

keeping system. Some months, facilities may have no information to add. With 3,400 facilities at 6 hours/year, the total would be 20,400 hours for facilities. Using a clerical wage cost of \$10 per hour, the total facility burden is estimated to be \$204,000.

We are submitting a copy of regulation § 483.160 to OMB for its review of the information collection requirements. The revision is not effective until OMB has approved it.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following addresses:

Centers for Medicare & Medicaid Services, Office of Information Services, Information Technology Investment Management Group, Attn.: Julie Brown, Room C5-16-03, 7500 Security Boulevard, Baltimore, MD 21244-1850; and  
Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

Comments submitted to OMB may also be emailed to the following address: email: [baguilar@omb.eop.gov](mailto:baguilar@omb.eop.gov); or faxed to OMB at (202) 395-6974.

## VI. Regulatory Impact Statement

### A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 directs 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). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This rule is not a major rule. The costs of using feeding assistants will be covered by existing Medicare payment and, most likely Medicaid payment, depending on how a State establishes payment rates. Skilled nursing facilities receive an all-inclusive per diem Medicare payment rate for each resident's care. This includes all costs (routine, ancillary, and capital) of covered skilled nursing facility services

furnished to beneficiaries under Part A of the Medicare program. Skilled nursing facilities will not receive additional Medicare payment for the costs of using feeding assistants.

Medicaid payments for nursing facilities are established by each State. Therefore, it would be up to individual States to determine whether they would need to change their payment rates for those facilities that use feeding assistants and how the rates would be changed. However, because feeding assistants will likely be paid at a minimum wage, which is less than the wage paid to certified nurse aides, facilities participating in Medicare and Medicaid that use feeding assistants may incur less cost than if they had hired additional certified nurse aides to perform feeding and hydration duties.

State costs associated with feeding assistant training programs are considered administrative expenses and are funded under Medicaid with matching funds at 50 percent Federal financial participation. Any information we have on potential State costs of implementing feeding assistant programs comes from States that have used such programs in the past. One State, Wisconsin, has a well-structured program and has experienced relatively minimal costs. One registered nurse spends approximately 10 percent of her time reviewing and approving facility feeding assistant training programs. This represents 10 percent of a full-time equivalent position (FTE), which is reported by Wisconsin to be a cost of about \$7,000 per year. At a time when the use of feeding assistants was highest, a quarter of Wisconsin's 420 nursing homes, or 100 to 110 facilities, used feeding assistants. The number of feeding assistants used by each facility varies according to the size of the home, with the maximum number estimated to be 5 for a large, 200- to 250-bed home. Feeding assistants are typically paid at the same minimum wage. The number of hours each feeding assistant works at a facility is also variable and different for each worker and facility. Further, some facilities use only existing staff as trained feeding assistants. Because of the number of hours worked by each feeding assistant is variable, we do not have an exact estimate of the total cost to Wisconsin for using feeding assistants. However, this summary of Wisconsin's program may be helpful to other States, which are interested in establishing feeding assistant programs.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small

government jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$6 to \$29 million in any 1 year. For purposes of the RFA, all long-term care facilities are considered to be small entities. Individuals and States are not included in the definition of a small entity. The Small Business Administration considers 62 percent of long term care facilities to meet their definition of small entity (those facilities with total revenues of \$11.5 million or less in any 1 year. We have determined that this rule will affect these entities, but, in general, we expect any cost to be covered by Medicare and Medicaid program payments.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. This final rule does not affect small rural hospitals.

For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined that this rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million. This final rule will not have a cost greater than \$110 million on the governments mentioned or on the private sector. In general, we believe that existing Medicare and Medicaid payments will cover the facility costs of using feeding assistants. Costs associated with surveys of long term care facilities are Federally funded, as are costs of State approval of training programs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We believe that this rule contributes to State flexibility by giving States the option to allow the use of feeding