Through submission of these SIP revisions, the State and any affected local or tribal governments have elected to adopt the program provided for under sections 110 and 182 of the CAA. These rules may bind State, local, and tribal governments to perform certain actions and also require the private sector to perform certain duties. To the extent that the rules being approved today will impose any mandate upon the State, local, or tribal governments either as the owner or operator of a source or as a regulator, or would impose any mandate upon the private sector, EPA's action will impose no new requirements; such sources are already subject to these requirements under State law. Similarly, EPA's withdrawal of the FIP contingency process will not impose any new requirements. Accordingly, no additional costs to State, local, or tribal governments, or to the private sector, result from this action. EPA has also determined that this action does not include a mandate that may result in estimated costs of $100 million or more to State, local, or tribal governments in the aggregate or to the private sector. This federal action approves pre-existing requirements under State or local law, imposes no new Federal requirements, and withdraws other federal requirements applicable only to EPA. Accordingly, no additional costs to State, local or tribal governments, or to the private sector, result from this action.

D. Submission to Congress and the General Accounting Office

Under 5 U.S.C. 801(a)(1)(A) added by the Small Business Regulatory Enforcement Fairness Act of 1996, EPA submitted a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives and the Comptroller General of the General Accounting Office prior to publication of the rule in today's Federal Register. This rule is not a ''major rule'' as defined by 5 U.S.C. 804(2).

E. Petitions for Judicial Review

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by December 2, 1996. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. See section 307(b)(2).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Carbon monoxide, Incorporation by reference, Intergovernmental relations.

Dated: September 26, 1996.

Carol M. Browner,

Administrator.

For the reasons set forth in this preamble, 40 CFR part 52 is amended as follows:

PART 52—[AMENDED]

1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401–7671q.

Subpart D—Arizona

2. Section 52.120 is amended by adding paragraphs (c)(83) and (c)(85) to read as follows:

§ 52.120 Identification of plan.

* * * * *

(83) Plan revisions were submitted on December 11, 1992, by the Governor's designee.

(i) Incorporation by reference.

(A) State Transportation Board of Arizona.

(*1*) Resolution to Implement a Measure in the Maricopa Association of Governments 1992 Carbon Monoxide Contingency Plan, adopted on November 20, 1992.

(85) Plan revisions were submitted on April 4, 1994, by the Governor's designee.

(i) Incorporation by reference.

(A) Arizona Revised Statutes.

(*1*) House Bill 2001, Section 27: ARS 49–542.01(E) approved by the Governor on November 12, 1993.

[FR Doc. 96–25400 Filed 10–2–96; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 413

[BPD–805–F]

RIN 0938–AG68

Medicare and Medicaid Programs; New Payment Methodology for Routine Extended Care Services Provided in a Swing-Bed Hospital

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule revises the regulations governing the methodology for payment of routine extended care services furnished in a swing-bed hospital. Medicare payment for these services is determined based on the average rate per patient day paid by Medicare for these same services provided in freestanding skilled nursing facilities (SNFs) in the region in which the hospital is located. The reasonable cost for these services is the higher of the reasonable cost rates in effect for the current calendar year or for the previous calendar year. In addition, this final rule revises the regulations concerning the method used to allocate hospital general routine inpatient service costs for purposes of determining payments to swing-bed hospitals. These changes are necessary to conform the regulations to section 1883 of the Social Security Act (the Act), and section 4008(j) of the Omnibus Budget Reconciliation Act of 1990.

EFFECTIVE DATE: These regulations are effective on November 4, 1996.

FOR FURTHER INFORMATION CONTACT: John Davis (410) 786–0008.

