1	1.50		253.71		16.78	86.32	356.81
CD2	1.56		263.86		16.78	86.32	366.96
CD1	1.38		233.41		16.78	86.32	336.51
CC2	1.29		218.19		16.78	86.32	321.29
CC1	1.15		194.51		16.78	86.32	297.61
CB2	1.15		194.51		16.78	86.32	297.61
CB1	1.02		172.52		16.78	86.32	275.62
CA2	0.88		148.84		16.78	86.32	251.94
CA1	0.78		131.93		16.78	86.32	235.03
BB2	0.97		164.07		16.78	86.32	267.17
BB1	0.90		152.23		16.78	86.32	255.33
BA2	0.70		118.40		16.78	86.32	221.50
BA1	0.64		108.25		16.78	86.32	211.35
PE2	1.50		253.71		16.78	86.32	356.81
PE1	1.40		236.80		16.78	86.32	339.90
PD2	1.38		233.41		16.78	86.32	336.51
PD1	1.28		216.50		16.78	86.32	319.60
PC2	1.10		186.05		16.78	86.32	289.15
PC1	1.02		172.52		16.78	86.32	275.62
PB2	0.84		142.08		16.78	86.32	245.18
PB1	0.78		131.93		16.78	86.32	235.03
PA2	0.59		99.79		16.78	86.32	202.89
PA1	0.54		91.34		16.78	86.32	194.44

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	$431.45	$274.70		$87.92	$794.07
RUL	2.57	1.87	415.29	274.70		87.92	777.91
RVX	2.61	1.28	421.75	188.03		87.92	697.70
RVL	2.19	1.28	353.88	188.03		87.92	629.83
RHX	2.55	0.85	412.05	124.87		87.92	624.84
RHL	2.15	0.85	347.42	124.87		87.92	560.21
RMX	2.47	0.55	399.13	80.80		87.92	567.85
RML	2.19	0.55	353.88	80.80		87.92	522.60
RLX	2.26	0.28	365.19	41.13		87.92	494.24
RUC	1.56	1.87	252.08	274.70		87.92	614.70
RUB	1.56	1.87	252.08	274.70		87.92	614.70
RUA	0.99	1.87	159.97	274.70		87.92	522.59
RVC	1.51	1.28	244.00	188.03		87.92	519.95
RVB	1.11	1.28	179.36	188.03		87.92	455.31
RVA	1.10	1.28	177.75	188.03		87.92	453.70
RHC	1.45	0.85	234.31	124.87		87.92	447.10
RHB	1.19	0.85	192.29	124.87		87.92	405.08
RHA	0.91	0.85	147.05	124.87		87.92	359.84
RMC	1.36	0.55	219.76	80.80		87.92	388.48
RMB	1.22	0.55	197.14	80.80		87.92	365.86
RMA	0.84	0.55	135.74	80.80		87.92	304.46
RLB	1.50	0.28	242.39	41.13		87.92	371.44
RLA	0.71	0.28	114.73	41.13		87.92	243.78
ES3	3.58		578.49		17.92	87.92	684.33
ES2	2.67		431.45		17.92	87.92	537.29
ES1	2.32		374.89		17.92	87.92	480.73
HE2	2.22		358.73		17.92	87.92	464.57
HE1	1.74		281.17		17.92	87.92	387.01
HD2	2.04		329.64		17.92	87.92	435.48
HD1	1.60		258.54		17.92	87.92	364.38

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

RUG–IV Category	Nursing index	Therapy index	Nursing component	Therapy component	Non-case mix therapy comp	Non-case mix component	Total rate
HC2	1.89		305.41		17.92	87.92	411.25
HC1	1.48		239.15		17.92	87.92	344.99
HB2	1.86		300.56		17.92	87.92	406.40
HB1	1.46		235.92		17.92	87.92	341.76
LE2	1.96		316.72		17.92	87.92	422.56
LE1	1.54		248.85		17.92	87.92	354.69
LD2	1.86		300.56		17.92	87.92	406.40
LD1	1.46		235.92		17.92	87.92	341.76
LC2	1.56		252.08		17.92	87.92	357.92
LC1	1.22		197.14		17.92	87.92	302.98
LB2	1.45		234.31		17.92	87.92	340.15
LB1	1.14		184.21		17.92	87.92	290.05
CE2	1.68		271.47		17.92	87.92	377.31
CE1	1.50		242.39		17.92	87.92	348.23
CD2	1.56		252.08		17.92	87.92	357.92
CD1	1.38		222.99		17.92	87.92	328.83
CC2	1.29		208.45		17.92	87.92	314.29
CC1	1.15		185.83		17.92	87.92	291.67
CB2	1.15		185.83		17.92	87.92	291.67
CB1	1.02		164.82		17.92	87.92	270.66
CA2	0.88		142.20		17.92	87.92	248.04
CA1	0.78		126.04		17.92	87.92	231.88
BB2	0.97		156.74		17.92	87.92	262.58
BB1	0.90		145.43		17.92	87.92	251.27
BA2	0.70		113.11		17.92	87.92	218.95
BA1	0.64		103.42		17.92	87.92	209.26
PE2	1.50		242.39		17.92	87.92	348.23
PE1	1.40		226.23		17.92	87.92	332.07
PD2	1.38		222.99		17.92	87.92	328.83
PD1	1.28		206.84		17.92	87.92	312.68
PC2	1.10		177.75		17.92	87.92	283.59
PC1	1.02		164.82		17.92	87.92	270.66
PB2	0.84		135.74		17.92	87.92	241.58
PB1	0.78		126.04		17.92	87.92	231.88
PA2	0.59		95.34		17.92	87.92	201.18
PA1	0.54		87.26		17.92	87.92	193.10

D. 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. We propose 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 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 addition, we propose 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 that do not have hospitals, and thus, this methodology would not be applied. 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.

Once calculated, we would apply the wage index adjustment to the labor-related portion of the federal rate. 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. In the SNF PPS final rule for FY 2014 (78 FR 47944 through 47946), we finalized a proposal to revise 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; 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 above, the proposed new OMB delineations would be used to identify a facility's urban or rural status for the purpose of determining which set of rate tables would apply to them beginning on October 1, 2014. Table 12 in section V.A.3. 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	776.18	$539.55	$236.63
RUL	759.27	527.79	231.48
RVX	690.86	480.24	210.62
RVL	619.82	430.86	188.96
RHX	625.93	435.10	190.83
RHL	558.27	388.07	170.20
RMX	574.18	399.13	175.05
RML	526.82	366.21	160.61
RLX	504.25	350.52	153.73
RUC	588.44	409.04	179.40
RUB	588.44	409.04	179.40
RUA	492.03	342.02	150.01
RVC	504.80	350.90	153.90
RVB	437.15	303.88	133.27
RVA	435.45	302.69	132.76
RHC	439.87	305.77	134.10
RHB	395.90	275.20	120.70
RHA	348.54	242.28	106.26
RMC	386.43	268.62	117.81
RMB	362.75	252.16	110.59
RMA	298.48	207.48	91.00
RLB	375.70	261.16	114.54
RLA	242.08	168.28	73.80
ES3	708.62	492.58	216.04
ES2	554.70	385.59	169.11
ES1	495.50	344.44	151.06
HE2	478.59	332.68	145.91
HE1	397.40	276.24	121.16
HD2	448.15	311.52	136.63
HD1	373.72	259.78	113.94
HC2	422.77	293.88	128.89
HC1	353.43	245.68	107.75
HB2	417.70	290.36	127.34
HB1	350.04	243.32	106.72
LE2	434.61	302.11	132.50
LE1	363.58	252.74	110.84
LD2	417.70	290.36	127.34
LD1	350.04	243.32	106.72
LC2	366.96	255.08	111.88
LC1	309.45	215.11	94.34
LB2	348.35	242.15	106.20
LB1	295.92	205.70	90.22
CE2	387.26	269.20	118.06
CE1	356.81	248.03	108.78
CD2	366.96	255.08	111.88
CD1	336.51	233.92	102.59
CC2	321.29	223.34	97.95
CC1	297.61	206.88	90.73
CB2	297.61	206.88	90.73
CB1	275.62	191.59	84.03
CA2	251.94	175.13	76.81
CA1	235.03	163.38	71.65
BB2	267.17	185.72	81.45
BB1	255.33	177.49	77.84
BA2	221.50	153.97	67.53
BA1	211.35	146.92	64.43
PE2	356.81	248.03	108.78
PE1	339.90	236.27	103.63
PD2	336.51	233.92	102.59
PD1	319.60	222.16	97.44
PC2	289.15	201.00	88.15
PC1	275.62	191.59	84.03
PB2	245.18	170.43	74.75
PB1	235.03	163.38	71.65
PA2	202.89	141.03	61.86
PA1	194.44	135.16	59.28

