

2. The case-mix classification system to be applied with respect to these services during the FY.

3. The factors to be applied in making the area wage adjustment with respect to these services.

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 RUG-III classification structure (see section II.E of this preamble).

Along with a number of other revisions discussed later in this preamble, this proposed rule provides the annual updates to the Federal rates as mandated by the Act.

C. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA)

There were several provisions in the BBRA that resulted in adjustments to the SNF PPS. These provisions were described in detail in the final rule that we published in the **Federal Register** on July 31, 2000 (65 FR 46770). In particular, section 101 of the BBRA provided for a temporary 20 percent increase in the per diem adjusted payment rates for 15 specified RUG-III groups (SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, CA1, RHC, RMC, and RMB). Under the law, this temporary increase remains in effect until the later of October 1, 2000, or the implementation of case-mix refinements in the PPS. Section 101 also included a 4 percent across-the-board increase in the adjusted Federal per diem payment rates each year for FYs 2001 and 2002, exclusive of the 20 percent increase. Accordingly, this 4 percent temporary increase has now expired.

We included further information on all of the provisions of the BBRA that affect the SNF PPS in Program Memoranda A-99-53 and A-99-61 (December 1999), and Program Memorandum AB-00-18 (March 2000). In addition, for swing-bed hospitals with more than 49 (but less than 100) beds, section 408 of the BBRA provided for the repeal of certain statutory restrictions on length of stay and aggregate payment for patient days, effective with the end of the SNF PPS transition period described in section 1888(e)(2)(E) of the Act. In the July 31, 2001 final rule (66 FR 39562), we made conforming changes to the regulations in § 413.114(d), effective for services furnished in cost reporting periods beginning on or after July 1, 2002.

D. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA)

The BIPA also included several provisions that resulted in adjustments to the PPS for SNFs. These provisions were described in detail in the final rule that we published in the **Federal Register** on July 31, 2001 (66 FR 39562) as follows:

- Section 203 of the BIPA exempted critical access hospital (CAH) swing-beds from the SNF PPS; we included further information on this provision in Program Memorandum A-01-09 (January 16, 2001).

- Section 311 of the BIPA eliminated the one percent reduction in the SNF market basket that the statutory update formula had previously specified for FY 2001, and changed the one percent reduction specified for FYs 2002 and 2003 to a 0.5 percent reduction. This section also required us to conduct a study of alternative case-mix classification systems for the SNF PPS, and to submit a report to the Congress by January 1, 2005.

- Section 312 of the BIPA provided for a temporary 16.66 percent increase in the nursing component of the case-mix adjusted Federal rate for services furnished on or after April 1, 2001, and before October 1, 2002. Accordingly, this temporary increase has now expired. This section also required the General Accounting Office (GAO) to conduct an audit of SNF nursing staff ratios and submit a report to the Congress on whether the temporary increase in the nursing component should be continued.

- Section 313 of the BIPA repealed the consolidated billing requirement for services (other than physical, occupational, and speech-language therapy) furnished to SNF residents during noncovered stays, effective January 1, 2001.

- Section 314 of the BIPA adjusted the payment rates for all of the rehabilitation RUGs to correct an anomaly under which the existing payment rates for the RHC, RMC, and RMB rehabilitation groups were higher than the rates for some other, more intensive rehabilitation RUGs.

- Section 315 of the BIPA 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.

We included further information on several of these provisions in Program Memorandum A-01-08 (January 16, 2001).

E. Skilled Nursing Facility Prospective Payment—General Overview

We implemented the Medicare SNF PPS for cost reporting periods beginning on or after July 1, 1998. Under the PPS, we pay SNFs through prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services. These payment rates cover all the costs of furnishing covered skilled nursing services (routine, ancillary, and capital-related costs) other than costs associated with approved educational activities. Covered SNF services include post-hospital services for which benefits are provided under Part A and all items and services that, before July 1, 1998, had been paid under Part B (other than physician and certain other services specifically excluded under the BBA) but furnished to Medicare beneficiaries in a SNF during a covered Part A stay. A complete discussion of these provisions appears in the May 12, 1998 interim final rule (63 FR 26252).

1. Payment Provisions—Federal Rate

The PPS uses per diem Federal payment rates based on mean SNF costs in a base year 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 an estimate of the amounts that would be 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 PPS (the 15-month period beginning July 1, 1998) using a SNF market basket, and then standardized for the costs of facility differences in case-mix and for geographic variations in wages. Providers that received new provider exemptions from the routine cost limits were excluded from the database used to compute the Federal payment rates, as well as costs related to payments for exceptions to the routine cost limits. In accordance with the formula prescribed in the BBA, 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. In addition, we adjusted the