SUPPLEMENTARY INFORMATION:

I. Background

Before the enactment of the Omnibus Budget Reconciliation Act of 1980 (Public Law 96–499), small rural hospitals had difficulty in establishing separately identifiable units for Medicare and Medicaid long-term care because of limitations in their physical plant and accounting capabilities. These hospitals often had an excess of hospital beds, while their communities had a scarcity of long-term care beds in Medicare and Medicaid participating facilities. To alleviate this problem, Congress enacted section 904 of Public Law 96–499, known as the ''swing-bed provision,'' which authorized a cost-efficient means of providing nursing home care in rural communities. This provision added sections 1883 and 1913 of the Social Security Act (the Act), under which certain rural hospitals with fewer than 50 beds could use their inpatient facilities to furnish long-term care services to Medicare and Medicaid patients. These hospitals were paid at rates that were deemed appropriate for those services and were generally lower than hospital rates. Medicare payment for routine SNF services was made at the average Statewide Medicaid rate for the previous calendar year. Payment for ancillary services was made based on reasonable cost.

On December 22, 1987, the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) (Public Law 100–203) was enacted. Section 4005(b) of OBRA 1987 amended section 1883(b)(1) of the Act to provide for an expansion of the existing Medicare swing-bed program to include rural hospitals with more than 49 but fewer than 100 beds, effective for swing-bed agreements entered into after March 31, 1988. Although rural hospitals having more than 49 beds but fewer than 100 beds can be swing-bed hospitals, they are subject to additional payment limitations that do not apply to the smaller swing-bed hospitals.

Also, sections 4201(a)(3), 4204, 4211(h)(9), and 4214 of OBRA 1987 provide that effective with services furnished on or after October 1, 1990, the terms ''skilled nursing facilities'' (SNFs) and ''intermediate care facilities'' (ICFs) are no longer to be used for the purpose of certifying a facility for the Medicaid program. Instead, they are replaced by the term ''nursing facility'' (NF). Thus, for purposes of the Medicaid program, facilities are no longer certified as ICFs but instead are certified only as NFs, and can provide services as defined in section 1919(a)(1) of the Act. Effective October 1, 1990, these long-term care services furnished by swing-bed hospitals to Medicaid and to other non-Medicare patients have been referred to as NF-type services.

On November 5, 1990, the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) (Public Law 101–508) was enacted. Section 4008(j) of OBRA 1990 amended section 1883(a)(2)(B)(ii)(II) of the Act to provide for a new methodology to pay for routine SNF services provided in a swing-bed hospital. Effective for services furnished on or after October 1, 1990, Medicare payment for routine SNF services in a swing-bed hospital is based on the average rate per patient day paid by Medicare for routine services provided in freestanding SNFs in the region in which the hospital is located. The rates are calculated using the regions as defined in section 1886(d)(2)(D) of the Act.

Section 4008(j)(2) of OBRA 1990 also provides for a ''hold-harmless harmless'' provision. Under this provision, if the reasonable cost of routine SNF services furnished by a hospital during a calendar year is less than the reasonable cost of these services determined for the prior calendar year, payment is to be based on the reasonable cost determination for the prior calendar year.

II. Provisions of the Proposed Rule

On April 22, 1996, we published a proposed rule in the Federal Register (61 FR 17677), in which we included the following provisions.

New Payment Rate Methodology

We proposed to implement in regulations a revised methodology for Medicare payment of routine SNF services provided in a swing-bed hospital. Under the proposed rule, Medicare payment to a swing-bed hospital for routine SNF services would be based on the average rate per patient day paid by Medicare for routine SNF services provided in a freestanding SNF in the region in which the hospital is located. These rates would be determined prospectively based on the most current SNF settled cost reporting data available (increased in a compounded manner, using the increase applicable to the SNF routine cost limits, up to and including the calendar year for which the rates are in effect). Rates would be calculated using the regions as defined in section 1886(d)(2)(D) of the Act (that is, one of the nine census divisions established by the Bureau of the Census). Payment for ancillary services furnished as SNF services in swing-bed hospitals would continue to be paid on a reasonable cost basis.

We published the rates applicable to calendar years 1990 through 1994 (see below), which had been published in section 2231 of the Provider Reimbursement Manual (HCFA Pub. 15–1). We stated our intent to continue to publish annual updates in that manual.

