total facility population (which includes Medicare, Medicaid, and private pay patients). We believe that it continues to be highly effective in this area. While we have found that pharmacy costs are correlated somewhat with the nursing case-mix indexes in RUG–III, it is important to note that such costs are, by and large, difficult to account for in case-mix systems because drug costs do not necessarily follow physical condition, resource use, or functional and clinical pathways.

We look forward to addressing this important issue through the study of alternative case-mix systems required under BIPA 2000, which provides an opportunity for a deliberate analytical approach to the question of how best to refine the current classification system or to redirect Medicare's payment system to produce more equitable

the SNF PPS (which bases payment amounts on the clinical information entered on the MDS) is no exception. In this context, we note that fiscal intermediaries (FIs) will continue reviewing SNF PPS bills. As with current practice, the FIs will focus on identifying instances in which inappropriate services were provided or where the beneficiary did not meet the requirements for Medicare Part A coverage in an SNF. As part of this review, the MDS and the medical record is assessed to verify that the reported information supports the RUG category billed.

We believe that the practice of FIs using a data driven approach to focus medical review efforts will help address the incentive for upcoding. Once bills have been targeted for review, the FIs will identify instances in which

on a routine basis, concurrent therapy. Concurrent therapy is the practice of one professional therapist treating more than one Medicare beneficiary at a time—in some cases, many more than one individual at a time.

Concurrent therapy is distinguished from group therapy, because all participants in group therapy are working on some common skill development and the ratio of participants to therapist may be no higher than 4 to 1. In addition, in the July 30, 1999 SNF PPS final rule (64 FR 41662), we specified that the minutes of group therapy received by the beneficiary may account for no more than 25 percent of the therapy (per discipline) received in a 7 day period. By contrast, a beneficiary who is receiving concurrent therapy with one or more other beneficiaries likely is not

receiving services that relate to those needed by any of the other participants. Although each beneficiary may be receiving care that is prescribed in his individual plan of treatment, it is not being delivered according to Medicare coverage guidelines; that is, the therapy is not being provided individually, and it is unlikely that the services being delivered are at the complex skill level required for coverage by Medicare.

The Medicare SNF benefit provides

than one beneficiary. We now wish to advise the providers of care of our concern about the potentially adverse effect of this practice on the quality of the therapy provided to beneficiaries in Part A SNF stays, as well as our concern about the implications of making payments in such situations. We solicit public comments regarding the scope and magnitude of this problem, and possible approaches for addressing this issue.

First, we compute the FY 2002 price index level for the total market basket and each cost category of the market basket. Second, we calculate a ratio for each cost category by dividing the FY 2002 price index level for that cost category by the total market basket price index level. Third, we determine the FY 2002 relative importance for each cost category by multiplying this ratio by the base year (FY 1997) weight. Finally, we