

values. These tables do not reflect the temporary add-on to the specified RUG-III groups provided in the BBRA, which is applied only after all other adjustments (wage and case-mix) have been made.

Meanwhile, we are continuing to explore both short-term and longer-range revisions to our case-mix classification methodology. In July 2001, we awarded a contract to the Urban Institute for research to aid us in making incremental refinements to the case-mix classification system under section 1888(e)(4)(G)(i) of the Act and to begin the case-mix study mandated by section 311(e) of the BIPA. The results of our current research will be included in the report to the Congress that section 311(e) of the BIPA requires us to submit by January 1, 2005. As we noted in the May 10, 2001 proposed rule (66 FR 23990), this research may also support a longer term goal of developing more integrated approaches for the payment and delivery system for Medicare post acute services in general. This broader, ongoing research project will pursue several avenues in studying various case-mix classification systems. Our preliminary research has focused on incorporating comorbidities and complications into the classification strategy, and we will thoroughly explore and evaluate this approach and other approaches (including procedures that might account more accurately for ancillary services) in our ongoing work.

*Comment:* Several commenters commended our decision not to implement case-mix refinements in FY 2004. They expressed the belief that incremental refinements may only represent "patches" on a system that needs a more comprehensive redesign, and could destabilize an already vulnerable health care industry. Other commenters urged us to move quickly to identify and implement short-term incremental improvements to provide more appropriate reimbursement for patients with heavy non-therapy ancillary needs.

*Response:* As discussed in the proposed rule, we continue to explore both short-term case-mix refinements and longer-range redesign of the SNF PPS methodology. Our primary goal is to enhance the accuracy of our reimbursement system by more closely

matching payment with resource utilization, particularly in the utilization of non-therapy ancillaries. We have made this issue a research priority to ensure continued access to quality care for this very vulnerable heavy care population. However, we are cautious about premature implementation of any policy that has not been thoroughly analyzed to allocate payment dollars more accurately. Therefore, we have decided not to implement case-mix refinements for FY 2004. However, we are proceeding with our research and plan to evaluate the feasibility of implementing refinements again next year.

*Comment:* Several commenters agreed with the need for short-term action to stabilize the SNF PPS and suggested some alternative methodologies for achieving these goals, including more frequent updating of the SNF market basket and the development of an outlier pool that could address beneficiaries with heavy non-therapy ancillary needs. A few commenters suggested addressing the non-therapy ancillary needs by seeking a legislative change to redirect the 6.7 percent add-on payments for the 14 RUG-III therapy groups to those RUG-III groups used for beneficiaries with complex medical conditions and high utilization of non-therapy ancillary services.

*Response:* Each of the suggestions discussed above would require statutory authority that does not currently exist. However, we will carefully consider the comments that we received and use these comments to assist us in exploring potential solutions. While we will continue to focus on the needs of those beneficiaries who require an unusually heavy combination of clinical care, rehabilitation services, and ancillary utilization, we will also continue to consider a broad range of potential changes. We expect to discuss our research findings by January 1, 2005, in the report to the Congress that is required under section 311(e) of the BIPA.

*Comment:* Most of the commenters supported the continuation of our long-term research efforts designed to identify possible alternatives to the existing SNF PPS. Many commenters suggested expanding communications with providers and other interest groups

in a manner similar to the approach that we have adopted for Open Door meetings. Most commenters recommended that we also enhance communications by sharing our research findings, and by including a detailed analysis in the 2005 report to the Congress.

*Response:* We appreciate the interest shown by providers and other stakeholders in our continuing research. We plan to consider all of the comments that we have received regarding potential changes to the classification system, as well as to other components of the SNF PPS, as we continue our analysis and prepare the required report to the Congress. As we pursue our research effort and evaluate our options, we will seek appropriate means to establish ongoing communication with, and input from, all stakeholder groups.

*Comment:* Most commenters urged us to minimize provider burden by providing adequate lead time for comment and for implementation of any significant changes. One commenter also suggested that we improve our coordination of related projects such as the Minimum Data Set (MDS) 3.0 implementation and the SNF PPS redesign, so that providers can incorporate changes smoothly and provide necessary staff training with minimal disruption to staff and patients.

*Response:* We recognize the inherent difficulties in coordinating potential changes to the MDS with potential changes to the SNF PPS. In fact, our staff in the payment, quality monitoring, and survey and certification areas have addressed this issue by establishing an in-house work group to share information and coordinate activities. By working together, we believe that we enhance our effectiveness and can introduce changes with minimal disruption and burden to providers. In addition, the introduction of the MDS 3.0 and any case-mix refinement changes to the SNF PPS would be accomplished through established administrative processes that will solicit stakeholder input. Finally, we fully agree that providers and other stakeholders will need adequate lead time to implement significant policy and operational changes.

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