

services, furnished to the HMO's or CMP's Medicare enrollees, as provided under part 417 of this chapter.

(d) Effective for cost reporting periods beginning on or after October 1, 2002, covered inpatient hospital services furnished to Medicare beneficiaries by a long-term care hospital that meets the conditions for payment of §§ 412.505 through 412.511 are paid under the prospective payment system described in subpart O of this part.

(e) Inpatient hospital services will not be paid under the prospective payment systems specified in § 412.1(a)(1) under any of the following circumstances:

(1) The services are furnished by a hospital (or hospital unit) explicitly excluded from the prospective payment systems under §§ 412.23, 412.25, 412.27, and 412.29.

(2) The services are emergency services furnished by a nonparticipating hospital in accordance with § 424.103 of this chapter.

(3) The services are paid for by an HMO or competitive medical plan (CMP) that elects not to have CMS make payments directly to a hospital for inpatient hospital services furnished to the HMO's or CMP's Medicare enrollees, as provided in § 417.240(d) and § 417.586 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 53 FR 6648, Mar. 2, 1988; 57 FR 39820, Sept. 1, 1992; 59 FR 45400, Sept. 1, 1994; 66 FR 41386, Aug. 7, 2001; 67 FR 56048, Aug. 30, 2002; 68 FR 45698, Aug. 1, 2003; 69 FR 66976, Nov. 15, 2004]

§ 412.22 Excluded hospitals and hospital units: General rules.

(a) *Criteria.* Subject to the criteria set forth in paragraph (e) of this section, a hospital is excluded from the prospective payment systems specified in § 412.1(a)(1) of this part if it meets the criteria for one or more of the excluded classifications described in § 412.23. For purposes of this subpart, the term "hospital" includes a critical access hospital (CAH).

(b) *Cost reimbursement.* Except for those hospitals specified in paragraph (c) of this section, and § 412.20(b), (c), and (d), all excluded hospitals (and excluded hospital units, as described in § 412.23 through § 412.29) are reimbursed under the cost reimbursement rules set

forth in part 413 of this chapter, and are subject to the ceiling on the rate of hospital cost increases as specified in § 413.40 of this chapter.

(c) *Special payment provisions.* The following classifications of hospitals are paid under special provisions and therefore are not generally subject to the cost reimbursement or prospective payment rules of this chapter.

(1) Veterans Administration hospitals.

(2) Hospitals reimbursed under State cost control systems approved under part 403 of this chapter.

(3) Hospitals reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U.S.C. 1395b-1 (note)).

(4) Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

(d) *Changes in hospitals' status.* For purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of the hospital are made only at the start of a cost reporting period.

(e) *Hospitals-within-hospitals.* Except as provided in paragraph (f) of this section, a hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1):

(1) Except as specified in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997—

(i) *Separate governing body.* The hospital has a governing body that is separate from the governing body of the hospital occupying space in the same building or on the same campus. The hospital's governing body is not under the control of the hospital occupying space in the same building or on the

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same campus, or of any third entity that controls both hospitals.

(ii) *Separate chief medical officer.* The hospital has a single chief medical officer who reports directly to the governing body and who is responsible for all medical staff activities of the hospital. The chief medical officer of the hospital is not employed by or under contract with either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(iii) *Separate medical staff.* The hospital has a medical staff that is separate from the medical staff of the hospital occupying space in the same building or on the same campus. The hospital's medical staff is directly accountable to the governing body for the quality of medical care provided in the hospital, and adopts and enforces by-laws governing medical staff activities, including criteria and procedures for recommending to the governing body the privileges to be granted to individual practitioners.

(iv) *Chief executive officer.* The hospital has a single chief executive officer through whom all administration authority flows, and who exercises control and surveillance over all administrative activities of the hospital. The chief executive officer is not employed by, or under contract with, either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(v) *Performance of basic hospital functions.* The hospital meets one of the following criteria:

(A) The hospital performs the basic functions specified in §§ 482.21 through 482.27, 482.30, 482.42, 482.43, and 482.45 of this chapter through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or on the same campus, or a third entity that controls both hospitals. Food and dietetic services and housekeeping, maintenance, and other services necessary to maintain a clean and safe physical environment could be obtained under contracts or other agreements with the hospital occupying space in the same building or

on the same campus, or with a third entity that controls both hospitals.