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	794.07	$551.98	$242.09
RUL	777.91	540.75	237.16
RVX	697.70	484.99	212.71
RVL	629.83	437.81	192.02
RHX	624.84	434.35	190.49
RHL	560.21	389.42	170.79
RMX	567.85	394.73	173.12
RML	522.60	363.27	159.33
RLX	494.24	343.56	150.68
RUC	614.70	427.30	187.40
RUB	614.70	427.30	187.40
RUA	522.59	363.27	159.32
RVC	519.95	361.43	158.52
RVB	455.31	316.50	138.81
RVA	453.70	315.38	138.32
RHC	447.10	310.79	136.31
RHB	405.08	281.58	123.50
RHA	359.84	250.14	109.70
RMC	388.48	270.04	118.44
RMB	365.86	254.32	111.54
RMA	304.46	211.64	92.82
RLB	371.44	258.20	113.24
RLA	243.78	169.46	74.32
ES3	684.33	475.70	208.63
ES2	537.29	373.49	163.80
ES1	480.73	334.17	146.56
HE2	464.57	322.94	141.63
HE1	387.01	269.02	117.99
HD2	435.48	302.72	132.76
HD1	364.38	253.29	111.09
HC2	411.25	285.87	125.38
HC1	344.99	239.81	105.18
HB2	406.40	282.50	123.90
HB1	341.76	237.57	104.19
LE2	422.56	293.73	128.83
LE1	354.69	246.56	108.13
LD2	406.40	282.50	123.90
LD1	341.76	237.57	104.19
LC2	357.92	248.80	109.12
LC1	302.98	210.61	92.37
LB2	340.15	236.45	103.70
LB1	290.05	201.62	88.43
CE2	377.31	262.28	115.03
CE1	348.23	242.07	106.16
CD2	357.92	248.80	109.12
CD1	328.83	228.58	100.25
CC2	314.29	218.47	95.82
CC1	291.67	202.75	88.92
CB2	291.67	202.75	88.92
CB1	270.66	188.14	82.52
CA2	248.04	172.42	75.62

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

RUG–IV Category	Total rate	Labor portion	Non-labor portion
CA1	231.88	161.19	70.69
BB2	262.58	182.53	80.05
BB1	251.27	174.67	76.60
BA2	218.95	152.20	66.75
BA1	209.26	145.46	63.80
PE2	348.23	242.07	106.16
PE1	332.07	230.83	101.24
PD2	328.83	228.58	100.25
PD1	312.68	217.35	95.33
PC2	283.59	197.13	86.46
PC1	270.66	188.14	82.52
PB2	241.58	167.93	73.65
PB1	231.88	161.19	70.69
PA2	201.18	139.85	61.33
PA1	193.10	134.23	58.87

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 would otherwise be made if the wage adjustment had not been made. For FY 2015 (federal rates effective October 1, 2014), we would apply an adjustment to fulfill the budget neutrality requirement. We would meet this requirement by multiplying each of the components of the unadjusted federal rates by a budget neutrality factor equal to the ratio of the weighted average wage adjustment factor for FY 2014 to the weighted average wage adjustment factor for FY 2015, based on the blended wage index for FY 2015 as proposed later in this proposed 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 would be 1.0001.

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 one-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 one-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, we are proposing 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 one-year transition with a blended wage index for FY 2015. These proposed changes are discussed further in section V.A. of this proposed rule. The proposed wage index applicable to FY 2015 is set forth in Table A available on the CMS Web site 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 proposed revised OMB delineations, as well as the proposed transition wage index values that would be in effect in FY 2015 if these proposed changes are finalized.

E. 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 proposed 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: 0.8883
[See Proposed 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	$480.24	0.8883	$426.60	$210.62	$637.22	$637.22	14	$8,921.08
ES2	385.59	0.8883	342.52	169.11	511.63	511.63	30	15,348.90
RHA	242.28	0.8883	215.22	106.26	321.48	321.48	16	5,143.68
CC2*	223.34	0.8883	198.39	97.95	296.34	675.66	10	6,756.60
BA2	153.97	0.8883	136.77	67.53	204.30	204.30	30	6,129.00
							100	42,299.26

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

IV. Additional Aspects of the SNF PPS

A. 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 III.C. of this proposed 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 2011 SNF PPS update notice (75 FR 42910), this designation reflects an administrative presumption under the 66-group RUG–IV system that beneficiaries who are correctly assigned to one of the upper 52 RUG–IV groups on the initial 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 proposed 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.

B. 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 Web site 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). In this proposed rule, we specifically invite 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. We may consider excluding a particular service if it meets our criteria for exclusion as specified above. Commenters should identify in their comments the specific HCPCS code that is associated with the service in question, as well as their rationale for requesting that the identified HCPCS code(s) be excluded.

We note that the original BBRA amendment (as well as the implementing regulations) identified a set of excluded services by means of specifying HCPCS codes that were in effect as of a particular date (in that case, as of July 1, 1999). Identifying the excluded services in this manner made it possible for us to utilize program issuances as the vehicle for accomplishing routine updates of the excluded codes, to reflect any minor revisions that might subsequently occur in the coding system itself (for example, the assignment of a different code number to the same service). Accordingly, in the event that we identify through the current rulemaking cycle any new services that would actually represent a substantive change in the scope of the exclusions from SNF consolidated billing, we would identify these additional excluded services by means of the HCPCS codes that are in effect as of a specific date (in this case, as of October 1, 2014). By making any new exclusions in this manner, we could similarly accomplish routine future updates of these additional codes through the issuance of program instructions.

C. 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 earlier sections of this proposed rule for the SNF PPS also apply to all non-CAH swing-bed rural hospitals. A complete discussion of assessment schedules, the MDS, and the transmission software (RAVEN–SB for Swing Beds) appears in the FY 2002 final rule (66 FR 39562) and in the FY 2010 final rule (74 FR 40288). As finalized in the FY 2010 SNF PPS final rule (74 FR 40356–57), effective October 1, 2010, non-CAH swing-bed rural hospitals are required to complete an MDS 3.0 swing-bed assessment which is limited to the required demographic, payment, and quality items. The latest changes in the MDS for swing-bed rural hospitals appear on the SNF PPS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html.*

V. Other Issues

A. Proposed Changes to SNF PPS Wage Index

1. 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 III.D of this proposed rule, we are proposing to 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), and the outmigration adjustment under section 1886(d)(13) (see the FY 2006 SNF PPS proposed rule (70 FR 29090 through 29092)). 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 preamble 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 this FY 2015 SNF PPS proposed rule. As discussed below, in this proposed rule, we are proposing to implement the new OMB delineations as described in the February 28, 2013 OMB Bulletin No. 13–01, for SNF PPS wage index beginning in FY 2015.

2. Proposed Implementation of New Labor Market Delineations

As discussed in the FY 2014 SNF PPS proposed rule (78 FR 26448) and final rule (78 FR 47952), CMS delayed implementing the new OMB statistical area delineations to allow for sufficient time to assess the new changes. 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 Web site 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. 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. 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 are proposing to implement the new OMB delineations as described in the February 28, 2013 OMB Bulletin No. 13–01, for the SNF PPS wage index effective beginning in FY 2015. As discussed further below, we are proposing to implement a one-year transition with a blended wage index for all providers in FY 2015 to assist providers in adapting to the new OMB delineations (if we finalize implementation of such delineations for the SNF PPS wage index beginning in FY 2015). We invite comments on this proposal. This proposed transition is discussed in more detail below.

a. Micropolitan Statistical Areas

As discussed in the FY 2006 SNF PPS proposed rule (70 FR 29093 through 29094) and final rule (70 FR 45041), CMS considered how to use the Micropolitan Statistical Area definitions in the calculation of the wage index. OMB defines a ''Micropolitan Statistical Area'' as a CBSA ''associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000'' (75 FR 37252). We refer to these as Micropolitan Areas. After extensive impact analysis, consistent with the treatment of these areas under the IPPS as discussed in the FY 2005 IPPS final rule (69 FR 49029 through 49032), CMS determined the best course of action would be to treat Micropolitan Areas as ''rural'' and include them in the calculation of each state's SNF PPS rural wage index (see 70 FR 29094 and 70 FR 45040 through 45041)). Thus, the SNF PPS statewide rural wage index is determined using IPPS hospital data from hospitals located in non-MSA areas, and the statewide rural wage index is assigned to SNFs located in those areas. Because Micropolitan Areas tend to encompass smaller population centers and contain fewer hospitals than MSAs, we determined that if Micropolitan Areas were to be treated as separate labor market areas, the SNF PPS wage index would have included significantly more single-provider labor market areas. As we explained in the FY 2006 SNF PPS proposed rule (70 FR 29094), 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 these reasons, we adopted a policy to include Micropolitan Areas in the state's rural wage area for purposes of the SNF PPS wage index, and have continued this policy through the present.

Based upon the new 2010 Decennial Census data, a number of urban counties have switched status and have joined or became Micropolitan Areas, and some counties that once were part of a Micropolitan Area, have become urban. Overall, there are fewer Micropolitan Areas (541) under the new OMB delineations based on the 2010 Census than existed under the latest data from the 2000 Census (581). We believe that the best course of action would be to continue the policy established in the FY 2006 SNF PPS final rule and include Micropolitan Areas in each state's rural wage index. These areas continue to be defined as having relatively small urban cores (populations of 10,000 to 49,999). We do not believe it would be appropriate to calculate a separate wage index for areas that typically may include only a few hospitals for the reasons discussed in the FY 2006 SNF PPS proposed rule, and as discussed above. Therefore, in conjunction with our proposal to implement the new OMB labor market delineations beginning in FY 2015 and consistent with the treatment of Micropolitan Areas under the IPPS, we are proposing to continue to treat Micropolitan Areas as ''rural'' and to include Micropolitan Areas in the calculation of the state's rural wage index.

b. Urban Counties Becoming Rural

As previously discussed, we are proposing to implement the new OMB statistical area delineations (based upon the 2010 decennial Census data) beginning in FY 2015 for the SNF PPS wage index. Our analysis shows that a total of 37 counties (and county equivalents) that are currently considered part of an urban CBSA would be considered located in a rural

area, beginning in FY 2015, if we adopt the new OMB delineations. Table 9 below lists the 37 urban counties that would be rural if we finalize our proposal to implement the new OMB delineations.