We described the methodology for calculating the Medicare swing-bed rates, and provided the rates for services furnished on or after October 1, 1990, and before December 31, 1990, as well as for services furnished in calendar years 1991, 1992, 1993, 1994, and 1995.

In accordance with section 4008(j)(2) of OBRA 1990, we also proposed a hold-harmless provision for Medicare swing-bed payments. As noted above, this provision would allow for payment of the higher of the payment rate in effect for the current calendar year or the payment rate received by the swing-bed hospital for the prior calendar year.

Development of Medicare Swing Bed Rates Effective for Services Furnished on or after October 1, 1990 and before January 1, 1995

—Data—In developing the Medicare payment rates for swing-bed care, we used the actual freestanding SNF inpatient routine service payments obtained from settled Medicare cost reports. For fiscal years 1990–1993, cost reports used were for periods ending on or after June 30, 1989 and through May 31, 1990; for 1994, cost reports used were for periods ending on or after September 30, 1990 through August 31, 1991; and for 1995, cost reports used were for periods ending on or after October 31, 1992 through September 30, 1993. The data consist of routine service payments that were adjusted for utilization review, primary payor amounts, and application of lower of cost or charges. For proprietary providers, the return on equity portion of the swing-bed rate was adjusted to include only the routine portion (that is, the return on equity component related to ancillary services costs was removed).

HCFA adjusts these data, using the SNF market basket index (the annual percent increase in SNF expenditures, considering inflation plus an allowance for new technology) to inflate costs from the cost reporting periods in the data base to the midpoint of the applicable year to which the rates apply.

—Group Means—HCFA calculated the means of adjusted routine service payments and the routine portion of return on equity for each census region as shown in Tables A through D.

(We noted that effective October 1, 1993, section 13503(c) of the Omnibus Budget Reconciliation Act of 1993 amended sections 1861(v)(1)(B) and 1878(f)(2) of the Act to eliminate return on equity capital for SNF services furnished in a proprietary hospital. The return on equity capital component was not added to the routine payment rate for the months of October, November, and December of 1993 (Table D) nor for any subsequent years.)

TABLE A.—MEDICARE SWING BED RATES—FOR SERVICES FURNISHED ON OR AFTER OCTOBER 1, 1990 AND BEFORE DECEMBER 31, 1990

Region	Routine payment	Return on equity [1]
1. New England (CT, ME, MA, NH, RI, VT)	$86.51	$1.42
2. Middle Atlantic (PA, NJ, NY)	86.39	1.27
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	75.28	1.48
4. East North Central (IL, IN, MI, OH, WI)	75.03	1.18
5. East South Central (AL, KY, MS, TN)	65.79	1.21
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	74.09	1.34
7. West South Central (AR, LA, OK, TX)	67.85	1.87
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	81.32	1.47
9. Pacific (AK, CA, HI, OR, WA)	86.73	1.07

[1] The return of equity component is included only in the rate paid to proprietary hospitals.

TABLE B.—MEDICARE SWING BED RATES—FOR SERVICES FURNISHED ON OR AFTER JANUARY 1, 1991 AND BEFORE DECEMBER 31, 1991

Region	Routine payment	Return on equity [2]
1. New England (CT, ME, MA, NH, RI, VT)	$90.92	$1.42
2. Middle Atlantic (PA, NJ, NY)	90.73	1.27
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	79.03	1.28
4. East North Central (IL, IN, MI, OH, WI)	78.78	1.18
5. East South Central (AL, KY, MS, TN)	69.14	1.21
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	77.83	1.34
7. West South Central (AR, LA, OK, TX)	71.22	1.87
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	85.34	1.47
9. Pacific (AK, CA, HI, OR, WA)	91.10	1.07

[2] The reutrn on equity component is included in the rate paid to propriety hospitals.