(B) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of patients in § 412.23(d)(2) or the length-of-stay criterion in § 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for a period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the cost of the services that the hospital obtains under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals, is no more than 15 percent of the hospital's total inpatient operating costs, as defined in § 412.2(c). For purposes of this paragraph (e)(1)(v)(B), however, the costs of preadmission services are those specified under § 413.40(c)(2) rather than those specified under § 412.2(c)(5).

(C) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of inpatients in § 412.23(d)(2) or the length-of-stay criterion in § 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for the period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the hospital has an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same building or on the same campus.

(2) Effective for long-term care hospitals-within-hospitals for cost reporting periods beginning on or after October 1, 2004, the hospital must meet the governance and control requirements at paragraphs (e)(1)(i) through (e)(1)(iv) of this section.

(3) *Notification of co-located status.* A long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (e)(1) or (e)(2) of this section must notify its fiscal intermediary and CMS in writing of its co-location and

identify by name, address, and Medicare provider number those hospital(s) with which it is co-located.

(f) *Application for certain hospitals.* Except as provided in paragraph (f)(3) of this section, if a hospital was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital, the criteria in paragraph (e) of this section do not apply to the hospital as long as the hospital—

(1) Continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment in effect on September 30, 1995; or

(2) In the case of a hospital that changes the terms and conditions under which it operates after September 30, 1995, but before October 1, 2003, continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment in effect on September 30, 2003.

(3) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (f)(1) or (f)(2) of this section, any hospital that was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital may increase or decrease the square footage or decrease the number of beds considered to be part of the hospital at any time without affecting the provisions of paragraph (f)(1) or (f)(2) of this section.

(i) If a hospital to which the provisions of paragraph (f)(1) of this section applies decreases its number of beds below the number of beds considered to be part of the hospital on September 30, 1995, it may subsequently increase the number of beds at any time as long

as the resulting total number of beds considered to be part of the hospital does not exceed the number of beds at the hospital on September 30, 1995.

(ii) If a hospital to which the provisions of paragraph (f)(2) of this section applies decreases its number of beds below the number of beds considered to be part of the hospital on September 30, 2003, it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the hospital does not exceed the number of beds at the hospital on September 30, 2003.

(g) *Definition of control.* For purposes of this section, control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(h) *Satellite facilities.* (1) For purposes of paragraphs (h)(2) through (h)(5) of this section, a satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Except as provided in paragraphs (h)(3), (h)(4), (h)(5), (h)(7) and (h)(8) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

(i) In the case of a hospital (other than a children's hospital) that was excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the hospital's number of State-licensed and Medicare-certified beds, including those at the satellite facilities, does not exceed the hospital's number of State-licensed and Medicare-certified beds on the last day of the hospital's last cost reporting period beginning before October 1, 1997.

(ii) The satellite facility independently complies with—

(A) For psychiatric hospitals, the requirements under § 412.23(a);

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(B) For rehabilitation hospitals, the requirements under § 412.23(b)(2);

(C) For the children's hospitals, the requirements under § 412.23(d)(2); or

(D) For long-term care hospitals, the requirements under §§ 412.23(e)(1) through (e)(3)(i).

(iii) The satellite facility meets all of the following requirements:

(A) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical officer of the hospital in which it is located.

(B) It maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.

(C) It has beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located.

(D) It is serviced by the same fiscal intermediary as the hospital of which it is a part.

(E) It is treated as a separate cost center of the hospital of which it is a part.

(F) For cost reporting and apportionment purposes, it uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.

(G) It reports its costs on the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.

(3) Except as provided in paragraphs (h)(4) and (h)(5) of this section, the provisions of paragraph (h)(2) of this section do not apply to—

(4) For cost reporting periods beginning before October 1, 2006, in applying the provisions of paragraph (h)(3) of this section, any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility if these changes

are made necessary by relocation of a facility—

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(5) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (h)(3) of this section—

(i) Any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage or decrease the number of beds considered to be part of the satellite facility at any time without affecting the provisions of paragraph (h)(3) of this section; and

(ii) If the satellite facility decreases its number of beds below the number of beds considered to be part of the satellite facility on September 30, 1999, it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the satellite facility does not exceed the number of beds at the satellite facility on September 30, 1999.

