

Response: As we stated in the proposed rule of May 16, 2003 (68 FR 26758), the growing frequency of hospital mergers (in which each of the merging hospitals brings its own distinct part SNF and/or NF into the merger) has created situations where the newly merged hospital entity includes multiple physical plants in which SNF and/or NF services are provided in different physical locations: that is, the creation of a composite distinct part SNF and/or NF. Moreover, that hospital might additionally purchase a freestanding SNF and/or NF for use in placing those of its inpatients who are ready for hospital discharge. Existing guidance on what constitutes a distinct part does not address these types of situations. Thus, we have established these criteria in an effort to reduce uncertainty and to allow providers to make informed decisions. This rule also establishes protections for beneficiaries who reside in composite distinct parts.

Comment: A commenter questioned if States would be required to apply the same definition in determining distinct part approval for purposes of State licensing and Medicaid reimbursement laws.

Response: The criteria and definitions set forth in this rule apply to SNFs and NFs that are approved to participate in either the Medicare program or the State Medicaid program (or both). As such, for participation in the Medicare and/or Medicaid programs, the criteria in this rule must be met.

Comment: A commenter stated that we should consider CMS staff time that will be required to approve mergers.

Response: Providers who are participating in the Medicare and/or Medicaid program are required to notify us of any proposed change of ownership before the effective date of the transaction, since these transactions directly affect the provider agreement. Reviewing these transactions is a function that our Regional Offices are currently performing and will not require additional CMS staff time.

In the proposed § 483.5(c)(2)(iii), we inadvertently used the term “hospitals” rather than “institutions” in our discussion of changes of ownership. We are revising § 483.5(c)(2)(iii) by replacing the word “hospitals” with “institutions,” since this provision is meant to apply more generally to institutions, which could include, but are not limited to, hospitals. We are also replacing the word “merged” with “change of ownership” throughout the regulations text since this provision more accurately applies in all cases where there is a change of ownership. For the same reason, we are deleting the

examples referencing hospitals at § 483.5(b)(1).

Comment: A commenter stated that our policy of allowing only one distinct part SNF and/or one distinct part NF is problematic as it could jeopardize the funding for certain programs that are predicated on specific State program requirements.

Response: It has been our longstanding policy that an institution or institutional complex only be allowed to have one distinct part SNF and/or one distinct part NF. Moreover, our policy is based on sections 1819(a) and 1919(a) of the Act, which define a SNF and a NF, respectively, as “an institution (or a distinct part of an institution). * * *” It is our view that this reference to the singular, that is, “a” distinct part indicates that the Congress did not contemplate permitting the establishment of more than one distinct part SNF or NF in any given institution. This language is also reflected in the Committee Report accompanying the original Medicare legislation previously discussed in the May 16, 2003 proposed rule (68 FR 26777).

Comment: Several commenters suggested the term “distinct part” be defined using language that had previously appeared in the State Operations Manual § 2110, “The term ‘distinct part’ denotes that the unit is organized and operated to give a distinct type of care within a larger organization which otherwise renders other types or levels of care. * * *”

Response: We are not making the revision, as suggested by the commenters, because this would necessitate a change in the statute.

Comment: Two commenters expressed a concern that the restrictions on room changes made within the locations of the composite distinct part would affect the transfer of residents between levels of care (that is, skilled nursing facility services are provided in one location of the composite distinct part and nursing facility services are provided in another location of the composite distinct part.)

Response: We do not consider the resident protections in newly added § 483.12(a)(8) that apply to room changes to have any impact on residents transferring between different levels of care within a composite distinct part. There is a distinction between room changes and transfers. Room changes occur within the same certified facility, such as within a composite distinct part. Section 483.12(a)(1) defines transfers and discharges as, “* * * movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer

and discharge does not refer to the movement of a resident within the same certified facility.”

Comment: The commenter urged us to implement the definitions for distinct parts and composite distinct parts in a manner that neither adds administrative burden on SNFs or NFs, nor adversely affects their quality of care or financial status. The commenter stated further that State Medicaid programs and other payers should not be required to use the new definitions, and that the creation of the definitions should not hamper their ability to use the previous definitions.

Response: It is not our intent in defining the terms distinct part and composite distinct part to add to a SNF's or NF's administrative burdens or to adversely affect the quality of care provided to the residents, or to affect the SNF's or NF's financial status. We believe that our definitions of these terms should be clearly stated in regulations in order to reduce uncertainty and allow providers to make informed decisions and enhance the survey and certification process.

We do expect that the distinct part regulations be applied to SNFs participating in the Medicare program and NFs participating in the Medicaid program in exactly the same manner. As we have discussed previously, the statutory definitions of a SNF and a NF that appear in sections 1819(a) and 1919(a) of the Act, respectively, use identical language, “an institution (or a distinct part of an institution)” and thus are not intended to be treated differently. Moreover, § 440.155 and the Medicare guidelines concerning distinct parts have always correlated, and we believe that to allow different distinct part rules for the two programs would only create confusion and would not be consistent with the intent of the Congress. We are also making editorial technical changes to § 440.40(a)(1)(ii)(A), § 483.5(b)(1), § 483.5(b)(2), § 483.5(c), and § 483.10(b)(12). These were made solely to clarify and make more understandable the regulations text.

L. Quality of Care Efforts Under the SNF PPS

In the supplemental proposed rule (68 FR 34772), we expressed our expectation that the majority of any additional payments that might result from the introduction of a forecast error adjustment (as discussed previously in section III.H.3 of this final rule) would be used for direct care services to nursing home residents and quality improvement activities and programs. We also solicited comments on how SNFs could account for these direct care