TABLE C.—MEDICARE SWING BED RATES—FOR SERVICES FURNISHED ON OR AFTER JANUARY 1, 1992 AND BEFORE DECEMBER 31, 1992

Region	Routine payment	Return on equity [3]
1. New England (CT, ME, MA, NH, RI, VT)	$95.10	$1.42
2. Middle Atlantic (PA, NJ, NY)	94.91	1.27
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	82.67	1.48
4. East North Central (IL, IN, MI, OH, WI)	82.40	1.18
5. East South Central (AL, KY, MS, TN)	72.32	1.21
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	81.41	1.34
7. West South Central (AR, LA, OK, TX)	74.50	1.87
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	89.27	1.47
9. Pacific (AK, CA, HI, OR, WA)	95.29	1.07

[3] The return on equity component is included only in the rate paid to proprietary hospitals.

TABLE D.—MEDICARE SWING BED RATES—FOR SERVICES FURNISHED ON OR AFTER JANUARY 1, 1993 AND BEFORE DECEMBER 31, 1993

Region	Routine payment	Return on equity [4]
1. New England (CT, ME, MA, NH, RI, VT)	$100.05	$1.42
2. Middle Atlantic (PA, NJ, NY)	99.84	1.27
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	86.97	1.48
4. East North Central (IL, IN, MI, OH, WI)	86.69	1.18
5. East South Central (AL, KY, MS, TN)	76.08	1.21
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	85.64	1.34
7. West South Central (AR, LA, OK, TX)	78.37	1.87
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	93.91	1.47
9. Pacific (AK, CA, HI, OR, WA)	100.24	1.07

[4] The return on equity component should be included in the rate paid to proprietary hospitals only for the months of January through September of this calendar year.

TABLE E.—MEDICARE SWING BED RATES—FOR SERVICES FURNISHED ON OR AFTER JANUARY 1, 1994 AND BEFORE DECEMBER 31, 1994

Region	Routine payment
1. New England (CT, ME, MA, NH, RI, VT)	$108.48
2. Middle Atlantic (PA, NJ, NY)	104.33
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	89.47
4. East North Central (IL, IN, MI, OH, WI)	88.76
5. East South Central (AL, KY, MS, TN)	79.44
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	83.84
7. West South Central (AR, LA, OK, TX)	84.97
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	100.11
9. Pacific (AK, CA, HI, OR, WA)	104.58

TABLE F.—MEDICARE SWING BED RATES—FOR SERVICES FURNISHED ON OR AFTER JANUARY 1, 1995 AND BEFORE DECEMBER 31, 1995

Region	Routine payment
1. New England (CT, ME, MA, NH, RI, VT)	$121.71
2. Middle Atlantic (PA, NJ, NY)	117.28
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	105.22
4. East North Central (IL, IN, MI, OH, WI)	105.73
5. East South Central (AL, KY, MS, TN)	94.61
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	99.75
7. West South Central (AR, LA, OK, TX)	99.63
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	117.21
9. Pacific (AK, CA, HI, OR, WA)	125.80

TABLE G.—MEDICARE SWING BED RATES—FOR SERVICES FURNISHED ON OR AFTER JANUARY 1, 1996 AND BEFORE DECEMBER 31, 1996

Region	Routine payment
1. New England (CT, ME, MA, NH, RI, VT)	$126.65
2. Middle Atlantic (PA, NJ, NY)	121.74
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	109.04
4. East North Central (IL, IN, MI, OH, WI)	109.51
5. East South Central (AL, KY, MS, TN)	99.11
6. West North Central (IA, KS, MN, MO, NB, ND, SD)	103.38
7. West South Central (AR, LA, OK, TX)	102.89
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	121.31
9. Pacific (AK, CA, HI, OR, WA)	130.62

The Carve-Out Method

In a swing-bed hospital, acute care services and long-term care services are furnished interchangeably. To determine payment for inpatient hospital services in a swing-bed hospital, section 1883(e) of the Act provides that the costs attributable to routine long-term care (SNF-type and ICF-type) services for all classes of patients are to be subtracted (''carved out'') from the total allowable inpatient cost for general inpatient routine services. The resulting amount represents the general inpatient routine costs applicable to hospital routine care. Once amounts attributable to SNF-type and ICF-type services have been carved out, the average per diem cost of general routine hospital services for swing-bed hospitals not subject to the prospective payment system is then determined by dividing the remaining amount by the total number of inpatient general routine hospital days (excluding SNF days and ICF days). This method was chosen to avoid imposing a burdensome cost finding process to allocate general routine service costs between hospital and long-term care.

