

Dated: April 10, 1996.  
 Felicia Marcus,  
*Regional Administrator.*  
 [FR Doc. 96-9848 Filed 4-19-96; 8:45 am]  
 BILLING CODE 6560-50-P

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Health Care Financing Administration

#### 42 CFR Part 413

[BPD-805-P]

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:** Proposed Rule.

**SUMMARY:** This proposed rule would revise 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 proposed rule would revise 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.

**DATES:** Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on June 21, 1996.

**ADDRESSES:** Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD-805-P, P.O. Box 7517, Baltimore, MD 21207.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201, or

Room C5-09-26, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code BPD-805-P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309-G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690-7890).

**FOR FURTHER INFORMATION CONTACT:** Katie Walker (410) 786-7278.

#### SUPPLEMENTARY INFORMATION:

##### I. Background

Frequently, hospitals participating in Medicare and Medicaid, particularly those located in rural areas, have provided both inpatient acute and long-term care in the same facility. However, Medicaid regulations at 42 CFR 440.40 require that long-term care be provided in a separately identifiable "distinct-part" unit.

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 are thus permitted to vary the level of care they provide in response to changing patient needs by using the same bed to furnish hospital services at one time and SNF services at another.

Hospitals with approved swing-bed programs that furnished long-term care services 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.

Specifically, section 1883(d) of the Act states that Medicare payment for SNF services furnished by hospitals with more than 49 beds but fewer than 100 beds may not be made either for: (1) extended care services that are furnished to a swing-bed hospital SNF patient more than 5 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 5-day period that the transfer of the patient is not medically appropriate; or (2) days of SNF care in a cost reporting period once Medicare covered days of SNF care exceed 15 percent of the product of the number of days in the period and the average number of licensed beds in the hospital during that period. Payment will, however, continue to be made for patients who are receiving SNF care at the time the limit is reached.

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) would no longer be used for the purpose of certifying a facility for the Medicaid program. Instead, they would be replaced by the term "nursing facility" (NF). Before that date, under the Medicaid program, a swing-bed hospital could furnish SNF-type, as well as ICF-type, services to non-Medicare patients. Now, the NF level of care encompasses services that were previously known as SNF-type and ICF-type services. 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" 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 This Proposed Rule

### A. New Payment Rate Methodology

In accordance with section 1883 of the Act, as amended by section 4008(j) of OBRA 1990, this proposed rule would implement in regulations a revised methodology for Medicare payment of routine SNF services provided in a swing-bed hospital. Presently, under § 413.114(c)(1), the reasonable cost of routine SNF services is based on the average Statewide rate per patient day paid under the State Medicaid plan for routine services furnished by SNFs in that State during the previous calendar year. Under this proposed rule, Medicare payment to a swing-bed hospital for routine 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.

The rates applicable to calendar years 1990 through 1994, listed below, have been published in section 2231 of the Provider Reimbursement Manual (HCFA Pub. 15-1). We will continue to publish annual updates in that manual.

Section B below describes the methodology for calculating the Medicare swing-bed rates. Tables A through E provide the Medicare swing-bed 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. (These rates were applied beginning October 1, 1990. Implementation of the rates was accomplished by means of HCFA administrative issuances, as addressed above.) If there are additional changes in the methodology, these revisions would be published through notice and comment rulemaking in the Federal Register.

In accordance with section 4008(j)(2) of OBRA 1990, this proposed rule also includes 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.

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

1. *Data*—In developing the Medicare payment rates for swing-bed care, we use 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.

2. *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 note 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 <sup>1</sup>
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

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

Region	Routine payment	Return on equity <sup>1</sup>
9. Pacific (AK, CA, HI, OR, WA) .....	86.73	1.07

<sup>1</sup> 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 <sup>2</sup>
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

<sup>2</sup> The return on equity component is included only in the rate paid to proprietary 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 <sup>3</sup>
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

<sup>3</sup> 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 <sup>4</sup>
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

<sup>4</sup> 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

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

Region	Routine payment
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

### C. 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.

This proposed rule would revise § 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 would be 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, would be 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 would be 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 would be used for non-Medicare covered swing-bed days because such services may encompass services that were formerly known as ICF and SNF-type services.)

