

Robert Van Dyk
CHAIR

Van Dyk Health Care
Ridgewood, NJ

Neil Pruitt, Jr.
VICE CHAIR

UHS-Pruitt Corporation
Norcross, GA

Rick Miller
IMMEDIATE PAST CHAIR
Avamere Health Services
Wilsonville, OR

Leonard Russ
SECRETARY/TREASURER
Bayberry Care Center
New Rochelle, NY

Fran Kirley
EXECUTIVE COMMITTEE LIAISON
Nexion Health
Sykesville, MD

Orlando Bisbano, Jr.
AT-LARGE MEMBER
Orchard View Manor Nursing &
Rehabilitation Center
East Providence, RI

Lane Bowen
AT-LARGE MEMBER
Kindred Healthcare
Louisville, KY

William Council, III
AT-LARGE MEMBER
Advocat Inc.
Brentwood, TN

Phil Fogg, Jr.
AT-LARGE MEMBER
Marquis Companies
Milwaukie, OR

Robin Hillier
AT-LARGE MEMBER
Lake Point Rehab & Nursing Center
Conneaut, OH

Richard Kase
AT-LARGE MEMBER
Cypress Health Care Management
Sarasota, FL

Ted LeNeave
AT-LARGE MEMBER
American HealthCare, LLC
Roanoke, VA

Gary Kelso
NOT FOR PROFIT MEMBER
Mission Health Services
Huntsville, UT

Nicolette Merino
NCAL MEMBER
Avamere Health Services
Wilsonville, OR

Steve Ackerson
ASHCAE MEMBER
Iowa Health Care Association
West Des Moines, IA

Gail Rader
ASSOCIATE BUSINESS MEMBER
Care Perspectives
Phillipsburg, NJ

Mark Parkinson
PRESIDENT & CEO

MEMORANDUM

TO: AHCA Members

FROM: Peter Gruhn, Director of Research

C.C.: Elise Smith, Senior Vice President, Finance Policy & Legal Affairs
William W. Hartung, Vice President, Research
Sandra Fitzler, Senior Director, Clinical Operations
Lyn Bentley, Director of Regulatory Services

SUBJECT: Overview of the Skilled Nursing Facility Prospective Payment System
Final Rule for FY 2012

DATE: August 3, 2011

On July 29, 2011, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for the fiscal year (FY) 2012 skilled nursing facility (SNF) prospective payment system (PPS): *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012*. The final rule will be published August 8, 2011 in the *Federal Register*. A desk copy of the [final rule](#) and a spreadsheet with the final FY 2012 SNF PPS [wage indexes](#) can be viewed on the [Medicare page](#) of the Facility Operations section of the AHCA website.

We have highlighted key components of the final rule, which range from financial and regulatory matters to clinical and quality issues. These highlights are followed by a more detailed overview.

Highlights

Market Basket and Budget Neutrality Adjustment

- As a result of the final rule, CMS estimates that net Medicare Part A payments to SNFs will decrease by about \$3.87 billion in FY 2012, which represents an 11.1% reduction in aggregate payments (this was revised upwards from a 11.3% reduction in the proposed rule).
- The final rule provides for a **market basket increase for SNFs of 1.7%** beginning October 1, 2011. The 1.7% market basket update **reflects a full market basket increase of 2.7%, less a revised 1.0% multifactor productivity adjustment** required by Section 3401(b) of the *Affordable Care Act (ACA)*. CMS estimates that the productivity adjusted market basket update would increase SNF payments by approximately **\$600 million in FY 2012** compared to FY 2011 (revised up from \$530 million noted in the proposed rule).