TABLE 9—COUNTIES THAT WOULD LOSE URBAN STATUS

County	State	Previous CBSA	Previous urban area (constituent counties)
Greene County	IN	14020	Bloomington, IN.
Anson County	NC	16740	Charlotte-Gastonia-Rock Hill, NC-SC.
Franklin County	IN	17140	Cincinnati-Middletown, OH-KY-IN.
Stewart County	TN	17300	Clarksville, TN-KY.
Howard County	MO	17860	Columbia, MO.
Delta County	TX	19124	Dallas-Fort Worth-Arlington, TX.
Pittsylvania County	VA	19260	Danville, VA.
Danville City	VA	19260	Danville, VA.
Preble County	OH	19380	Dayton, OH.
Gibson County	IN	21780	Evansville, IN-KY.
Webster County	KY	21780	Evansville, IN-KY.
Franklin County	AR	22900	Fort Smith, AR-OK.
Ionia County	MI	24340	Grand Rapids-Wyoming, MI.
Newaygo County	MI	24340	Grand Rapids-Wyoming, MI.
Greene County	NC	24780	Greenville, NC.
Stone County	MS	25060	Gulfport-Biloxi, MS.
Morgan County	WV	25180	Hagerstown-Martinsburg, MD-WV.
San Jacinto County	TX	26420	Houston-Sugar Land-Baytown, TX.
Franklin County	KS	28140	Kansas City, MO-KS.
Tipton County	IN	29020	Kokomo, IN.
Nelson County	KY	31140	Louisville/Jefferson County, KY-IN.
Geary County	KS	31740	Manhattan, KS.
Washington County	OH	37620	Parkersburg-Marietta-Vienna, WV-OH.
Pleasants County	WV	37620	Parkersburg-Marietta-Vienna, WV-OH.
George County	MS	37700	Pascagoula, MS.
Power County	ID	38540	Pocatello, ID.
Cumberland County	VA	40060	Richmond, VA.
King and Queen County	VA	40060	Richmond, VA.
Louisa County	VA	40060	Richmond, VA.
Washington County	MO	41180	St. Louis, MO-IL.
Summit County	UT	41620	Salt Lake City, UT.
Erie County	OH	41780	Sandusky, OH.
Franklin County	MA	44140	Springfield, MA.
Ottawa County	OH	45780	Toledo, OH.
Greene County	AL	46220	Tuscaloosa, AL.
Calhoun County	TX	47020	Victoria, TX.
Surry County	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC.

We are proposing that the wage data for all hospitals located in the counties listed above would now be considered rural when calculating their respective state's rural wage index value, which rural wage index value would be used under the SNF PPS. Furthermore, for SNF providers currently located in an urban county that would be considered rural, should this proposal be finalized, CMS would utilize the rural unadjusted per-diem rates, found in Table 3 above, as the basis for determining this facility's payment rates beginning on October 1, 2014.

c. Rural Counties Becoming Urban

Analysis of the new OMB delineations (based upon the 2010 decennial Census data) shows that a total of 105 counties (and county equivalents) that are currently located in rural areas would be located in urban areas, if we finalize our proposal to implement the new OMB delineations. Table 10 below lists the 105 rural counties that would be urban if we finalize this proposal.

TABLE 10—COUNTIES THAT WOULD GAIN URBAN STATUS

County	State	New CBSA	Urban area (constituent counties)
Utuado Municipio	PR	10380	Aguadilla-Isabela, PR.
Linn County	OR	10540	Albany, OR.
Oldham County	TX	11100	Amarillo, TX.
Morgan County	GA	12060	Atlanta-Sandy Springs-Roswell, GA.
Lincoln County	GA	12260	Augusta-Richmond County, GA-SC.
Newton County	TX	13140	Beaumont-Port Arthur, TX.
Fayette County	WV	13220	Beckley, WV.
Raleigh County	WV	13220	Beckley, WV.
Golden Valley County	MT	13740	Billings, MT.
Oliver County	ND	13900	Bismarck, ND.

TABLE 10—COUNTIES THAT WOULD GAIN URBAN STATUS—Continued

County	State	New CBSA	Urban area (constituent counties)
Sioux County	ND	13900	Bismarck, ND.
Floyd County	VI	13980	Blacksburg-Christiansburg-Radford, VA.
De Witt County	IL	14010	Bloomington, IL.
Columbia County	PA	14100	Bloomsburg-Berwick, PA.
Montour County	PA	14100	Bloomsburg-Berwick, PA.
Allen County	KY	14540	Bowling Green, KY.
Butler County	KY	14540	Bowling Green, KY.
St. Mary's County	MD	15680	California-Lexington Park, MD.
Jackson County	IL	16060	Carbondale-Marion, IL.
Williamson County	IL	16060	Carbondale-Marion, IL.
Franklin County	PA	16540	Chambersburg-Waynesboro, PA.
Iredell County	NC	16740	Charlotte-Concord-Gastonia, NC-SC.
Lincoln County	NC	16740	Charlotte-Concord-Gastonia, NC-SC.
Rowan County	NC	16740	Charlotte-Concord-Gastonia, NC-SC.
Chester County	SC	16740	Charlotte-Concord-Gastonia, NC-SC.
Lancaster County	SC	16740	Charlotte-Concord-Gastonia, NC-SC.
Buckingham County	VA	16820	Charlottesville, VA.
Union County	IN	17140	Cincinnati, OH-KY-IN.
Hocking County	OH	18140	Columbus, OH.
Perry County	OH	18140	Columbus, OH.
Walton County	FL	18880	Crestview-Fort Walton Beach-Destin, FL.
Hood County	TX	23104	Dallas-Fort Worth-Arlington, TX.
Somervell County	TX	23104	Dallas-Fort Worth-Arlington, TX.
Baldwin County	AL	19300	Daphne-Fairhope-Foley, AL.
Monroe County	PA	20700	East Stroudsburg, PA.
Hudspeth County	TX	21340	El Paso, TX.
Adams County	PA	23900	Gettysburg, PA.
Hall County	NE	24260	Grand Island, NE.
Hamilton County	NE	24260	Grand Island, NE.
Howard County	NE	24260	Grand Island, NE.
Merrick County	NE	24260	Grand Island, NE.
Montcalm County	MI	24340	Grand Rapids-Wyoming, MI.
Josephine County	OR	24420	Grants Pass, OR.
Tangipahoa Parish	LA	25220	Hammond, LA.
Beaufort County	SC	25940	Hilton Head Island-Bluffton-Beaufort, SC.
Jasper County	SC	25940	Hilton Head Island-Bluffton-Beaufort, SC.
Citrus County	FL	26140	Homosassa Springs, FL.
Butte County	ID	26820	Idaho Falls, ID.
Yazoo County	MS	27140	Jackson, MS.
Crockett County	TN	27180	Jackson, TN.
Kalawao County	HI	27980	Kahului-Wailuku-Lahaina, HI.
Maui County	HI	27980	Kahului-Wailuku-Lahaina, HI.
Campbell County	TN	28940	Knoxville, TN.
Morgan County	TN	28940	Knoxville, TN.
Roane County	TN	28940	Knoxville, TN.
Acadia Parish	LA	29180	Lafayette, LA.
Iberia Parish	LA	29180	Lafayette, LA.
Vermilion Parish	LA	29180	Lafayette, LA.
Cotton County	OK	30020	Lawton, OK.
Scott County	IN	31140	Louisville/Jefferson County, KY-IN.
Lynn County	TX	31180	Lubbock, TX.
Green County	WI	31540	Madison, WI.
Benton County	MS	32820	Memphis, TN-MS-AR.
Midland County	MI	33220	Midland, MI.
Martin County	TX	33260	Midland, TX.
Le Sueur County	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI.
Mille Lacs County	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI.
Sibley County	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI.
Maury County	TN	34980	Nashville-Davidson-Murfreesboro-Franklin, TN.
Craven County	NC	35100	New Bern, NC.
Jones County	NC	35100	New Bern, NC.
Pamlico County	NC	35100	New Bern, NC.
St. James Parish	LA	35380	New Orleans-Metairie, LA.
Box Elder County	UT	36260	Ogden-Clearfield, UT.
Gulf County	FL	37460	Panama City, FL.
Custer County	SD	39660	Rapid City, SD.
Fillmore County	MN	40340	Rochester, MN.

TABLE 10—COUNTIES THAT WOULD GAIN URBAN STATUS—Continued

County	State	New CBSA	Urban area (constituent counties)
Yates County	NY	40380	Rochester, NY.
Sussex County	DE	41540	Salisbury, MD-DE.
Worcester County	MA	41540	Salisbury, MD-DE.
Highlands County	FL	42700	Sebring, FL.
Webster Parish	LA	43340	Shreveport-Bossier City, LA.
Cochise County	AZ	43420	Sierra Vista-Douglas, AZ.
Plymouth County	IA	43580	Sioux City, IA-NE-SD.
Union County	SC	43900	Spartanburg, SC.
Pend Oreille County	WA	44060	Spokane-Spokane Valley, WA.
Stevens County	WA	44060	Spokane-Spokane Valley, WA.
Augusta County	VA	44420	Staunton-Waynesboro, VA.
Staunton City	VA	44420	Staunton-Waynesboro, VA.
Waynesboro City	VA	44420	Staunton-Waynesboro, VA.
Little River County	AR	45500	Texarkana, TX-AR.
Sumter County	FL	45540	The Villages, FL.
Pickens County	AL	46220	Tuscaloosa, AL.
Gates County	NC	47260	Virginia Beach-Norfolk-Newport News, VA-NC.
Falls County	TX	47380	Waco, TX.
Columbia County	WA	47460	Walla Walla, WA.
Walla Walla County	WA	47460	Walla Walla, WA.
Peach County	GA	47580	Warner Robins, GA.
Pulaski County	GA	47580	Warner Robins, GA.
Culpeper County	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV.
Rappahannock County	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV.
Jefferson County	NY	48060	Watertown-Fort Drum, NY.
Kingman County	KS	48620	Wichita, KS.
Davidson County	NC	49180	Winston-Salem, NC.
Windham County	CT	49340	Worcester, MA-CT.