Swing-bed hospitals subject to the prospective payment system (PPS) are paid for SNF-type services in the same manner as any other swing-bed hospital. The carve-out method would be used primarily to determine proper payment of pass-through costs. The prospective payment rates based on diagnosis related groups (DRGs) for inpatient hospital services under PPS are unaffected by the carve-out method.

As stated above, with the enactment of OBRA 1987, effective October 1, 1990, the distinction between SNFs and ICFs was eliminated under the Medicaid program and the two types of facility were combined under the term ''nursing facility'' (NF). This presented a problem in attempting to determine the amount of the carve-out. Since Medicaid payment is now determined based on a NF rate, the carve-out method could not be used as previously defined.

The proposed rule revised § 413.53(a)(2) to set forth our current policy regarding the carve-out method (presently explained in section 2230.5B of the Provider Reimbursement Manual) for SNF and NF services furnished on or after October 1, 1990. Under the revised carve-out method, the reasonable cost of hospital routine services is determined

by subtracting the reasonable costs attributable to routine SNF-type and NF-type services from total inpatient routine service costs. For swing-bed SNF days covered by Medicare, the amount subtracted, or carved out, is based on the regional Medicare swing-bed SNF rate. If, under the hold-harmless provision explained above, a swing-bed hospital is paid based on the swing-bed SNF rate that was in effect during the prior calendar year, that higher rate would also be used for purposes of calculating the reasonable cost of routine Medicare SNF days, to be subtracted from total routine costs under the carve-out method. For all non-Medicare swing-bed days, the amount subtracted is based on the average statewide rate paid for routine services in NFs under the State Medicaid plan during the prior calendar year, adjusted to approximate the average NF rate for the current calendar year. (The NF rate is used for non-Medicare covered swing-bed days because such services may encompass services that were formerly known as ICF and SNF-type services.)

Definitions

As discussed above, effective for services furnished on or after October 1, 1990, the terms SNFs and ICFs were no longer to be used for the purpose of certifying a facility for the Medicaid program, in accordance with the provisions of OBRA 1987. Instead, they were replaced by the term ''nursing facility'' (NF). Effective October 1, 1990, extended care services furnished by swing-bed hospitals to Medicaid and to other non-Medicare patients have been referred to as NF-type services.

To reflect the above provisions, we are making changes to the definitions in § 413.53(b) by (1) Revising the definition of ''average cost per diem for general routine services''; (2) removing the definition of ''ICF-type services;'' (3) adding a definition of ''nursing facility (NF)-type services;'' and (4) revising the definition of ''SNF-type services.''

III. Analysis of and Responses to Public Comments

In response to the April 22, 1996 proposed rule, we received one item of correspondence from the American Health Care Association. The Association essentially supports the proposed rule in that it modifies the regulations to conform with policies that have been in existence since 1990, and that are contained in the Provider Reimbursement Manual. However, the commenter points out that rural hospitals with more than 49 beds but less than 100 beds are subject to an additional payment limitation. The Medicare payment for SNF services by the hospital may not be made for more than five days (excluding weekends and holidays), after a bed in a SNF becomes available in the geographic region, unless the patient's physician certifies within the five-day period that the transfer is not medically appropriate. The commenter is concerned that hospitals are not strictly adhering to the five-day rule.

Response: We are not currently aware of any hospital that is violating the five-day rule. However, the hospital is subject to a periodic certification survey. It is during this survey that a sampling of the records for swing-bed patients is examined to ensure that the five-day rule is being followed correctly. Violators would endanger their continued certification as a swing-bed facility.