- In FY 2012, CMS will recalibrate the parity adjustment implemented in FY 2011 to maintain budget neutrality between the SNF PPS Resource Utilization Group, Version 3 (RUG-III) to RUG-IV systems. CMS estimates that this recalibration of the parity adjustment **would reduce payments to SNFs by approximately \$4.47 billion or 12.6% (about \$65 – \$70 per patient day)**.
- In implementing the recalibration for budget neutrality, CMS will continue to apply a 61% increase to the case-mix index (CMI) of the nursing component of the non-rehab RUGs, and apply a 19.84% increase to the nursing CMI of the rehab RUGs.
- CMS rejected American Health Care Association (AHCA) comments to phase-in the recalibration of the parity adjustment and to take into account the effects of FY 2012 SNF PPS policy changes as part of any budget neutral adjustment to the SNF PPS RUG system.
- There will not be a correction in the FY 2012 final rule for market basket forecasting errors, since the 0.2 percentage point overestimate in forecasting the market basket in FY 2010 (the most recently available fiscal year for which there is final data) is less than the 0.5 percentage point threshold for a forecast error correction.
- In accordance with the *Medicare Modernization Act (MMA)*, the per diem rate for SNF patients with Acquired Immune Deficiency Syndrome (AIDS) had been increased by 128% as of October 1, 2004. Under the CMS final rule, this add-on would remain in effect for FY 2012.
- The labor-related weight for FY 2012 is 68.693%, down from 69.311% for FY 2011.
- All rates and wage indexes outlined in the proposed and final rules for the SNF PPS for FY 2012 apply to all swing-bed rural hospitals but not to critical access hospitals (CAHs) that would continue to be paid on a reasonable cost basis for SNF services furnished under a swing-bed agreement.

Wage Index

- For FY 2012, CMS will continue to employ inpatient hospital wage data in the computation of the Core-Based Statistical Area (CBSA) SNF PPS wage index that is used to adjust the labor-related portion of the federal rate.
- In geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the SNF PPS wage index, CMS will continue to update the wage index using their alternative urban and rural methodologies in FY 2012.

Group Therapy

- CMS modified its definition of a group therapy group to be four (4) participants for Medicare payments purposes.
- CMS extended its SNF PPS policy on adjusting resident therapy minutes for concurrently provided rehabilitation to rehabilitation provided in group sessions. SNFs will continue to report the total unallocated group therapy minutes on the Minimum Data Set 3.0 (MDS 3.0) for each patient for FY 2012. In calculating minutes for RUG classification in FY 2012 however, an individual's reported group time will be divided by four to determine reimbursable group therapy minutes, which will be added together with individual therapy minutes and reimbursable

(allocated) concurrent therapy minutes to determine total reimbursable therapy minutes. CMS will divide reported group therapy time by four even if only two or three people participated in the group therapy session.

MDS 3.0 and OMRAs

- In order to address assessment timing issues that could result in an overlap of information from a previous assessment being used for a subsequent assessment, CMS modified the current Medicare-required assessment schedule. Beginning October 1, CMS will shorten the assessment reference date (ARD) window and trim grace days for selected required PPS assessments.
- In the final rule, CMS clarified its ARD policy for End-of-Therapy (EOT) Other Medicare Resident Assessments (OMRAs). Effective October 1, an EOT OMRA must be completed once therapy services cease or were missed for three consecutive days, regardless of the reason, whether planned or unplanned (e.g. due to illness, patient refusal, doctor office visits, etc.), and regardless of whether therapy services are offered by the SNF 5-days per week or 7-days per week.
- CMS will establish a new End-of-Therapy Resumption (EOT-R) OMRA. The EOT-R OMRA would be used in place of a Start-of-Therapy (SOT) OMRA in cases where therapy stopped, an EOT OMRA was completed, and therapy subsequently resumes within 5 consecutive calendar days and at the same RUG-IV classification level that had been in effect prior to the EOT OMRA.
- CMS also established a new Change-of-Therapy (COT) OMRA. The COT OMRA would be required in any case where there is a change in the provision of therapy services such that the patient's current RUG classification based on their last PPS assessment is no longer an accurate representation of the patient's clinical condition and the patient should be placed in a different RUG-IV category. COT OMRA evaluations are to take place every 7 days after the last Medicare PPS assessment.
- CMS clarified that a COT OMRA would be required in cases where a therapy discipline is discontinued and results in a patient no longer meeting the required number of therapy disciplines for a patient's current RUG category, as well as in cases where the requisite number of days of therapy required for classification into a particular RUG category also changed. CMS also clarified that a COT OMRA would be completed in cases where changes in the provision of therapy services would result in a change in rehab RUG categorization even when a patient is classified into a non-rehab RUG because of index maximization.

Consolidated Billing

- Based on stakeholder comment, CMS found that TREANDA® (HCPCS code J9033) met the *Balanced Budget Refinement Act's (BBRA's)* "high-cost, low-probability" criteria for excluding the drug from consolidated billing. CMS will include this new exclusion in a forthcoming consolidated billing update, with an effective date of October 1, 2011.