### D. 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. Impact Statement

For proposed 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 proposed 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 areas, 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 proposed rule would revise the regulations to incorporate a new methodology for payment of routine extended care services provided in a swing-bed hospital. As the statute specifies, we are proposing that Medicare payment for these services be 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 proposed rule would also provide 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 proposing a change to the carve 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 method as described in § 413.53(a)(2) for computing costs associated with routine SNF and ICF-type services cannot be used. This proposed rule would codify in regulations existing policy concerning the carve out method as set forth in section 2230.5B of the Provider Reimbursement Manual.

As noted above, the major provisions of this proposed 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 proposed regulations 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 method. Codifying this existing policy would have no economic impact.

Thus, we have determined, and we certify, that this proposed rule would 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 proposed rule was not reviewed by the Office of Management and Budget.

#### IV. 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 1980 (44 U.S.C. 3501 et seq.).

#### V. Response to Comments

Because of the large number of items of correspondence we normally receive on Federal Register documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

#### 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.* \* \* \*

(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 method*—(i) The carve 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.* \* \* \*

*Average cost per diem for general routine services* \* \* \*

(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.

\* \* \* \* \*

#### 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.* \* \* \*

(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.

\* \* \* \* \*

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

Note: This document received at the Office of the Federal Register on April 11, 1996.

Dated: September 29, 1995.

Bruce C. Vladeck,

*Administrator, Health Care Financing Administration.*

[FR Doc. 96-9347 Filed 4-19-96; 8:45 am]

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## DEPARTMENT OF TRANSPORTATION

### Surface Transportation Board

#### 49 CFR Part 1313

[STB Ex Parte No. 541]

#### Railroad Contracts

**AGENCY:** Surface Transportation Board.

**ACTION:** Advance notice of proposed rulemaking; extension of comment due date.

**SUMMARY:** The original comment due date in this proceeding of April 25, 1996, is extended to May 28, 1996, at the request of the National Grain and Feed Association (NGFA), the Association of American Railroads (AAR), and the National Industrial Transportation League (NITL). This proceeding solicited suggestions from the transportation community for appropriate regulations to implement the new rail contract provisions.

**DATES:** Comments are due on May 28, 1996.

**ADDRESSES:** Send comments (an original and 10 copies) referring to STB Ex Parte No. 541 to: Surface Transportation Board, Office of the Secretary, Case Control Branch, 1201 Constitution Avenue NW., Washington, DC 20423.

**FOR FURTHER INFORMATION CONTACT:** Beryl Gordon, (202) 927-5610. [TDD for the hearing impaired: (202) 927-5721.]

**SUPPLEMENTARY INFORMATION:** On March 26, 1996, an advance notice of proposed rulemaking (ANPR) was served and published in the Federal Register, at 61 FR 13147-13148, soliciting suggestions from the transportation community for

appropriate regulations to implement the new rail contract provisions of 49 U.S.C. 10709. On April 15, 1996, a joint request was filed by NGFA, AAR, and NITL, requesting an extension of the comment due date until May 28, 1996, to give shipper and carrier organizations the opportunity to reach negotiated agreements regarding issues relevant to the proceeding.

In the ANPR, the various sectors of the transportation community were encouraged to discuss the issues and present a proposal for consideration. The jointly filed extension request is in keeping with that encouragement. Accordingly, the due date for comments will be extended to May 28, 1996.

Decided: April 16, 1996.

By the Board, Linda J. Morgan, Chairman.  
Vernon A. Williams,  
*Secretary.*

[FR Doc. 96-9790 Filed 4-19-96; 8:45 am]

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## DEPARTMENT OF COMMERCE

### National Oceanic and Atmospheric Administration

#### 50 CFR Part 625

[Docket No. 960412110-6110-01; I.D. 030596E]

RIN 0648-A193

#### Summer Flounder Fishery; Proposed 1996 Recreational Fishery Management Measures

**AGENCY:** National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

**ACTION:** Proposed rule; request for comments.

**SUMMARY:** NMFS issues this proposed rule to amend the regulations implementing the Fishery Management Plan for the Summer Flounder Fishery (FMP). This rule proposes a possession limit of eight fish per person and a minimum fish size of 14 inches (35.6 cm) for the 1996 summer flounder recreational fishery. The intent of this action is to comply with implementing regulations for the fishery that require NMFS to publish measures for the upcoming fishing year that will prevent overfishing of the resource.

**DATES:** Public comments on this proposed rule must be received on or before May 17, 1996.

**ADDRESSES:** Comments should be sent to: Director, Northeast Region, NMFS, One Blackburn Drive, Gloucester, MA 01930.