We are proposing that when calculating the area wage index, the wage data for hospitals located in these counties would be included in their new respective urban CBSAs. Furthermore, for SNF providers currently located in a rural county that would be considered urban, should this proposal be finalized, CMS would utilize the urban unadjusted per-diem rates, found in Table 2 above, as the basis for determining this facility's payment rates beginning on October 1, 2014

d. Urban Counties Moving to a Different Urban CBSA

In addition to rural counties becoming urban and urban counties becoming rural, several urban counties would shift from one urban CBSA to another urban CBSA under our proposal to adopt the new OMB delineations. In other cases, applying the new OMB delineations would involve a change only in CBSA name or number, while the CBSA continues to encompass the same constituent counties. For example, CBSA 29140 (Lafayette, IN), would experience both a change to its number and its name, and would become CBSA 29200 (Lafayette-West Lafayette, IN), while all of its three constituent counties would remain the same. We are not discussing these proposed changes in this section because they are inconsequential changes with respect to the SNF PPS wage index. However, in other cases, if we adopt the new OMB delineations, counties would shift between existing and new CBSAs, changing the constituent makeup of the CBSAs.

In one type of change, an entire CBSA would be subsumed by another CBSA. For example, CBSA 37380 (Palm Coast, FL) currently is a single county (Flagler, FL) CBSA. Flagler County would be a part of CBSA 19660 (Deltona-Daytona Beach-Ormond Beach, FL) under the new OMB delineations.

In another type of change, some CBSAs have counties that would split off to become part of or to form entirely new labor market areas. For example, CBSA 37964 (Philadelphia Metropolitan Division of MSA 37980) currently is comprised of five Pennsylvania counties (Bucks, Chester, Delaware, Montgomery, and Philadelphia). If we adopt the new OMB delineations, Montgomery, Bucks, and Chester counties would split off and form the new CBSA 33874 (Montgomery County-Bucks County-Chester County, PA Metropolitan Division of MSA 37980), while Delaware and Philadelphia counties would remain in CBSA 37964.

Finally, in some cases, a CBSA would lose counties to another existing CBSA if we adopt the new OMB delineations. For example, Lincoln County and Putnam County, WV would move from CBSA 16620 (Charleston, WV) to CBSA 26580 (Huntington-Ashland, WV–KY–OH). CBSA 16620 would still exist in the new labor market delineations with fewer constituent counties. Table 11 lists the urban counties that would move from one urban CBSA to another urban CBSA if we adopt the new OMB delineations.

TABLE 11—COUNTIES THAT WOULD CHANGE TO A DIFFERENT CBSA

Prior CBSA	New CBSA	County	State
11300	26900	Madison County	IN.

TABLE 11—COUNTIES THAT WOULD CHANGE TO A DIFFERENT CBSA—Continued

Prior CBSA	New CBSA	County	State
11340	24860	Anderson County	SC.
14060	14010	McLean County	IL.
37764	15764	Essex County	MA.
16620	26580	Lincoln County	WV.
16620	26580	Putnam County	WV.
16974	20994	DeKalb County	IL.
16974	20994	Kane County	IL.
21940	41980	Ceiba Municipio	PR.
21940	41980	Fajardo Municipio	PR.
21940	41980	Luquillo Municipio	PR.
26100	24340	Ottawa County	MI.
31140	21060	Meade County	KY.
34100	28940	Grainger County	TN.
35644	35614	Bergen County	NJ.
35644	35614	Hudson County	NJ.
20764	35614	Middlesex County	NJ.
20764	35614	Monmouth County	NJ.
20764	35614	Ocean County	NJ.
35644	35614	Passaic County	NJ.
20764	35084	Somerset County	NJ.
35644	35614	Bronx County	NY.
35644	35614	Kings County	NY.
35644	35614	New York County	NY.
35644	20524	Putnam County	NY.
35644	35614	Queens County	NY.
35644	35614	Richmond County	NY.
35644	35614	Rockland County	NY.
35644	35614	Westchester County	NY.
37380	19660	Flagler County	FL.
37700	25060	Jackson County	MS.
37964	33874	Bucks County	PA.
37964	33874	Chester County	PA.
37964	33874	Montgomery County	PA.
39100	20524	Dutchess County	NY.
39100	35614	Orange County	NY.
41884	42034	Marin County	CA.
41980	11640	Arecibo Municipio	PR.
41980	11640	Camuy Municipio	PR.
41980	11640	Hatillo Municipio	PR.
41980	11640	Quebradillas Municipio	PR.
48900	34820	Brunswick County	NC.
49500	38660	Guánica Municipio	PR.
49500	38660	Guayanilla Municipio	PR.
49500	38660	Peñuelas Municipio	PR.
49500	38660	Yauco Municipio	PR.

If providers located in these counties move from one CBSA to another under the new OMB delineations, there may be impacts, both negative and positive, upon their specific wage index values. As discussed below, we propose to implement a transition wage index to adjust for these possible impacts.

e. Transition Period

Overall, we believe implementing the new OMB delineations would result in wage index values being more representative of the actual costs of labor in a given area. Further, we recognize that some providers (15 percent) would have a higher wage index due to our proposed implementation of the new labor market area delineations. However, we also recognize that more providers (22 percent) would experience decreases in wage index values as a result of our proposed implementation of the new labor market area delineations. Therefore, we believe it would be appropriate to consider, as we did in FY 2006, whether or not a transition period should be used in order to implement these proposed changes to the wage index.

We considered having no transition period and fully implementing the proposed 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 would experience a decrease in wage index due to implementation of the proposed new OMB delineations than would experience an increase. Thus, we believe that it would be appropriate to provide for a transition period to mitigate the resulting short-term instability and negative impacts 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 29094–29095) to adopt the new CBSA definitions without a transition period, we anticipate that providers would have similar concerns with not having a transition period for the proposed new OMB delineations. Therefore, as further discussed below, 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 proposing a one-year transition blended wage index for all SNFs to assist providers in adapting to the new OMB delineations (should we finalize implementation of such delineations for the SNF PPS wage index beginning in FY 2015). 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 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, which argues for a faster transition to the revised OMB delineations. As discussed above in section V.A.2 of this proposed rule, 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 one-year (rather than a multiple year) transition with a blended wage index in FY 2015 would strike the best balance.

Second, we considered what type of blend would be appropriate for purposes of the transition wage index. We are proposing that providers would receive a one-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 OMB delineations used in FY 2014. We believe that a 50/50 blend would best mitigate the negative payment impacts associated with the implementation of the proposed 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 this proposal, 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. If we were to apply the transition policy only to those providers that would experience a decrease in their respective wage index values due to the implementation of the revised OMB delineations, then providers that would experience either no change in wage index or an increase in wage index due to the revised OMB delineations would be immediately transitioned to the FY 2015 wage index under 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, if we were to apply the transition policy only to those providers that would experience a decrease in their respective wage index values due to implementation of the revised OMB delineations, the budget neutrality factor, discussed in section III.D, calculated based on this this approach would be 0.9986, which would result in reduced base rates for all providers as compared to the budget neutrality factor of 1.0001 which would result from applying the blended wage index to all providers. Furthermore, based on our analysis of the wage index changes associated with fully implementing the revised OMB delineations, we determined that the new OMB delineations would only affect the wage index values of approximately 37 percent of facilities. Given that our goal is to provide relief to the largest percentage of adversely-affected SNFs with the least impact to the rest of the facilities (whose wage index values either would remain the same or would increase), we believe that using a blended wage index for all providers would be the best option. This option would assist the 22 percent of providers that would be adversely affected by the proposed implementation of the new OMB delineations without reducing the base rates for all providers, 63 percent of which would otherwise be unaffected by the proposed implementation of the new OMB delineations. In other words, this option is based on a balance between the interests of all SNF providers, including the 15 percent of providers that would experience an increase in their wage index value due to the proposed implementation of the new OMB delineations, the 22 percent of providers that would experience a decrease in their wage index value due to the proposed implementation of the new OMB delineations, and the 63 percent of providers that would be unaffected by the proposed implementation of the new OMB delineations. As discussed above, if we were to apply the blended wage index only to the 22 percent of providers that would experience a decrease in their respective wage index values due to the proposed implementation of the new OMB delineations in an effort to preserve the full increase in wage index value for the 15 percent of providers that would experience such an increase due to the proposed implementation of the new OMB delineations, the budget neutrality factor of 1.0001 referenced in section III.D, which is based on applying the blended wage index to all providers, would be revised to 0.9986. As such, this would mean a reduction in the base rate for all providers, most notably the 63 percent of providers that would be unaffected by the proposed implementation of the new OMB delineations, but also for that 15 percent of providers that would experience an increase in their wage index value.