Disclosure

- In the proposed rule, CMS asked for comment on revisions to reporting requirements that Medicare SNFs and Medicaid nursing facilities must disclose at the time of enrollment and when any change in ownership occurs, in accordance with section 6101 of the *Affordable Care Act*. A

separate final rule specifically addressing the provisions of these disclosure requirements will be published in early calendar year 2012.

Additional Information

To assist AHCA members in examining and evaluating the impact of the CMS FY 2012 SNF PPS final rule, AHCA has prepared a Medicare rate calculator (rate simulation model). Using information on the distribution of Medicare Part A days by RUG category, the calculator will allow you to simulate and understand the impact of SNF PPS payment policy changes for FY 2010, FY 2011, and FY 2012 on a facility. The [Medicare rate calculator](#) can be found on the Research and Data Funding page of the AHCA website.

Over the coming days, weeks, and months, AHCA will be reviewing and examining the implications of changes in the CMS FY 2012 SNF PPS final rule, evaluating and revising approach and strategies as necessary, and following-up with CMS on many of these important issues. We welcome your feedback and suggestions on the CMS final rule and next steps as we prepare to re-engage with CMS on these and other issues. Thank you in advance for your assistance. Please email your comments to Peter Gruhn (pgruhn@ahca.org).

Discussion

I. CMS Projected Impact of the Final Rule

For FY 2012, CMS estimates the aggregate reduction in Medicare Part A payments to SNFs associated with this final rule at \$3.87 billion (about \$55 - \$60 per patient day). This reflects a \$600 million net increase from the update to payment rates, and a \$4.47 billion reduction due to the recalibration of the SNF PPS RUG-III to RUG-IV parity adjustment that sought to make the change in Resource Utilization Group (RUG) systems budget neutral for the Medicare program in FY 2011.

The distributional effect of the final rule and the recalibration of the parity adjustment is detailed in the table below:

Projected Impact to the SNF PPS for FY 2012

	Revised CMIs	Wage Index	Total Impact
Total	-12.6%	0.0%	-11.1%
Urban	-12.8%	0.0%	-11.3%
Rural	-11.9%	0.1%	-10.3%
Hospital based urban	-12.4%	0.1%	-10.8%
Freestanding urban	-12.8%	0.0%	-11.3%
Hospital based rural	-11.3%	0.0%	-9.8%
Freestanding rural	-11.9%	0.1%	-10.3%
Government	-12.4%	-0.1%	-11.0%
Profit	-12.6%	0.0%	-11.1%
Non-profit	-12.7%	0.0%	-11.2%

II. The SNF PPS Market Basket Update

The final rule provides for a market basket increase for SNFs of 1.7% beginning October 1, 2011. The 1.7% market basket update reflects a full market basket increase of 2.7%, less a 1.0% multifactor productivity adjustment required by Section 3401(b) of the *Affordable Care Act (ACA)*. CMS estimates that the market basket update would increase SNF payments by approximately \$600 million in FY 2012 compared to FY 2011.

Every year, CMS calculates a revised labor-related share based on the relative importance of labor-related cost categories in the price index. The labor-related weight for FY 2012 is 68.693%, down from 69.311% for FY 2011.

Relative Importance of Labor Share

	FY 2011 10:2 forecast	FY 2012 11:2 forecast
Wages and salaries	50.654	50.129
Employee benefits	11.511	11.502
Nonmedical professional fees	1.32	1.31
Labor-intensive services	3.247	3.394
Capital-related (.391)	2.399	2.358
Total	69.311	68.693

III. The SNF PPS Market Basket Multifactor Productivity Adjustment

Section 3401(b) of the *ACA* requires that the SNF market basket update be reduced by a productivity adjustment. The purpose of the adjustment is to help ensure that the increase in the cost of goods and services used to provide patient care in SNFs that is reflected in the market basket also reflects improvements in productivity that reduce the cost of providing SNF services. Section 1886(b)(3)(B) of the *ACA* amended *Social Security Act (SSA)* defines the productivity adjustment to be equal to the 10-year moving average of changes in the annual economy-wide private nonfarm business multi-factor productivity (MFP), as projected by the Secretary for the 10-year period ending with the applicable year/period.

