

noncovered days of stay for Medicare patients) as calculated under the criteria of § 412.23(e)(3). In calculating this average Medicare inpatient length of stay, data from the hospital's most recently filed cost report are used to make this determination. However, if the hospital has not yet filed a cost report or if there is an indication that the most recently filed cost report does not accurately reflect the hospital's current Medicare average length of stay, data from the most recent 6-month period are used.

Our interpretation of § 412.23(e)(3)(ii) and (e)(3)(iii) was to allow hospitals that submit data for purposes of exclusion from the IPPS to use a period of at least 5 months of the most recent data from the preceding 6-month period. This longstanding policy interpretation was necessary in order to comply with the time requirement in § 412.22(d) that specifies that, for purposes of the IPPS, status is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Therefore, in the May 19, 2003 proposed rule, we proposed to revise §§ 412.23(e)(3)(ii) and (iii) to reflect our longstanding interpretation of the regulations.

*Comment:* One commenter suggested that we clarify the source of our data for computing the average length of stay for purposes of designation as a LTCH.

*Response:* Although we did not propose any policy change regarding the average length of stay calculation, we did describe the data source for this calculation, which is set forth at § 412.23(e)(3). Therefore, we will take this opportunity to correct an inadvertent misstatement of the data source for this calculation and clarify present data collection procedures. In the proposed rule, we stated that we relied on data from a “. . . hospital's most recently filed cost report . . .” for determining whether it qualified as a LTCH. However, the regulation does not specify or require that the hospital's cost report (Hospital and Hospital Health Care Complex Cost Report, CMS Form 2552–96) be the source of these data used in the determination for LTCH classification. Specifically, the regulation only notes that the calculation requires dividing the total Medicare inpatient days by the total number of Medicare discharges occurring for the *hospital's most recent complete cost reporting period* (§ 412.23(e)(3)). (A detailed description of the designation process is included in the August 30, 2002 IPPS final rule (67 FR 55970 through 55974).)

Prior to the October 1, 2002 implementation of the LTCH

prospective payment system, we did rely on data from the most recently *submitted* cost report for this purpose. In addition, the calculation, for purposes of qualifying as a LTCH, was based on total days and discharges for all LTCH inpatients. However, with the implementation of the LTCH PPS, we revised § 412.23(e)(3)(i) to only count total days and discharges for Medicare inpatients (67 FR 55970, August 30, 2002). Presently, we are unable to capture these data on our present cost reporting forms. Therefore, until the cost reporting form is revised, for purposes of the average length of stay calculation, we will be relying upon patient census data extracted from MedPAR files that reflect each LTCH's cost reporting period. Fiscal intermediaries and LTCHs have been informed of this course of action through official agency transmittals, but we want to emphasize that this temporary shift in data sources should have no effect on the evaluation policy set forth in regulations at §§ 412.22(d) and 412.23(e)(3) and the procedures described in the August 30, 2002 final rule.

#### *D. Criteria for Payment on a Reasonable Cost Basis for Clinical Diagnostic Laboratory Services Performed by CAHs*

Section 1820 of the Act provides for the establishment of Medicare Rural Hospital Flexibility Programs, under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participation in 42 CFR Part 485, Subpart F, will be certified as CAHs by CMS. Section 1834(g) of the Act states that the amount of payment for outpatient services furnished by a CAH will be the reasonable costs of the CAH in providing these services.

Regulations implementing section 1834(g) of the Act are set forth at § 413.70. These regulations state, in paragraph (b)(2)(iii), that payment to a CAH for outpatient clinical diagnostic laboratory tests will be made on a reasonable cost basis only if the individuals for whom the tests are performed are outpatients of the CAH, as defined in § 410.2, at the time the specimens are collected. The regulations also state that clinical diagnostic laboratory tests for persons who are not patients of the CAH at the time the specimens are collected will be paid for in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act. These provisions, which also are the basis for payment for clinical diagnostic laboratory tests performed by independent laboratories and by

hospitals on specimens drawn at other locations, set payment at the least of: (1) charges determined under the fee schedule as set forth in section 1833(h)(1) or section 1834(d)(1) of the Act; (2) the limitation amount for that test determined under section 1833(h)(4)(B) of the Act; or (3) a negotiated rate established under section 1833(h)(6) of the Act. Payments determined under this methodology are typically referred to as “fee schedule payments,” and are so described here both for ease of reference and to differentiate them from payments determined on a reasonable cost basis.

The definition of an “outpatient” in § 410.2 states that an outpatient means a person who has not been admitted as an inpatient but who is registered on hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

Recently, we have received numerous questions about how Medicare pays for laboratory services that a CAH may furnish to Medicare beneficiaries in various settings other than the CAH. Specifically, the questioners have asked whether a CAH may obtain reasonable cost payment for such services to individuals in other locations by sending a CAH employee into the setting and registering the individual as a CAH patient while the blood is drawn or other specimen collection is accomplished. The settings that have been referred to most frequently are: (1) a rural health clinic (RHC), especially one that is provider-based with respect to the CAH; (2) the individual's home; and (3) an SNF.

We have considered these suggestions and understand the position taken by those who believe that nominal compliance with the requirements for outpatient status should be enough to warrant reasonable cost payment for clinical diagnostic laboratory tests for individuals at locations outside the CAH. However, we do not agree that providing reasonable cost payment under these circumstances would be appropriate. On the contrary, we believe that extending reasonable cost payment for services furnished to individuals who are not at the CAH when the specimen is drawn would duplicate existing coverage, create confusion for beneficiaries and others by blurring the distinction between CAHs and other providers, such as SNFs and HHAs, and increase the costs of care to Medicare patients without enhancing either the quality or the availability of that care.

To clarify our policies in this area and avoid possible misunderstandings about the scope of the CAH benefit, in the May