Moreover, while providers experience wage index changes from year to year based on updating the wage data, full implementation of the proposed new OMB delineations would dramatically increase the magnitude of those changes for some providers. Year-to-year wage index changes usually vary from decreases as high as 10 percent to increases as high as 10 percent. Using FY 2011 wage data (the data used for the FY 2015 wage index), the range of changes in the wage index values due solely to full implementation of the proposed OMB delineations would span from decreases of over 20 percent to increases of over 30 percent. Therefore, in addition to mitigating the impact of the proposed OMB delineations on the facilities that are adversely affected by them and providing a period to adjust, we believe a transition wage index could also mitigate the volatility of the SNF PPS wage index caused by these proposed changes.

Therefore, for the reasons discussed above, if we finalize implementation of the new OMB delineations, we are proposing to apply a one-year transition with a 50/50 blended wage index for all providers in FY 2015. We propose to calculate the FY 2015 wage indexes using both the current FY 2014 and proposed new labor market delineations. Specifically, 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 area delineations for FY 2014 (both using FY 2011 hospital wage data). This ultimately results in an average of the two values. As we stated in the FY 2006 SNF PPS final rule (70 FR 45041), we believe that our proposed transition approach would best achieve our objective of providing relief to the largest percentage of adversely-affected

SNFs with the least impact to the rest of the facilities, because it reduces the impact of the transition on the base rates for all providers. For the reasons discussed above, and based on provider reaction during the FY 2006 rulemaking cycle to the proposed adoption of the new CBSA definitions, we are proposing to provide a one-year blended wage index for all SNFs to assist providers in adapting to these proposed changes. We refer to this blended wage index as the FY 2015 SNF PPS transition wage index. This transition policy would be for a one-year period, going into effect October 1, 2014, and continuing through September 30, 2015. Thus, beginning October 1, 2015, the wage index for all SNFs would be fully based on the new OMB delineations. We invite comments on our proposed transition methodology, as well as on the other transition options discussed above.

The proposed wage index applicable to FY 2015 is set forth in Table A available on the CMS Web site 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 proposed revised OMB delineations, as well as the proposed transition wage index values that would be in effect in FY 2015 if these proposed changes are finalized.

3. 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 III.D of this proposed rule. Table 12 summarizes the proposed 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 14:1 forecast [2]
Wages and salaries	49.118	49.116
Employee benefits	11.423	11.373
Nonmedical Professional fees: labor-related	3.446	3.460
Administrative and facilities support services	0.499	0.503
All Other: Labor-related services	2.287	2.285
Capital-related (.391)	2.772	2.776
Total	69.545	69.513

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

B. 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 this proposed rule, we are taking the opportunity to update the public on the current state of this project. In September 2013, we completed the first phase of the research project, which included a literature review, stakeholder outreach, supplementary analyses, and a comprehensive review of options for a viable alternative to the current therapy payment model. CMS produced a report outlining the most promising and viable options that we plan to pursue in the second phase of the project. The report is available on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*.

During the second phase of the project, which began in September 2013, our team will further develop the options outlined in the aforementioned report and perform more comprehensive data analysis to determine which of these options would work best as a potential replacement for the existing therapy payment model. In keeping with the public comments we received on this project previously, we also plan to engage the stakeholder community by convening a Technical Expert Panel during this second phase of the project to discuss the available alternatives, as well as present some of the initial data analysis that is currently being conducted. We hope that by convening this Technical Expert Panel, we can best ensure that we utilize the expertise of the stakeholder community in identifying the most viable alternative to the current therapy payment model.

As before, comments may be included as part of comments on this proposed rule. We are also soliciting comments 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 Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html*.

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

On October 1, 2011, CMS introduced the Change of Therapy (COT) Other Medicare Required Assessment (OMRA), which is an assessment designed to capture changes in the therapy services provided to a given SNF resident during the past 7 days. As discussed in the FY 2012 SNF PPS final rule, this assessment was implemented because we had found that in certain cases, ''the therapy recorded on a given PPS assessment did not provide an accurate account of the therapy provided to a given resident outside the observation window used for the most recent assessment'' (76 FR 48518).

To address this situation, effective for services provided on or after October 1, 2011, we required facilities to complete a COT OMRA for patients classified into a RUG–IV therapy category, whenever the intensity of therapy (that is, the total reimbursable therapy minutes delivered or other therapy category qualifiers, such as the number of days the patient received therapy during the week or the number of therapy disciplines) changes to such a degree that it would no longer reflect the RUG–IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment (see 76 FR 48525). In addition, as discussed in the FY 2012 SNF PPS final rule (76 FR 48523 through 48524, 48526), the COT OMRA policy also applies to patients who are receiving a level of therapy sufficient for classification into a therapy RUG, but are classified into a nursing RUG because of index maximization. An evaluation of the necessity for a COT OMRA must be completed every 7 calendar days starting from the day following the Assessment Reference Date (ARD) set for the most recent scheduled or unscheduled PPS assessment (or in the case of an End of Therapy–Resumption-OMRA, starting the day that therapy resumes). This rolling 7-day window is called the COT observation period. As discussed in the FY 2012 SNF PPS final rule (76 FR 48523), the purpose of the COT OMRA is to track changes in a patient's condition and in the provision of therapy services more accurately to ensure that the patient is placed in the appropriate RUG category, thereby improving the accuracy of reimbursement.

As discussed above, the resident must be classified into a RUG–IV therapy category or into a nursing RUG because of index maximization (while receiving a level of therapy sufficient for classification into a RUG–IV therapy category) in order for the COT OMRA requirements to apply. However, since implementation of this assessment, we have learned that, in rare cases where a resident has been classified into a RUG–IV therapy category, therapy services provided to the resident during a COT observation period may not be sufficient to continue to qualify the resident for any therapy RUG, resulting in classification of the resident into a non-therapy RUG. During a subsequent week when the therapy services are sufficient to again qualify the resident for a therapy RUG, providers have indicated that they cannot complete a subsequent COT OMRA to reclassify the resident into a therapy RUG because the resident is no longer in a therapy RUG or in a nursing RUG because of index maximization as discussed above (pursuant to the conditions set forth in the FY 2012 SNF PPS final rule and in Section 2.9 of the MDS 3.0 RAI manual). As a result, providers are unable to use the COT OMRA to capture the increased therapy services provided to the resident to ensure accurate payment for the services provided, which is the express purpose of the COT OMRA.

Accordingly, we propose to revise the existing COT OMRA policy to 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 as discussed above, 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. Under the proposed policy, while a COT OMRA may be used to *reclassify* a resident into a therapy RUG in the circumstances described above, it may not be used to *initially* classify a resident into a therapy RUG. We believe it is appropriate to revise the COT OMRA policy in this manner to provide for more accurate payment for services provided to those residents who have qualified for a RUG–IV therapy group during their Medicare Part A stay and continue to receive skilled therapy services during their Medicare Part A stay (even though they may have been classified into a non-therapy RUG as discussed above).

Consider, for example, if Mr. A. was 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 how much therapy 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 to a non-therapy RUG group. Let us further assume that the facility continues to provide Mr. A. with skilled therapy and that, when looking back on Mr. A.'s services from Day 44 (7 days after the ARD of the COT OMRA), Mr. A. again qualifies for classification in the RUG group RUA.

Under the existing COT OMRA policy, it would not be possible for this provider to reclassify Mr. A. back into RUA from the non-therapy group by using a COT OMRA. Instead, Mr. A. could only be classified into a therapy RUG either by discontinuing his therapy using an End of Therapy (EOT) OMRA and beginning a new therapy program and completing a Start of Therapy (SOT) OMRA, or by waiting until the next scheduled assessment. Under our proposed revised policy, this provider would be permitted to complete a COT OMRA with an ARD of Day 44 in order to reclassify Mr. A. back into the RUA group. The facility would then continue to review the therapy services provided to Mr. A. in order to ensure that these services continue to reflect Mr. A.'s current RUG–IV therapy classification.

To further clarify the scope of this proposal, consider a slightly different example in which 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 previous situation where the resident's therapy continued during the week following the COT OMRA, let us assume that the facility decides to discontinue his therapy services by completing an End of Therapy OMRA with an ARD set for Day 39, resulting in a non-therapy RUG classification for Mr. A. The facility subsequently decides to restart Mr. A.'s therapy services, beginning on Day 41 of his stay. The facility looks back from Day 47 (7 days following the day therapy began on Day 41, including Day 41) to review the therapy services provided to Mr. A. during the prior week and finds that Mr. A. would qualify for the RUG group RVA.

As in the prior example, under the existing COT OMRA policy, it would not be possible for this provider to classify Mr. A. into RVA from the non-therapy group by using a COT OMRA. However, as opposed to the prior example, under the revised COT OMRA policy proposed in this proposed rule, the facility would still not be permitted to complete the COT OMRA in this instance, as a discontinuation of therapy services had occurred 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 would have been used to reclassify the patient into a RUG–IV therapy group if it had been permitted. Based on this example, in order to reclassify the resident into a RUG–IV therapy group, the provider would need to either complete a Start of Therapy OMRA or wait until the next regularly scheduled assessment.