CMS calculated the MFP-adjusted market basket update for the SNF PPS by subtracting the projected MFP percentage adjustment from the FY 2012 market basket percentage. CMS computed the MFP adjustment as the 10-year moving average of changes in the MFP for the period ending September 30, 2012, and rounded the final annual adjustment to the nearest tenth of a percentage point. As noted above, the MFP adjustment is calculated as 1.0 percentage points for FY 2012. The MFP adjustment is effective for FY 2012 and each subsequent fiscal year. It will be recalculated each year moving forward. Furthermore, the reduction of the market basket percentage change by the MFP adjustment may result in the market basket percentage change being less than zero for a fiscal year, and may result in unadjusted Federal payment rates being less than such payment rates for the preceding fiscal year.

IV. The Forecast Error Correction to the SNF Market Basket

The SNF PPS contains a provision to correct for major, unexpected errors in the annual forecast of the market basket. For FY 2012, there will not be a market basket forecast error correction in the SNF PPS market basket. Based on FY 2010 data (the most recently available fiscal year for which there is final data), the estimated increase in the market basket index was 2.2 percentage points, while the actual

increase was 2.0 percentage points – a difference of 0.2 percentage points. Since the difference between the estimated and actual market basket forecast error is less than the 0.5 percentage point threshold, the payment rates for FY 2012 do not include a forecast error adjustment.

Difference between Forecasted & Actual Market Basket Increases for FY 2012

Index	Forecasted FY 2010 Increase	Actual FY 2010 Increase	FY 2010 Difference
SNF	2.2%	2.0%	0.2%

V. Recalibration of Parity-Adjustment & Other Factors

Section 1888(e)(4)(G)(i) of the *Social Security Act* requires the Secretary of the Department of Health & Human Services (HHS) to make an adjustment to account for case-mix. The statute specifies that the adjustment is to reflect both a resident classification system that the Secretary establishes to account for the relative resource use of different patient types, as well as resident assessment and other data that the Secretary considers appropriate. The Staff Time Resource Intensity Verification (STRIVE) project was established to (1) refine the current RUG classification systems, and to (2) develop updated CMI. Based in part on findings from the STRIVE project, CMS implemented changes to the RUG classification structure (RUG-IV) and relative weights for FY 2011.

In moving from the Minimum Data Set, Version 2.0 (MDS 2.0) based RUG-III SNF PPS to the MDS 3.0 based RUG-IV SNF PPS, CMS sought to implement the change without increasing or decreasing overall Medicare expenditures (i.e., budget neutral). As part of the implementation of MDS 3.0 and RUG-IV, CMS increased the case-mix index of the nursing component of the SNF PPS by 61% in order to achieve parity in Medicare payments between the RUG-III and RUG-IV SNF PPS systems. Given overpayment issues that arose related to the parity adjustment CMS used in moving from the RUG-44 to the RUG-53 RUG systems in 2006, CMS indicated in last year’s final rule that the agency intended to assess the effectiveness of the parity adjustment in maintaining budget neutrality, and if necessary, to recalibrate the adjustment in future years, and that it would monitor, and if necessary, act to respond to changes in overall SNF payments that result from changes in coding or classification of patients that do not reflect real changes in case-mix (i.e., so-called “code creep”).

For FY 2012, CMS will recalibrate the SNF PPS RUG-III to RUG-IV parity adjustment originally implemented in FY 2011. CMS estimates that this recalibration of the parity adjustment would reduce payments to SNFs by approximately \$4.47 billion or 12.6% (about \$65 to \$70 per patient day). CMS further notes that the recalibration will be implemented on a prospective basis only. **There will be no retrospective recovery of FY 2011 “over” payments.**

CMS will not however apply the recalibration of the parity adjustment to all RUG categories. In the proposed and final rule, the agency indicates that the most notable differences between expected and actual utilization patterns occurred within the therapy RUG categories, and that rather than apply the new parity adjustment percentage to all the nursing CMIs, it would be more appropriate to achieve budget neutrality between the RUG-III and RUG-IV system by maintaining the 61% parity adjustment to the nursing CMIs for the RUG-IV non-therapy groups, and reducing the parity adjustment applied to the nursing CMIs for the RUG-IV therapy groups to 19.84%.

