

section 1888(e) of the Social Security Act (the Act), as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106–113) (the BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) (the BIPA), relating to Medicare payments and consolidated billing for SNFs. In the proposed rule, we invited public comments on a number of proposed revisions and technical corrections to the associated regulations. Following the publication of that proposed rule, we then published a supplemental proposed rule (hereinafter referred to as the “supplemental proposed rule”) on June 10, 2003 (68 FR 34768), in which we invited public comments on possibly revising the annual update methodology by establishing an adjustment to account for forecast error. In addition, we also invited comments on ways to ensure that additional payments that could result from such an adjustment would be used to promote quality of care in the SNF setting (including direct care services to residents).

A. Current System for Payment of SNF Services Under Part A of the Medicare Program

Section 4432 of the Balanced Budget Act of 1997 (Pub. L. 105–33) (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 are updating 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, were paid under Part B but 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 III.C of this final rule, 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 the 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 III.E of this final rule. Another SNF benefit requirement is that the SNF 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 III.K of this final rule, we discuss a clarification that we are making in defining the term “distinct part” with respect to SNFs.

- *Consolidated Billing.* The SNF PPS includes a consolidated billing provision that requires a SNF to submit consolidated Medicare bills for almost all of the services that the resident receives 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 few 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. We discuss this

provision in greater detail in section III.I of this final rule.

- *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, these 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 III.J of this final rule.

- *Technical corrections.* We are also taking this opportunity to make a number of technical corrections in the text of the regulations, as discussed in greater detail in section IV of this final rule.

B. Requirements of the Balanced Budget Act of 1997 (the BBA) for Updating the SNF PPS

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 fiscal year.
2. The case-mix classification system to be applied with respect to these services during the fiscal year.
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 III.E of this final rule).

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 statute, this temporary increase remains in effect