We believe this proposal would address the concern of those providers who have experienced the rare occurrence of a COT OMRA classifying a resident into a non-therapy RUG group from a therapy RUG group, where the patient continues to receive therapy and later qualifies again for a therapy RUG. We believe this proposed revision to the COT OMRA policy would ensure the most accurate payment for therapy services furnished to such residents by allowing providers to capture variations in therapy services on a weekly basis. As with other similar policy changes, if this revision is finalized, then we intend to monitor the impact of this revision to ensure that is has the intended effect. We invite comments on this proposed change to the existing COT OMRA policy.

D. Civil Money Penalties (Section 6111 of the Affordable Care Act)

Sections 6111 of the Patient Protection and Affordable Care Act (Affordable Care Act), amended sections 1819(h) and 1919(h) of the Act to incorporate specific provisions pertaining to the imposition and collection of civil money penalties (CMPs). Sections 1819(h)(2)(B)(ii)(IV)(ff) and 1919(h)(3)(C)(ii)(IV)(ff) of the Act specifies that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary). These changes were implemented in a final rule published on March 18, 2011 entitled ''Medicare and Medicaid Programs; Civil Money Penalties for Nursing Homes.'' At § 488.433, we specify that these funds may not be used for survey and certification operations but must be used entirely for activities that protect or improve the quality of care for residents and that these activities must be approved by CMS.

This proposed rule would clarify statutory requirements as specified in section 6111 of the Affordable Care Act regarding the approval and use of CMPs imposed by CMS. It is important to note that these clarifications not only apply to the Federal share of collected CMP funds granted for approved projects that benefit residents under § 488.433, but they also apply to the portion of the CMPs collected by CMS that is disbursed to the states based on the proportion of Medicaid eligible nursing home residents under § 488.442(e)(2) and (f). The amendments made by section 6111 of the Affordable Care Act makes it clear that the specified use of CMP funds collected from SNFs, SNF/NFs, and NF-only facilities as a result of CMPs imposed by CMS, must be approved by CMS by specifying that the activities that CMP funds are used for must be approved by the Secretary. Sections 1819(h)(2)(B)(ii)(IV)(ff) and 1919(h)(3)(C)(ii)(IV)(ff) of the Act also provide for flexibility on how CMP funds imposed by CMS may be used within the bounds established by law. The regulations at § 488.433 specify that collected CMP funds must be used entirely for activities that protect or improve the quality of care for residents, and may not be used for survey and certification operations. However, we are aware of instances in which states have used federal CMP funds without obtaining prior approval from CMS, have used these funds even though CMS had disapproved their intended use, have not used these funds at all, or have used these funds for purposes other than to support activities that benefit residents as specified in statute and regulation. For example, information reported by the CMS Regional Offices for CY 2012 indicates that 24 states had not approved any projects using CMP funds. While some states have only small amounts of CMP funds available and seek to maintain a core reserve in the event of emergencies or involuntary termination that necessitates timely relocation for resident safety and well-being, other states maintain significant amounts of funds. One state, for example, maintained more than $15 million in FY 2012. While it is very prudent to maintain a reserve fund for emergencies, we believe that maintenance of large amounts of unused CMP funds is not desirable or consistent with ensuring that collected CMP funds be used to benefit nursing home residents. In addition, large amounts of unused CMP funds may create the appearance that CMPs are being levied for purposes other than to benefit nursing home residents.

A key function of the CMP remedy is to prompt quick compliance with the federal health and safety requirements. These monies must be used to support projects or activities that will benefit nursing home residents. Entities applying for approval of projects utilizing CMP funds must demonstrate that the planned use will benefit nursing home residents and promote compliance with the regulations.

We propose 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 CMPs and the approval process, and to permit an opportunity for greater transparency and accountability of CMP monies utilized by States.

We invite public comment on our proposed changes. This proposed rule would explicitly clarify the intended use and statutory requirements of collected CMP funds. Specifically, we propose to: (1) Specify that CMP funds may not be used for state management operations except for the reasonable costs that are consistent with managing projects utilizing CMP funds; (the rationale for this clarification is explained further in section VI.); (2) clarify CMS's expectations that States must obtain prior approval for use of these CMP funds; (3) outline specific requirements that must be included in proposals submitted for CMS approval; (4) specify that CMPs funds may not be used for projects that have been disapproved by CMS; (5) specify that states are responsible for having an acceptable plan to solicit, accept, monitor and track projects utilizing CMP funds and make the results of all approved projects publicly available on at least an annual basis; (6) 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 (7) specify that if a state is not spending collected CMPs in accordance with the law or not at all, 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. We do not believe this has significant cost implications and it will benefit nursing home residents to ensure that CMP funds will be used for their intended purpose. We further invite public comment on CMS's proposed methods to ensure compliance with these requirements.

E. Observations on Therapy Utilization Trends

In the FY 2014 SNF PPS final rule (78 FR 47959 through 47960), we discussed our monitoring efforts associated with the impact of certain policy changes finalized in the FY 2012 SNF PPS final rule (76 FR 48486). We noted that we would continue these monitoring efforts and report any new information as appropriate. We are not proposing new Medicare policy in this discussion of observed trends but merely highlighting that we will continue to monitor these observed trends which may serve as the basis for future policy development.

In the FY 2014 SNF PPS proposed rule (78 FR 26464), we presented data which compared various utilization metrics including, in particular, the case-mix distribution for the RUG–IV therapy categories (Ultra-High Rehabilitation or RU, Very-High Rehabilitation or RV, High Rehabilitation or RH, Medium Rehabilitation or RM, and Low Rehabilitation or RL), for FY 2011 and FY 2012. It was observed based on those data that the percentage of billed days of service being classified into the RU RUG groups had increased from 44.8 percent in FY 2011 to 48.6 percent in FY 2012, while utilization in all other therapy RUG categories either remained stable or declined. We have since updated this data set using data from FY 2013 and have posted a memo to the SNF PPS Web site (available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Spotlight.html*) which demonstrates that the percentage of billed service days in the RU RUG groups has increased to over 50 percent. These revised data in the aforementioned memo are presented in a slightly different format than they have been presented in the past, which is to show how, over the course of the past 3 years since October of 2010, the percentage of residents classified into one of these Ultra-High Rehabilitation groups has not only increased, but done so rather steadily.

The second identified trend that we would highlight here and is discussed in the memo referenced above is that, most notably in the cases of RU and RV RUG groups, the amount of therapy reported on the MDS is just enough to surpass the relevant therapy minute threshold for a given therapy RUG category. For example, as demonstrated in Figure 2 in the aforementioned memo, the percentage of claims-matched MDS assessments in the range of 720 minutes to 739 minutes, which is just enough to surpass the therapy minute threshold for RU RUG groups of 720 minutes, has increased from 21 percent in FY 2011 to 33 percent in FY 2013. As stated above, this trend also holds for residents classified into a RV RUG group, where the largest percentage of service days were provided in the 500 to 520 minutes range, which just surpasses the therapy minute threshold for the RV RUG groups of 500 minutes.

We invite comment on the data presented here and the discussion of observed trends.

F. Accelerating Health Information Exchange in SNFs

As we have stated in the past, we believe all patients, and others involved in the patient's care, and their healthcare providers should have consistent and timely access to their health information in a standardized format that can be securely exchanged between the patient, providers, and others involved in the patient's care. (HHS August 2013 Statement, ''Principles and Strategies for Accelerating Health Information Exchange.'') The Department is committed to accelerating health information exchange (HIE) through the use of electronic health records (EHRs) and other types of health information technology (HIT) 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 HIT and HIE services through Medicare and Medicaid payment policies; (2) adoption of common standards and certification requirements for interoperable HIT; (3) support for privacy and security of patient information across all HIE-focused initiatives; and (4) governance of health information networks. These initiatives are designed to improve care delivery and coordination across the entire care continuum and encourage HIE among all health care providers, including professionals and hospitals eligible for the Medicare and Medicaid EHR Incentive Programs and those who are not eligible for the EHR Incentive Programs. To increase flexibility in ONC's HIT Certification Program and expand HIT certification, ONC has issued a proposed rule concerning a voluntary 2015 Edition of EHR certification criteria which would more easily accommodate certification of HIT used in other types of health care settings where individual or institutional health care providers are not typically eligible for incentive payments under the Medicare and Medicaid EHR Incentive Programs, such as long-term and post-acute care and behavioral health settings.

We believe that HIE and the use of certified EHRs by SNFs and other types of providers that are ineligible for the Medicare and Medicaid EHR Incentive Programs can effectively and efficiently help providers improve internal care delivery practices, support management of patient care across the continuum, and enable the reporting of electronically specified clinical quality measures (eCQMs). More information on the identification of EHR certification criteria and development of standards applicable to SNFs can be found at:

- *http://healthit.gov/policy-researchers-implementers/standards-and-certification-regulations.*
- *http://www.healthit.gov/facas/FACAS/health-it-policy-committee/hitpc-workgroups/certificationadoption.*
- *http://wiki.siframework.org/LCC+LTPAC+Care+Transition+SWG.*
- *http://wiki.siframework.org/Longitudinal+Coordination+of+Care.*

VI. Provisions of the Proposed Rule

As discussed in section III. of this proposed rule, this proposed rule would update 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 propose to use the most current OMB delineations (discussed in section V.A) to identify a facility's urban or rural status for the purpose of determining which set of rate tables would apply to the facility (section III.B.). Furthermore, as discussed in section V. of this proposed rule, we propose changes to the wage index based on the most current OMB delineations, including a one-year transition with a blended wage index for FY 2015 (section V.A.); propose to revise the policy governing use of the COT OMRA (section V.C.); and finally, propose changes to the enforcement regulations related to civil money penalties utilized by states (section V.D.).