VI. Area Wage Index Adjustment to the Federal Rates

Section 1888(e)(4)(G)(ii) of the *Social Security Act* requires that CMS adjust the federal rates to account for differences in area wage levels, using an appropriate wage index. Given the “volatility of existing SNF wage data and the significant amount of resources that would be required to improve the quality of the data,” CMS believes it is “appropriate and reasonable” to use hospital wage data for the SNF PPS wage index. Since the inception of a prospective payment system for SNFs, CMS has used hospital wage data in developing a wage index for the SNF PPS, a practice that CMS will continue for FY 2012.

Section 1888(e)(4)(G)(ii) of the *Social Security Act* also requires that CMS apply the wage index in a manner that does not result in aggregate payments that are greater or less than would otherwise be made in the absence of the wage adjustment. CMS currently adjusts the wage index to ensure that it is budget neutral in terms of aggregate payments. CMS will continue this practice as well.

CMS will continue to use its urban/rural alternative wage index methodology in geographic areas where there are no hospitals, and thus, no hospital wage data upon which to base calculations for the FY 2012 SNF PPS wage index. For rural geographic areas without hospital wage data, CMS will use the average wage index for all contiguous Core-Based Statistical Areas (CBSAs) as a reasonable proxy. For urban geographic areas without hospital wage data, CMS will use the average wage index of all of the urban areas within the state as a reasonable proxy. The alternative FY 2012 SNF PPS urban wage index methodology will be used to construct the wage index for Hinesville-Fort Stewart, Georgia (CBSA 25890). Given that there is at least one hospital with wage data in all rural areas, the alternative rural wage index methodology will not be required in FY 2012.

VII. Group Therapy & Therapy Documentation

CMS believes that one-on-one therapy is generally the most appropriate mode of delivering therapy for Medicare and Medicaid patients who are among the frailest and most vulnerable. CMS also believes that group therapy offers additional benefits to patients from the interaction with other patients during the group therapy session as they have the opportunity to observe and learn from other patients. However, the agency also believes that the current method of reporting group therapy, along with the allocation of concurrent therapy minutes, creates an inappropriate payment incentive to deliver group therapy since it does not require allocation of therapist time among all the involved patients.

To better align incentives, CMS will modify its definition of a group therapy group to be four (4) participants for Medicare payments purposes. CMS will also extend its SNF PPS policy on adjusting resident therapy minutes for concurrently provided rehabilitation to rehabilitation provided in group sessions. Under the final rule, SNFs would continue to report the total unallocated group therapy minutes on the MDS 3.0 for each patient. In calculating minutes for RUG classification for FY 2012, an individual’s reported group time will be divided by four to determine reimbursable group therapy minutes, which will be added together with individual therapy minutes and reimbursable (allocated) concurrent therapy minutes to determine total reimbursable therapy minutes. Unfortunately, CMS will not make any adjustments to the group size denominator to reflect actual average industry group size nor reflect the actual number of patients in a group session. Rather, CMS will simply divide reported group therapy time by four even if only two or three people participated in the group therapy session.

VIII. MDS 3.0 Assessment Schedules

CMS believes that the combination of the current grace period allowances and observation period could cause MDS assessments to be performed in such a way that some of the information coded on a

subsequent assessment is duplicative of the previous assessment. As a result, CMS will modify the current Medicare-required assessment schedule to incorporate new assessment windows and grace day period. CMS believes that these changes will more appropriately reflect changes in patients' status and in services and treatments provided over the course of a stay, and to reduce the possibility that information from the same days of the patient's stay may be used on different scheduled MDS assessments. The current and new MDS 3.0 assessment schedules are below.

Current MDS 3.0 Assessment Schedule

Medicare MDS Assessment type	Reason for Assessment (A0310B code)	Assessment Reference Date Window	Assessment Reference Date Grace Days	Applicable Medicare Payment Days
5 day	01	Days 1 – 5	6 - 8	1 through 14
14 day	02	Days 11 - 14	15 – 19	15 through 30
30 day	03	Days 21 – 29	30 - 34	31 through 60
60 day	04	Days 50 - 59	60 – 64	61 through 90
90 day	05	Days 80 – 89	90 – 94	91 through 100