In addition to this periodic certification survey, if someone is aware that a hospital is violating the five-day rule, he or she can contact the State Department of Licensure and Certification and request that a complaint survey be done. A complaint survey is done within a matter of weeks or months, which is much faster than the three to six years that a periodic one takes.

IV. Provisions of the Final Regulations

This final rule incorporates the provisions of the proposed rule. The rates applicable to calendar year 1996 were not published in the proposed rule, but have been published in the Provider Reimbursement Manual. For the convenience of the reader, we are including them as Table G above in this final rule. Subsequent updates will be provided in the Provider Reimbursement Manual.

V. Impact Statement

For final rules such as this, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612). For purposes of a RFA, States and individuals are not considered small entities. However, providers are considered to be small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory flexibility analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain rural counties adjacent to urban ares, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

In accordance with the provisions of section 1883 of the Act, as amended by section 4008(j) of OBRA 1990, this final rule revises the regulations to incorporate a new methodology for payment of routine extended care services provided in a swing-bed hospital. As the statute specifies, Medicare payment for these services is determined based on the average rate per patient day paid by Medicare for these same services provided in freestanding skilled nursing facilities (SNFs) in the region in which the hospital is located, during the most recent year for which cost reporting data are available. This final rule also provides that the reasonable cost for these services is the higher of the reasonable cost rates in effect for the current calendar year or for the previous calendar year.

In addition to the changes mandated by section 4008(j) of OBRA 1990 regarding payment for routine extended care services, we are changing to the out method of determining routine inpatient hospital costs of swing-bed hospitals. As discussed above, with the enactment of OBRA 1987, the distinction between SNFs and ICFs was eliminated under the Medicaid program. Thus, the carve-out out method as described in § 413.53(a)(2) for computing costs associated with routine SNF and ICF-type services cannot be used. This final rule codifies in regulations existing policy concerning the carve-out out method as set forth in section 2230.5B of the Provider Reimbursement Manual.

As noted above, the major provisions of this final rule are required by section 1883 of the Act, as amended by section 4008(j) of OBRA 1990. Thus, a majority of the costs associated with these final rules are the result of legislation, and this rule, in and of itself, has little or no independent effect or burden. Although we are unable to provide a quantifiable estimate of impact, we note that the only discretionary aspect of this rule is to set forth in regulations our current policy concerning the carve-out out method. Codifying this existing policy would have no economic impact.

Thus, we have determined, and we certify, that this final rule does not have a significant impact on the operations of a substantial number of small entities or on small rural hospitals. Therefore, we have not prepared a regulatory flexibility analysis or an analysis of the effects of this rule on small rural hospitals.

In accordance with the provisions of Executive Order 12866, this final rule was not reviewed by the Office of Management and Budget.

This is not a major rule as defined by U.S.C. 804(2).

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

List of Subjects in 42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

Subpart D—Apportionment

2. Section 413.53 is amended by revising paragraph (a)(1)(ii)(C) and (a)(2); under paragraph (b), definition of ''average cost per diem for general routine services'', paragraph (2) is revised; the definition of ''ICF-type services'' is removed; a new definition of ''nursing facility (NF) type services'' is added; and the definition of ''SNF-type services'' is revised, to read as follows:

§ 413.53 Determination of cost of services to beneficiaries.

(a) Principle. * * *

(1) *Departmental method*

* * * * *

(ii) *Exception: Indirect cost of private rooms.* For cost reporting periods starting on or after October 1, 1982, except with respect to a hospital receiving payment under part 412 of this chapter (relating to the prospective payment system), the additional cost of furnishing services in private room accommodations is apportioned to Medicare only if these accommodations are furnished to program beneficiaries, and are medically necessary. To determine routine service cost applicable to beneficiaries—

* * * * *

(C) Effective October 1, 1990, do not include private rooms furnished for SNF-type and NF-type services under the swing-bed provision in the number of days in paragraphs (a)(1)(ii)(A) and (B) of this section.