(6) *Notification of co-located status.* A satellite of a long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (h)(1) through (h)(5) of this section must notify its fiscal intermediary and CMS in writing of its collocation and identify by name, address, and Medicare provider number, those hospital(s) with which it is co-located.

(7) The provisions of paragraph (h)(2)(i) of this section do not apply to any long-term care hospital that is subject to the long-term care hospital prospective payment system under Subpart O of this subpart, effective for cost reporting periods occurring on or after October 1, 2002, and that elects to be paid based on 100 percent of the Federal prospective payment rate as specified in § 412.533(c), beginning with the first cost reporting period following that election, or when the LTCH is fully transitioned to 100 percent of the Federal prospective rate, or to a new

long-term care hospital, as defined in § 412.23(e)(4).

(8) The provisions of paragraph (h)(2)(i) of this section do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of this part, effective for cost reporting periods beginning on or after October 1, 2003.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 57 FR 39820, Sept. 1, 1994; 62 FR 46026, Aug. 29, 1997; 63 FR 26357, May 12, 1998; 64 FR 41540, July 30, 1999; 66 FR 41386, Aug. 7, 2001; 67 FR 50111, Aug. 1, 2002; 67 FR 56048, Aug. 30, 2002; 68 FR 10988, Mar. 7, 2003; 68 FR 34162, June 6, 2003; 68 FR 45469, Aug. 1, 2003; 69 FR 49240, Aug. 11, 2004; 69 FR 60252, Oct. 7, 2004; 69 FR 66976, Nov. 15, 2004; 70 FR 24222, May 6, 2005; 71 FR 48136, Aug. 18, 2006]

§ 412.23 Excluded hospitals: Classifications.

Hospitals that meet the requirements for the classifications set forth in this section are not reimbursed under the prospective payment systems specified in § 412.1(a)(1):

(a) *Psychiatric hospitals.* A psychiatric hospital must—

(1) Meet the following requirements to be excluded from the prospective payment system as specified in § 412.1(a)(1) and to be paid under the prospective payment system as specified in § 412.1(a)(2) and in subpart N of this part;

(2) Be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and

(3) Meet the conditions of participation for hospitals and special conditions of participation for psychiatric hospitals set forth in part 482 of this chapter.

(b) *Rehabilitation hospitals.* A rehabilitation hospital must meet the following requirements to be excluded from the prospective payment systems specified in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(3) and in Subpart P of this part:

(1) Have a provider agreement under part 489 of this chapter to participate as a hospital.

(2) Except in the case of a newly participating hospital seeking classification under this paragraph as a rehabilitation hospital for its first 12-month cost reporting period, as described in paragraph (b)(8) of this section, a hospital must show that during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the fiscal intermediary), it served an inpatient population that meets the criteria under paragraph (b)(2)(i) or (b)(2)(ii) of this section.

(i) For cost reporting periods beginning on or after July 1, 2004 and before July 1, 2005, the hospital has served an inpatient population of whom at least 50 percent, and for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2007, the hospital has served an inpatient population of whom at least 60 percent, and for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008, the hospital has served an inpatient population of whom at least 65 percent required intensive rehabilitative services for treatment of one or more of the conditions specified at paragraph (b)(2)(iii) of this section. A patient with a comorbidity, as defined at § 412.602, may be included in the inpatient population that counts toward the required applicable percentage if—

(A) The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified in paragraph (b)(2)(iii) of this section;

(B) The patient has a comorbidity that falls in one of the conditions specified in paragraph (b)(2)(iii) of this section; and

(C) The comorbidity has caused significant decline in functional ability in the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under subpart P of this part and that cannot be appropriately performed in another care setting covered under this title.

(ii) For cost reporting periods beginning on or after July 1, 2008, the hospital has served an inpatient population of whom at least 75 percent required intensive rehabilitative services