New MDS 3.0 Assessment Schedule

Medicare MDS Assessment type	Reason for Assessment (A0310B code)	Assessment Reference Date Window	Assessment Reference Date Grace Days	Applicable Medicare Payment Days
5 day*	01	Days 1 – 5	6 - 8	1 through 14
14 day	02	Days 13 - 14	15 – 18	15 through 30
30 day	03	Days 27 – 29	30 - 33	31 through 60
60 day	04	Days 57 - 59	60 – 63	61 through 90
90 day	05	Days 87 – 89	90 – 93	91 through 100

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

IX. Other Medicare Required Assessments (OMRAs)

In response to SNF confusion over guidelines introduced in FY 2011 about the discontinuation of therapy services and its application to SNFs that regularly provide services 5-days per week and 7-days per week, CMS clarified its Assessment Reference Date (ARD) policy for an End-of-Therapy (EOT) Other Medicare-Required Assessment (OMRA) in the final rule. Effective October 1st, an EOT OMRA must be completed once therapy services cease or were missed for three consecutive days regardless of the reason, whether planned or unplanned, and regardless of whether therapy services are offered by the SNF 5-days per week or 7-days per week. By completing the EOT OMRA, the SNF will be paid the appropriate non-therapy RUG-IV rate. If therapy resumes, a Start-of-Therapy (SOT) OMRA can be completed to reclassify the patient into a therapy RUG-IV group at any time during the Part A stay.

To help address cases where therapy stopped and started again using the same mode and at the same intensity, CMS established a new End-of-Therapy Resumption (EOT-R) OMRA for FY 2012. The EOT-R OMRA could be used in place of a Start-of-Therapy (SOT) OMRA in cases where therapy stopped, an EOT OMRA was completed, and therapy subsequently resumes within 5 consecutive calendar days and at the same RUG-IV classification level that had been in effect prior to the EOT OMRA. For coding the resumption of therapy, 2 new items will be added to the Section O of the MDS. In cases where therapy resumes more than 5 consecutive days from the discontinuation of therapy, the SNF can either complete a SOT OMRA to classify the patient into a RUG-IV therapy group or wait until the next PPS assessment to classify the patient.

In response to concerns that therapy services recorded on a given PPS assessment did not provide an accurate account of the therapy provided to a given resident outside the observation window used for the most recent assessment, CMS established a new required PPS assessment, the Change-of-Therapy (COT) OMRA. The COT OMRA would be required in any case where there is a change in the provision of therapy services such that the patient's current RUG classification based on their last PPS assessment is no longer an accurate representation of the patient's clinical condition and the patient should be placed in a different RUG-IV category. CMS clarified in the final rule that a COT OMRA would be required in cases where a therapy discipline is discontinued and results in a patient no longer meeting the required number of therapy disciplines for a patient's current RUG category, as well as in cases where the requisite number of days of therapy required for classification into a particular RUG category also changed. CMS also clarified that a COT OMRA would be completed in cases where changes in the provision of therapy services would result in a change in rehab RUG categorization even when a patient is classified into a non-rehab RUG because of index maximization.

X. Therapy Student Supervision

In the preamble to the FY 2000 final rule, CMS specified that a therapy student in the SNF setting must "be under the 'line-of-sight' level of supervision of the professional therapist." In order to promote greater conformity with other inpatient settings under Part A, CMS will eliminate the standard that therapy students must perform activities in the line-of-sight of the supervisor. Beginning in FY 2012, "each SNF would determine for itself the appropriate manner of supervision of therapy students consistent with applicable State and local laws and practice standards."

CMS, however, believes that "students who treat SNF residents without line-of-sight supervision should be qualified based on specific guidelines" and that "the supervising therapist should have ultimate authority to determine whether a student clinician is adequately prepared to treat patients without line-of-sight supervision." Further, CMS expects

that professional associations, State and local licensing boards, and facilities should have very specific guidelines related to student clinicians' level of education and experience. Additionally, we expect that every student clinician should meet these standards and guidelines and that once met, the supervising therapist should have ultimate authority to determine whether a student clinician is adequately prepared to treat patients without line-of-sight supervision.

CMS also clarified that for the purposes of billing, therapy students are treated as a simple extension of the supervising therapist rather than being counted as an additional practitioner. Elimination of the student therapist line-of-sight requirement "would not change the manner in which therapy minutes currently are recorded on the MDS or cause the student's time to become separately billable".