

IFC	Interim Final Rule with Comment Period
MDS	Minimum Data Set
MEDPAR	Medicare Provider Analysis and Review File
MIP	Medicare Integrity Program
MSA	Metropolitan Statistical Area
NECMA	New England County Metropolitan Area
OIG	Office of the Inspector General
OMRA	Other Medicare Required Assessment
PCE	Personal Care Expenditures
PPI	Producer Price Index
PPS	Prospective Payment System
PRM	Provider Reimbursement Manual
RAI	Resident Assessment Instrument
RAP	Resident Assessment Protocol
RAVEN	Resident Assessment Validation Entry
RFA	Regulatory Flexibility Act, Pub. L. 96-354
RIA	Regulatory Impact Analysis
RUG	Resource Utilization Groups
SCHIP	State Children's Health Insurance Program
SNF	Skilled Nursing Facility
STM	Staff Time Measure
UMRA	Unfunded Mandates Reform Act, Pub. L. 104-4

I. Background

On July 31, 2002, we published a notice in the **Federal Register** (67 FR 49798) that set forth updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2003. Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act (the Act), as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), relating to Medicare payments and consolidated billing for SNFs.

A. Current System for Payment of Skilled Nursing Facility Services Under Part A of the Medicare Program

Section 4432 of the Balanced Budget Act of 1997 (the BBA) amended section 1888 of the Act to provide for the implementation of a per diem PPS for SNFs, covering all costs (routine, ancillary, and capital-related) of covered SNF services furnished to beneficiaries under Part A of the Medicare program, effective for cost reporting periods beginning on or after July 1, 1998. We propose to update the per diem payment rates for SNFs for FY 2004. Major elements of the SNF PPS include:

- **Rates.** Per diem Federal rates were established for urban and rural areas using allowable costs from FY 1995 cost

reports. These rates also included an estimate of the cost of services that, before July 1, 1998, had been paid under Part B but were furnished to Medicare beneficiaries in a SNF during a Part A covered stay. The rates were adjusted annually using a SNF market basket index. Rates were case-mix adjusted using a classification system (Resource Utilization Groups, version III (RUG-III)) based on beneficiary assessments (using the Minimum Data Set (MDS) 2.0). The rates were also adjusted by the hospital wage index to account for geographic variation in wages. (In section II.C of this preamble, we discuss the wage index adjustment in detail.) A correction notice was published on December 27, 2002 (67 FR 79123) that announced corrections to several of the wage factors. Additionally, as noted in the July 31, 2002 update notice (67 FR 49798), section 101 of the BBRA and certain sections of the BIPA also affect the payment rate.

- **Transition.** The SNF PPS included an initial 3-year, phased transition that blended a facility-specific payment rate with the Federal case-mix adjusted rate. For each cost reporting period after a facility migrated to the new system, the facility-specific portion of the blend decreased and the Federal portion increased in 25 percentage point increments. For most facilities, the facility-specific rate was based on allowable costs from FY 1995; however, since the last year of the transition was FY 2001, all facilities were paid at the full Federal rate by the following fiscal year (FY 2002). Therefore, we are no longer including adjustment factors related to facility-specific rates for the coming fiscal year.

- **Coverage.** The establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage. However, because RUG-III 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 involving level of care determinations with the outputs of beneficiary assessment and RUG-III classifying activities. We discuss this coordination in greater detail in section II.E of this preamble. Another SNF benefit requirement is that the SNF in which the services are furnished must be certified by Medicare as meeting the requirements for program participation contained in section 1819 of the Act. This provision of the law defines a SNF as " * * * an institution (or a distinct part of an institution). * * *" In section VI of this preamble, we discuss a clarification that we propose to make in

defining the term "distinct part" with respect to SNFs.

In addition, we are taking this opportunity to make a technical correction in a cross-reference that appears in § 409.20(c) of the regulations. Section 409.20 provides a general introduction to the subsequent sections (§ 409.21 through § 409.36) that set forth the specific requirements pertaining to the SNF benefit. However, in referring to the sections that follow, the cross-reference in § 409.20(c) concerning terminology inadvertently omits a reference to § 409.21, and we would now correct that omission by revising the cross-reference to read "§ 409.21 through § 409.36".

- **Consolidated Billing.** The SNF PPS includes a consolidated billing provision (described in greater detail in section IV of this proposed rule) that requires a SNF to submit consolidated Medicare bills for almost all of the services that its residents receive during the course of a covered Part A stay. (In addition, this provision places with the SNF the Medicare billing responsibility for physical, occupational, and speech-language therapy that the resident receives during a noncovered stay.) The statute excludes from the consolidated billing provision a small list of services—primarily those of physicians and certain other types of practitioners—which remain separately billable to Part B by the outside entity that furnishes them.

- **Application of the SNF PPS to SNF services furnished by swing-bed hospitals.** 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 care, as needed. For critical access hospitals (CAHs), Part A pays on a reasonable cost basis for SNF services furnished under a swing-bed agreement. However, in accordance with section 1888(e)(7) of the Act, such 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. A more detailed discussion of this provision appears in section V of this proposed rule.

B. Requirements of the Balanced Budget Act of 1997 (the BBA) for Updating the Prospective Payment System for Skilled Nursing Facilities

Section 1888(e)(4)(H) of the Act requires that we publish in the **Federal Register**:

1. The unadjusted Federal per diem rates to be applied to days of covered SNF services furnished during the FY.