

§ 412.23 Excluded hospitals: Classifications.

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(e) *Long-term care hospitals.* * * *(3) *Calculation of average length of stay.* * * *

(ii) If a change in the hospital's Medicare average length of stay is indicated, the calculation is made by the same method for the period of at least 5 months of the immediately preceding 6-month period.

(iii) If a hospital has undergone a change of ownership (as described in § 489.18 of this chapter) at the start of a cost reporting period or at any time within the period of at least 5 months of the preceding 6-month period, the hospital may be excluded from the prospective payment system as a long-term care hospital for a cost reporting period if, for the period of at least 5 months of the 6 months immediately preceding the start of the period (including time before the change of ownership), the hospital has the required Medicare average length of stay, continuously operated as a hospital, and continuously participated as a hospital in Medicare.

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§ 412.25 [Amended]

5. In § 412.25(e)(4), introductory text, the reference "paragraph (h)(3) of this section" is revised to read "paragraph (e)(3) of this section".

6. Section 412.87 is amended by revising paragraph (b)(3) to read as follows:

§ 412.87 Additional payment for new medical services and technologies: General provisions.

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(b) *Eligibility criteria.* * * *

(3) The DRG prospective payment rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate, based on application of a threshold amount to estimated charges incurred with respect to such discharges. To determine whether the payment would be adequate, CMS will determine whether the charges of the cases involving a new medical service or technology will exceed a threshold amount set at 75 percent of one standard deviation beyond the geometric mean standardized charge for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs if the new medical service or technology occurs in many different DRGs). Standardized charges reflect the actual charges of a case adjusted by the prospective payment system payment

factors applicable to an individual hospital, such as the wage index, the indirect medical education adjustment factor, and the disproportionate share adjustment factor.

7. Section 412.105 is amended by—

A. In paragraph (a)(1), introductory text, revising the phrase "paragraph (f) of this section" to read "paragraphs (f) and (h) of this section".

B. In paragraph (a)(1)(i), revising the phrase "affiliated groups" to read "Medicare GME affiliated groups".

C. Revising paragraph (b).

D. Adding a sentence at the end of paragraph (f)(1)(v).

E. In paragraph (f)(1)(vi), revising the phrase "affiliated group" to read "Medicare GME affiliated group".

F. Revising paragraph (f)(1)(x).

The revisions and additions read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

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(b) *Determination of number of beds.*

For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period. This count excludes bed days associated with—

(1) Beds in any other units or wards where the level of care provided would not be payable under the acute care hospital inpatient prospective payment system;

(2) Beds in units unoccupied for the previous 3 months;

(3) Beds that could not be made available for inpatient occupancy within 24 hours.

(4) Beds in excluded distinct part hospital units;

(5) Beds otherwise countable under this section used for outpatient observation services (unless the patient is subsequently admitted for acute inpatient care), skilled nursing swing-bed services, or ancillary labor/delivery services;

(6) Beds or bassinets in the healthy newborn nursery; and

(7) Custodial care beds;

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(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.* (1) * * *

(v) * * * Subject to the provisions of paragraph (f)(1)(x) of this section, effective for cost reporting periods beginning on or after April 1, 2000, FTE residents in a rural track program are included in the urban hospital's rolling

average calculation described in this paragraph (f)(1)(v).

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(x) An urban hospital that establishes a new residency program (as defined in § 413.86(g)(13) of this subchapter), or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks in accordance with the applicable provisions of § 413.86(g)(12) of this subchapter effective for discharges occurring on or after April 1, 2002 and before October 1, 2003, and the applicable provisions of § 413.86(g)(12) of this subchapter effective for discharges occurring on or after October 1, 2003.

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7. Section 412.106 is amended by revising paragraphs (a)(1)(ii) and (b)(4)(i) to read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(a) General considerations. (1) * * *

(ii) For purposes of this section, the number of patient days in a hospital includes only those days attributable to units or wards of the hospital providing acute care services generally payable under the prospective payment system and excludes patient days associated with—

(A) Beds in excluded distinct part hospital units;

(B) Beds otherwise countable under this section used for outpatient observation services (unless the patient is subsequently admitted for acute inpatient care), skilled nursing swing-bed services, or ancillary labor/delivery services; and

(C) Beds in any other units or wards where the level of care provided would not be payable under the acute care hospital inpatient prospective payment system.

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(b) *Determination of a hospital's disproportionate payment percentage.* * * *

(4) *Second computation.* * * *

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

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