With reference to the civil money penalty provisions discussed in section V.D. of this proposed rule, we propose to modify current CMS regulations to provide further clarification to states and the public regarding prior approval and appropriate use of these federal-imposed civil money penalty funds.

At § 488.433, civil money penalties: Uses and approval of civil money penalties imposed by CMS, we propose to amend this regulation to specify that civil money penalties may not be used for state management operations except for the costs that are consistent with managing the 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 states are responsible for monitoring and tracking the results of all approved activities utilizing civil money penalties and making this information publicly available, 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.

The proposed CMS regulation would 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 proposed § 488.433(a), we would clarify that approved projects may work to improve residents' quality of life and not just quality of care. We would also clarify that states 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 have not proposed a monetary or numeric limit on what might be considered reasonable, although one to 3 percent of available funds might be considered reasonable for an established fund. We invite comment on the question of appropriate limits.

At proposed § 488.433(b)(5), we would clarify in a new paragraph that in extraordinary situations involving closure of a facility, civil monetary 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 proposed change at § 488.433(b)(5) would clarify 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 CMP fund proposals being submitted to CMS for approval.

At new § 488.433 (d), we state that CMP funds may not be used for activities that have been disapproved by CMS.

At new § 488.433(e), we propose that states must maintain an acceptable plan for the effective use of civil monetary penalty funds, including a description of methods by which the state will solicit, accept, monitor, and track approved projects funded by CMP amounts and make key information publicly available. Examples of information that must be publically 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 propose that these plans provide for a minimum amount of funds that will generally be held in reserve for emergencies, 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 monetary penalty funds.

In § 488.433(f), we propose 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.

VII. Collection of Information Requirements

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

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

A. Information Collection Requirements (ICRs)

While this proposed rule does not have any PRA implications, we are soliciting comment on the following:

1. ICRs Regarding the SNF PPS Rate Setting Methodology (preamble sections III and V)

While sections III and V propose to revise certain policies related to the current rate setting methodology (such as the use of updated OMB delineations to assign a facility the urban or rural per diem rate and to calculate wage index adjustments), the provisions would not impose any new or revised reporting, recordkeeping, or third-party disclosure requirements. Nor would they require the development, acquisition, installation, and utilization of any new or revised technology or information systems. Consequently, they do not require review under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

The information collection requirements discussed in section III.C. concerning the resident assessment instrument (MDS 3.0) are currently approved by OMB under OCN 0938–1140 (CMS–10387).

2. ICRs Regarding the COT OMRA (Preamble Section V.C.)

While section V.C. proposes to revise current COT OMRA policy by permitting providers to complete a COT OMRA for a resident who is not currently classified into a RUG–IV therapy group in certain circumstances, this provision does not impose any new or revised reporting, recordkeeping, or third-party disclosure requirements. Consequently, it does not require review under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

3. ICRs Regarding the Use of Civil Money Penalties (§ 488.433(c))

In § 488.433(c), states proposing to use civil money penalties for certain activities are required to submit descriptions of the intended outcomes, deliverables, sustainability, and methods by which the results will be assessed, including specific measures. Prior to using these funds, the activities must be approved by CMS under existing regulations. The proposed language in this rule provides methods to ensure that these requirements are followed and to promote additional transparency.

The provision does not require additional OMB review under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.). In addition, as stated in the Civil Money Penalties for Nursing Homes final rule published on March 18, 2011 (76 FR 15125), sections 4204(b) and 4214(d) of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Public Law 100–203, enacted on December 21, 1987, provide waivers of Office of Management and Budget review of information collection requirements for the purpose of implementing the nursing home reform amendments. The provisions of OBRA '87 that exempt agency actions to collect information from states or facilities relevant to survey and enforcement activities from the Paperwork Reduction Act are not time-limited.

4. ICRs Regarding Civil Money Penalty Plans (§ 488.433(e))

In § 488.433(e), states would be required to maintain an acceptable plan (approved by CMS) for the effective use of civil money funds. The plan must include a description of methods by which the state will: (1) Solicit, accept, monitor, and track projects utilizing civil money penalty funds; (2) make information about the use of civil money penalty funds publicly available, including key information about approved projects, the grantee or contract recipients, and the results of projects; (3) ensure that a core amount of civil money penalty funds will be held in reserve for emergencies, such as unplanned relocation of residents pursuant to an involuntary termination from Medicare and Medicaid; and (4) ensure that a reasonable amount of funds, beyond those held in reserve, will be awarded or contracted each year.

Since current statute, regulations and/or CMS policy guidance released to the states already specifies that all proposed activities using civil money penalty funds must be submitted to CMS for approval and must contain information on the expected final outcomes of the activity and how the results of the activity will be assessed, states must already have plans in place to monitor and track the outcomes of all approved activities using these funds. Consequently, the proposed provision would not require any substantive revision to any state plans and would not impose any additional burden to states.

Since the provisions in § 488.433(e) would not impose any new or revised reporting, recordkeeping, or third-party disclosure requirements, they do not require additional OMB review under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.). In addition, as stated in the Civil Money Penalties for Nursing Homes final rule published on March 18, 2011 (76 FR 15125), sections 4204(b) and 4214(d) of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Public Law 100–203, enacted on December 21, 1987, provides waivers of OMB review of information collection requirements for the purpose of implementing the nursing home reform amendments. The provisions of OBRA '87 that exempt agency actions to collect information from states or facilities relevant to survey and enforcement activities from the Paperwork Reduction Act are not time-limited.

B. Submission of PRA-Related Comments

If you comment on any of these information collection requirements, please submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule.

Comments must be received on/by June 30, 2014.

VIII. Response to Comments

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

IX. Economic Analyses

A. Regulatory Impact Analysis

1. Introduction

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

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated an economically significant rule, under section 3(f)(1) of

Executive Order 12866. Accordingly, we have prepared a regulatory impact analysis (RIA) as further discussed below. Also, the rule has been reviewed by OMB.

2. Statement of Need

This proposed rule would update 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 proposed rule would 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.

3. Overall Impacts

This proposed rule sets forth proposed 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 proposed 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 proposed 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 proposed 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 V.D. of this proposed rule, we would 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 CMP funds are withheld from a state, we expect that the state would eventually come into compliance and that the state would later gain access to the withheld 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 proposed in Section V.A above, 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 proposing to implement beginning in FY 2015. Facilities should use these proposed 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 proposed 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 the proposed use of the revised OMB delineations, utilizing the proposed blended wage index. 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 2.4 percentage points, reduced by the 0.4 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 proposed in this rule, providers in the rural Pacific region would experience a 4.5 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	15,397	0.0	0.0	2.0
Urban	10,860	0.0	0.0	2.0
Rural	4,537	0.1	−0.2	1.9
Hospital based urban	572	0.1	0.0	2.0
Freestanding urban	10,288	0.0	0.0	2.0
Hospital based rural	640	0.1	−0.3	1.7
Freestanding rural	3,897	0.1	−0.2	1.9
Urban by region:				
New England	803	0.9	0.0	2.9
Middle Atlantic	1,490	0.3	0.1	2.5
South Atlantic	1,853	−0.3	0.0	1.7
East North Central	2,054	−0.3	0.0	1.6
East South Central	544	−1.0	0.0	1.0
West North Central	889	0.0	0.0	2.0
West South Central	1,293	−0.4	0.0	1.6
Mountain	501	0.1	−0.1	2.0
Pacific	1,427	0.3	0.0	2.3
Outlying	6	0.6	−0.2	2.4
Rural by region:				
New England	144	0.7	0.1	2.8
Middle Atlantic	228	1.5	−1.6	1.8
South Atlantic	504	−0.4	−0.2	1.4
East North Central	925	−0.1	0.0	1.9
East South Central	533	−0.3	−0.2	1.4
West North Central	1,093	0.3	−0.2	2.2
West South Central	770	0.3	−0.4	1.9
Mountain	235	−0.7	0.0	1.3
Pacific	105	2.6	−0.1	4.5
Outlying	0	0.0	0.0	2.0
Ownership:				
Government	852	0.1	0.1	2.2
Profit	10,783	0.0	0.0	2.0
Non-profit	3,762	0.1	0.0	2.0

Note: The Total column includes the 2.4 percent market basket increase, reduced by the 0.4 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 the proposal discussed in section V.A of this rule related to our proposed adoption of the revised OMB delineations for purposes of calculating the wage index, we believe implementing the new OMB delineations would result in wage index values being more representative of the actual costs of labor in a given area. Further, we recognize that some providers (15 percent) would have a higher wage index due to our proposed implementation of the new labor market delineations. However, we also recognize that more providers (22 percent) would experience decreases in wage index values as a result of our proposed implementation of the new labor market area delineations. Therefore, we believe it would be appropriate to consider, as we did in FY 2006, whether or not a transition period should be used in order to implement these proposed changes to the wage index.

We considered having no transition period and fully implementing the proposed 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 would experience a decrease in wage index due to implementation of the proposed new OMB delineations than would experience an increase. Thus, we believe that it would be 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 29094–29095) to adopt the new CBSA definitions without a transition period, we anticipate that providers would have similar concerns with not having a transition period for the proposed new OMB delineations. Therefore, as further discussed below, 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 proposing a one-year transition blended wage index for all SNFs to assist providers in adapting to the new OMB delineations (should we finalize implementation of such delineations for the SNF PPS wage index beginning in FY 2015). 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 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, which argues for a faster transition to the revised OMB delineations. As discussed above in section V.A.2 of this proposed rule, 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 one-year (rather than a multiple year) transition with a blended wage index in FY 2015 would strike the best balance.

