

Identifying the excluded services in this manner made it possible for us to utilize a Program Memorandum as the vehicle for accomplishing routine updates of the excluded codes, in order to reflect any minor revisions that might subsequently occur in the coding system itself (for example, the assignment of a different code number to the same service). Accordingly, for any new services that would actually represent a substantive change in the scope of services that are excluded from the SNF consolidated billing provision, we would identify these additional excluded services by means of the HCPCS codes that are in effect as of a specific date (in this case, October 1, 2002). By making any new exclusions in this manner, we could similarly accomplish routine future updates of these additional codes through the issuance of a Program Memorandum.

#### **V. Application of the SNF PPS to SNF Services Furnished by Swing-Bed Hospitals**

In the July 31, 2001 final rule (66 FR 39562), we announced the conversion of swing-bed hospitals to the SNF PPS, effective with the start of the provider's first cost reporting period beginning on or after July 1, 2002. We selected this date consistent with the statutory provision to integrate swing-bed hospitals into the SNF PPS by the end of the SNF transition period, that is, June 30, 2002.

By July 31, 2003, the SNF PPS will cover all swing-bed hospitals. Therefore, all rates and wage indexes outlined in earlier sections of this notice for SNF PPS also apply to all swing-bed hospitals. A complete discussion of assessment schedules, the MDS and the transmission software, Raven-SB for Swing Beds can be found in the July 31, 2001 final rule (66 FR 39562). The latest changes in the MDS for swing-bed hospitals are listed on our SNF PPS Web site, <http://www.cms.hhs.gov/providers/snfpps/default.asp>.

#### **VI. Distinct Part Definition**

While some SNFs function as separate, independent entities, we have recognized since the inception of the Medicare program that it is also possible for a SNF to operate as a component, or "distinct part," of a larger organization. As indicated in the discussion below, the predominant organizational form for such distinct part SNFs has been that of a component of a hospital that furnishes SNF services within the larger hospital complex. However, most program requirements that address SNF distinct parts have focused on operating and cost reporting procedures, without

precisely defining what a "distinct part" is. The definition of a distinct part is particularly meaningful in today's environment, since entities other than hospitals are increasingly exploring diversification to provide SNF services. In addition, the growing frequency of hospital mergers (in which each of the merging hospitals brings its own distinct part SNF into the merger) has created situations where the newly-merged hospital entity includes the merger of components that are furnishing SNF services at two different physical locations; that is, the creation of a "composite" distinct part SNF. Moreover, such a hospital might additionally purchase a freestanding SNF for use in placing those of its inpatients who are ready for hospital discharge.

As a result of these changes in facility practices, it has become increasingly important to document the assumptions used historically to survey and certify distinct part units. The purpose of this portion of the proposed rule is to clarify the definition of a "distinct part," to provide more precise guidance to providers and State licensure and certification agencies. This guidance will assist providers in understanding the criteria that govern the financial and organizational structure of such entities, which will facilitate the application and certification process. In this proposed rule, we also explain how the survey and certification requirements are being applied to distinct parts in separate physical locations.

This proposal is not expected to have any adverse financial impact on hospitals or other entities exploring or operating distinct part SNFs. In fact, clarifying our expectations regarding operating criteria could enable providers to identify as duplicative or unnecessary certain procedures that they may have adopted before these clarifications were available, but that are not actually required by our programs. We are also evaluating ways to ensure that the survey and certification process includes ongoing monitoring of changes in distinct part status, and we invite comments on appropriate ways to accomplish this.

Similarly, we do not anticipate any negative impact on beneficiary access to care or on the quality of care furnished in distinct part SNFs. Distinct part SNFs already operate under the same benefit, eligibility, and coverage regulations as freestanding SNFs, and beneficiaries who reside in a distinct part SNF also have the same rights and protections as beneficiaries residing in freestanding SNFs. In fact, in this proposed rule, we clarify how certain resident rights and

protections should be administered in composite distinct part SNFs. We anticipate that this clarification of our expectations will promote improved provider compliance with these program requirements.

#### **A. Background**

As noted in section I.A of this preamble, services are covered under the Part A SNF benefit only when furnished in a SNF that Medicare has certified as meeting the requirements for program participation contained in section 1819 of the Act. This section of the Act defines a SNF in terms of being " \* \* \* an institution (or a distinct part of an institution) \* \* \* ." The committee report that accompanied the original Medicare legislation (cited below) contained the following explanation of the distinct part concept as applied to "posthospital extended care facilities," or SNFs: " \* \* \* A posthospital extended care facility could be an institution, such as a skilled nursing home, or a distinct part of an institution, such as a ward or wing of a hospital or a section of a facility another part of which might serve as an old-age home." (Senate Finance Committee Rep. No. 404, 89th Cong., 1st Sess. 31-32 (1965)).

Under the reasonable cost payment methodology that applied to covered Part A SNF stays prior to the inception of the SNF PPS, a determination that a SNF was a distinct part of a hospital (or "hospital-based") rather than a freestanding facility directly affected the amount of the SNF's Medicare payment. This is because that payment methodology set higher limits on routine service costs for hospital-based SNFs than for freestanding facilities.

In the **Federal Register** of September 4, 1980 (45 FR 58701), we defined a "hospital-based SNF" for this purpose as being an integral and subordinate part of a hospital that is operated with other departments of the hospital under common licensure, governance, and professional supervision, with all services of both the hospital and the SNF being fully integrated. In addition, we included the following specific criteria:

- The SNF and hospital are subject to the bylaws and operating decisions of a common governing board;
- The SNF and hospital are financially integrated as evidenced by the cost report, which must reflect the certified or noncertified SNF beds of the hospital, the allocation of hospital overhead to the SNF through the required stepdown methodology, and common billing for all services of both facilities.