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

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

a. Concurrent Therapy

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

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

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

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

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

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

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