Second, we considered what type of blend would be appropriate for purposes of the transition wage index. We are proposing that providers would receive a one-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 would best mitigate the negative payment impacts associated with the implementation of the proposed 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 this proposal, 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. If we were to apply the transition policy only to those providers that would experience a decrease in their respective wage index values due to the implementation of the revised OMB delineations, then providers that would experience either no change in wage index or an increase in wage due to the revised OMB delineations would be immediately transitioned to the FY 2015 wage index under 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, if we were to apply the transition policy only to those providers that would experience a decrease in their respective wage index values due to implementation of the revised OMB delineations, the budget neutrality factor, discussed in section III.D, calculated based on this this approach would be 0.9986, which would result in reduced base rates for all providers as compared to the budget neutrality factor of 1.0001 which would result from applying the blended wage index to all providers. Furthermore, based on our analysis of the wage index changes associated with fully implementing the revised OMB delineations, we determined that the new OMB delineations would only affect the wage index values of approximately 37 percent of facilities. Given that our goal is to provide relief to the largest percentage of adversely-affected SNFs with the least impact to the rest of the facilities (whose wage index values either would remain the same or increase), we believe that using a blended wage index for all providers would be the best option. This option would assist the 22 percent of providers that would be adversely affected by the proposed implementation of the new OMB delineations without reducing the base rates for all providers, 63 percent of which would otherwise be unaffected by the proposed implementation of the new OMB delineations. In other words, this option is based on a balance between the interests of all SNF providers, including the 15 percent of providers that would experience an increase in their wage index value due to the proposed implementation of the new OMB delineations, the 22 percent of providers that would experience a decrease in their wage index value due to the proposed implementation of the new OMB delineations, and the 63 percent of providers that would be unaffected by the proposed implementation of the new OMB delineations. As discussed above, if we were to apply the blended wage index only to the 22 percent of providers that would experience a decrease in their respective wage index values due to the proposed implementation of the new OMB delineations in an effort to preserve the full increase in wage index

value for the 15 percent of providers that would experience such an increase due to the proposed implementation of the new OMB delineations, the budget neutrality factor of 1.0001 referenced in section III.D, which is based on applying the blended wage index to all providers, would be revised to 0.9986. As such, this would mean a reduction in the base rate for all providers, most notably the 63 percent of providers that would be unaffected by the proposed implementation of the new OMB delineations, but also for that 15 percent of providers that would experience an increase in their wage index value.

Moreover, while providers experience wage index changes from year to year based on updating the wage data, full implementation of the proposed new OMB delineations would dramatically increase the magnitude of those changes for some providers. Year-to-year wage index changes usually vary from decreases as high as 10 percent to increases as high as 10 percent. Using FY 2011 wage data (the data used for the FY 2015 wage index), the range of changes in the wage index values due solely to full implementation of the proposed OMB delineations would span from decreases of over 20 percent to increases of over 30 percent. Therefore, in addition to mitigating the impact of the proposed OMB delineations on the facilities that are adversely affected by them and providing a period to adjust, we believe a transition wage index could also mitigate the volatility of the SNF PPS wage index for certain providers caused by these proposed changes.

Therefore, if we finalize implementation of the new OMB delineations for the SNF PPS wage index, we are proposing to use a one-year transition with a blended wage index for all providers in FY 2015, as outlined in Section V.A.2.e. For the reasons discussed above, we believe that this proposed transition approach appropriately balances the interests of all SNFs, and would best achieve our objective of providing relief to the largest percentage of adversely affected SNFs with the least impact to the rest of the facilities. We believe this approach would mitigate negative impacts on providers as well as the volatility of the SNF PPS wage index for certain providers resulting from implementation of the proposed new OMB delineations. We invite comments on the alternatives discussed in this analysis.

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 proposed 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 proposed rule, based on the data for 15,397 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 proposed 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 4.5 percent. Providers in the urban East South Central region would experience the smallest increase in payments of 1.0 percent.

B. Regulatory Flexibility Act Analysis

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, non profit organizations, and small governmental jurisdictions. Most SNFs and most other providers and suppliers are small entities, either by their non-profit status or by having revenues of $25.5 million or less in any 1 year. 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 they may be affiliated with. 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 Web site 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 proposed 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 proposed 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 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. This proposed 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 proposed 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 proposed 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 proposed 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 proposed 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 proposes to amend 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 CMP 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 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 (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: April 16, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: April 22, 2014.

Kathleen Sebelius,

Secretary.

[FR Doc. 2014–10319 Filed 5–1–14; 4:15 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

[Docket No. FWS–R8–ES–2013–0049; 4500030113]

RIN 1018–AZ33

Endangered and Threatened Wildlife and Plants; Designation of Critical Habitat for Diplacus vandenbergensis (Vandenberg Monkeyflower)

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Proposed rule; revision and reopening of the comment period.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), announce the reopening of the public comment period on the proposed rule to designate critical habitat for *Diplacus vandenbergensis* (Vandenberg monkeyflower). We also announce the availability of a draft economic analysis (DEA) of the proposed designation of critical habitat for *D. vandenbergensis* and an amended required determinations section of the proposal. In addition, in this document, we are proposing revised unit names for the four previously described subunits, and a revised acreage for one subunit based on information we received on the proposal. These revisions result in an increase of approximately 24 acres (10 hectares) in the proposed designation of critical habitat. We are reopening the comment period to allow all interested parties an opportunity to comment simultaneously on the proposed rule, the associated DEA, the amended required determinations section, and the unit revisions described in this document. Comments previously submitted need not be resubmitted, as they will be fully considered in preparation of the final rule.

DATES: The comment period for the proposed rule published October 29, 2013 (at 78 FR 64446), is reopened. We will consider comments on that proposed rule or the changes to it proposed in this document that we receive or that are postmarked on or before June 5, 2014. Comments submitted electronically using the Federal eRulemaking Portal (see **ADDRESSES** section, below) must be received by 11:59 p.m. Eastern Time on the closing date.

ADDRESSES:

Document availability: You may obtain copies of the proposed rule and the associated DEA (Industrial Economics, Incorporated (IEc) 2014; Service 2014) on the internet at *http://www.regulations.gov* at Docket No. FWS–R8–ES–2013–0049 or by mail from the Ventura Fish and Wildlife Office (see **FOR FURTHER INFORMATION CONTACT**).

Written comments: You may submit written comments by one of the following methods:

(1) *Electronically:* Go to the Federal eRulemaking Portal: *http://www.regulations.gov.* Search for Docket No. FWS–R8–ES–2013–0049 (the docket number for the proposed critical habitat rule).

(2) *By hard copy:* Submit by U.S. mail or hand-delivery to: Public Comments Processing, Attn: FWS–R8–ES–2013–0049; Division of Policy and Directives Management; U.S. Fish and Wildlife Service; 4401 N. Fairfax Drive, MS 2042–PDM; Arlington, VA 22203.

We request that you send comments only by the methods described above. We will post all comments on *http://www.regulations.gov.* This generally means that we will post any personal information you provide us (see the Public Comments section below for more information).

FOR FURTHER INFORMATION CONTACT: Stephen P. Henry, Acting Field Supervisor, Ventura Fish and Wildlife Office, U.S. Fish and Wildlife Service, 2493 Portola Road, Suite B, Ventura, CA 93003; telephone 805–644–1766; facsimile 805–644–3958. Persons who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 800–877–8339.

SUPPLEMENTARY INFORMATION:

Public Comments

We will accept written comments and information during this reopened comment period on our proposed designation of critical habitat for *Diplacus vandenbergensis* (hereafter referred to as Vandenberg monkeyflower) that was published in the **Federal Register** on October 29, 2013 (78 FR 64446), our DEA (which comprises an economics screening memorandum (IEc 2014) and the Service's Incremental Effects Memorandum (Service 2014)) of the proposed designation, the amended required determinations provided in this document, and the revisions to the names and one unit as described in this document. We will consider information and recommendations from all interested parties. We are particularly interested in comments concerning:

(1) The reasons why we should or should not designate habitat as ''critical habitat'' under section 4 of the Endangered Species Act (16 U.S.C. 1531 *et seq.*) (Act), including whether there are threats to the species from human activity, the degree those threats can be expected to increase due to the designation, and whether that increase in threat outweighs the benefit of designation such that the designation of critical habitat is not prudent.

(2) Specific information on:

(a) The amount and distribution of Vandenberg monkeyflower and its habitat;

(b) What may constitute ''physical or biological features essential to the conservation of the species,'' within the geographical range currently occupied by the species;

(c) Where these features are currently found;

(d) Whether any of these features may require special management considerations or protection;

(e) What areas currently occupied by the species and that contain features essential to the conservation of the species should be included in the designation and why; and

(f) What areas not occupied at the time of listing are essential for the conservation of the species and why.

(3) Land use designations and current or planned activities in the areas occupied by the species or proposed to be designated as critical habitat, and possible impacts of these activities on this species and proposed critical habitat.

(4) Comments or information that may assist us in identifying or clarifying the primary constituent elements (PCEs).

(5) Information on the projected and reasonably likely impacts of climate change on Vandenberg monkeyflower and proposed critical habitat.

(6) Any probable economic, national security, or other relevant impacts of designating any area that may be