(2) *Carve-out out method*—(i) The carve-out out method is used to allocate hospital inpatient general routine service costs in a participating swing-bed hospital, as defined in § 413.114(b). Under this method, effective for services furnished on or after October 1, 1990, the reasonable costs attributable to the inpatient routine SNF-type and NF-type services furnished to all classes of patients are subtracted from total inpatient routine service costs before computing the average cost per diem for inpatient routine hospital care.

(ii) The cost per diem attributable to the routine SNF-type services covered by Medicare is based on the regional Medicare swing-bed SNF rate in effect for a given calendar year, as described in § 413.114(c). The Medicare SNF rate applies only to days covered and paid as Medicare days. When Medicare coverage runs out, the Medicare rate no longer applies.

(iii) The cost per diem attributable to all non-Medicare swing-bed days is based on the average statewide Medicaid NF rate for the prior calendar year, adjusted to approximate the average NF rate for the current calendar year.

(iv) The sum of total Medicare SNF-type days multiplied by the cost per diem attributable to Medicare SNF-type services and the total NF-type days multiplied by the cost per diem attributable to all non-Medicare days is subtracted from total inpatient general routine service costs. The cost per diem for inpatient routine hospital care is computed based on the remaining inpatient routine service costs.

* * * * *

(b) *Definitions.* As used in this section—

* * * * *

Average cost per diem for general routine services means the following:

* * * * *

(2) For swing-bed hospitals, the amount computed by—(i) Subtracting the routine costs associated with Medicare SNF-type days and non-Medicare NF-type days from the total allowable inpatient cost for routine services (excluding the cost of services provided in intensive care units, coronary care units, and other intensive care type inpatient hospital units and nursery costs); and

(ii) Dividing the remainder (excluding the total private room cost differential) by the total number of inpatient hospital days of care (excluding Medicare SNF-type days and non-Medicare NF-type days of care, days of care in intensive care units, coronary care units, and other intensive care type inpatient hospital units; and newborn days; but including total private room days).

* * * * *

Nursing facility (NF)-type services, formerly known as ICF and SNF-type services, are routine services furnished by a swing-bed hospital to Medicaid and other non-Medicare patients. Under the Medicaid program, effective October 1, 1990, facilities are no longer certified as SNFs or ICFs but instead are certified only as NFs and can provide services as defined in section 1919(a)(1) of the Act.

* * * * *

Skilled nursing facility (SNF)-type services are routine services furnished by a swing-bed hospital that would constitute extended care services if furnished by an SNF. SNF-type services include routine SNF services furnished in the distinct part SNF of a hospital complex that is combined with the hospital general routine service area cost center under § 413.24(d)(5). Effective October 1, 1990, only Medicare covered services are included in the definition of SNF-type services.

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Subpart F—Specific Categories of Costs

3. In § 413.114, paragraphs (c)(1) and (2) are removed, paragraph (c)(3) is redesignated as paragraph (c)(2), and a new paragraph (c)(1) is added to read as follows:

§ 413.114 Payment for posthospital SNF care furnished by a swing-bed hospital.

* * * * *

(c) *Principle.* The reasonable cost of posthospital SNF care furnished by a swing-bed hospital is determined as follows:

(1) The reasonable cost of routine SNF services is based on the average Medicare rate per patient day for routine services provided in freestanding SNFs in the region where the swing-bed hospital is located. The rates are calculated using the regions as defined in section 1886(d)(2)(D) of the Social Security Act. The rates are based on the most recent year for which settled cost reporting period data are available, increased in a compounded manner, using the increase applicable to the SNF routine cost limits, up to and including the calendar year for which the rates are in effect. If the current Medicare swing-bed rate for routine extended care services furnished by a swing-bed

hospital during a calendar year is less than the rate for the prior calendar year, payment is made based on the prior calendar year's rate.

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(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance;) Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: September 3, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

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