§ 412.86 Payment for extraordinarily high-cost day outliers.

For discharges occurring before October 1, 1997, if a discharge that qualifies for an additional payment under the provisions of §412.82 has charges adjusted to costs that exceed the cost outlier threshold criteria for an extraordinarily high-cost case as set forth in §412.80(a)(1)(ii), the additional payment made for the discharge is the greater of—

(a) The applicable per diem payment computed under §412.82(c) or (d); or

(b) The payment that would be made under §412.84(i) or (j) if the case had not met the day outlier criteria threshold set forth in §412.80(a)(1)(i).


Subpart G—Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Operating Costs

§ 412.90 General rules.

(a) Sole community hospitals. HCFA may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries. If a hospital meets the criteria for such an exception under §412.92(a), its prospective payment rates for inpatient operating costs are determined under §412.92(d).

(b) Referral center. HCFA may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital acts as a referral center for patients transferred from other hospitals. Criteria for identifying such referral centers are set forth in §412.96.

(c) [Reserved]

(d) Kidney acquisition costs incurred by hospitals approved as renal transplantation centers. HCFA pays for kidney acquisition costs incurred by renal transplantation centers on a reasonable cost basis. The criteria for this special payment provision are set forth in §412.100.

(e) Hospitals located in areas that are reclassified from urban to rural. (1) HCFA adjusts the rural Federal payment amounts for inpatient operating costs for hospitals located in geographic areas that are reclassified from urban
Health Care Financing Administration, HHS  

§ 412.92

(2) HCFA establishes a procedure by which certain individual hospitals located in urban areas may apply for reclassification as rural. The criteria for reclassification are set forth in § 412.103.

(f) Hospitals that have a high percentage of ESRD beneficiary discharges. HCFA makes an additional payment to a hospital if ten percent or more of its total Medicare discharges in a cost reporting period beginning on or after October 1, 1984 are ESRD beneficiary discharges. In determining ESRD discharges, discharges in DRG Nos. 302, 316, and 317 are excluded. The criteria for this additional payment are set forth in § 412.104.

(g) Hospitals that incur indirect costs for graduate medical education programs. HCFA makes an additional payment for inpatient operating costs to a hospital for indirect medical education costs attributable to an approved graduate medical education program. The criteria for this additional payment are set forth in § 412.105.

(h) Hospitals that serve a disproportionate share of low-income patients. For discharges occurring on or after May 1, 1986, HCFA makes an additional payment for inpatient operating costs to hospitals that serve a disproportionate share of low-income patients. The criteria for this additional payment are set forth in § 412.106.

(i) Hospitals that receive an additional update for FYs 1998 and 1999. For FYs 1998 and 1999, HCFA makes an upward adjustment to the standardized amounts for certain hospitals that do not receive indirect medical education or disproportionate share payments and are not Medicare-dependent, small rural hospitals. The criteria for identifying these hospitals are set forth in § 412.107.

(j) Medicare-dependent, small rural hospitals. For cost reporting periods beginning on or after April 1, 1990 and before October 1, 1994, or beginning on or after October 1, 1997 and before October 1, 2006, HCFA adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part if a hospital is classified as a Medicare-dependent, small rural hospital.

(k) Essential access community hospitals (EACHs). If a hospital was designated as an EACH by HCFA as described in § 412.109(a) and is located in a rural area as defined in § 412.109(b), HCFA determines the prospective payment rate for that hospital, as it does for sole community hospitals, under § 412.92(d).


§ 412.92 Special treatment: Sole community hospitals.

(a) Criteria for classification as a sole community hospital. HCFA classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in § 412.83(b)) and meets one of the following conditions:

(1) The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:

(i) No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital’s service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area;

(ii) The hospital has fewer than 50 beds and the intermediary certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital;

(iii) Because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(2) The hospital is located between 15 and 25 miles from other like hospitals...
but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

(b) Classification procedures. (1) Request for classification as sole community hospital. (i) The hospital must make its request to its fiscal intermediary.

(ii) If a hospital is seeking sole community hospital classification under paragraph (a)(1)(i) or (a)(1)(ii) of this section, the hospital must include the following information with its request:

(A) The hospital must provide patient origin data (for example, the number of patients from each zip code from which the hospital draws inpatients) for all inpatient discharges to document the boundaries of its service area.

(B) The hospital must provide patient origin data from all other hospitals located within a 35 mile radius of it or, if larger, within its service area, to document that no more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital’s service area and hospitalized for inpatient care were admitted to other like hospitals for care.

(iii)(A) If the hospital is unable to obtain the information required under paragraph (b)(1)(i)(A) of this section concerning the residences of Medicare beneficiaries who were inpatients in other hospitals located within a 50 mile radius of the hospital or, if larger, within the hospital’s service area, the hospital may request that HCFA provide this information.

(B) If a hospital obtains the information as requested under paragraph (b)(1)(iii)(A) of this section, that information is used by both the intermediary and HCFA in making the determination of the residences of Medicare beneficiaries under paragraphs (b)(1)(iii) and (b)(1)(iv) of this section, regardless of any other information concerning the residences of Medicare beneficiaries submitted by the hospital.

(iv) The intermediary reviews the request and send the request, with its recommendation, to HCFA.

(v) HCFA reviews the request and the intermediary’s recommendation and forward its approval or disapproval to the intermediary.

(2) Effective dates of classification. (i) Sole community hospital status is effective 30 days after the date of HCFA’s written notification of approval.

(ii) When a court order or a determination by the Provider Reimbursement Review Board (PRRB) reverses an HCFA denial of sole community hospital status and no further appeal is made, the sole community hospital status is effective as follows:

(A) If the hospital’s application was submitted prior to October 1, 1983, its status as a sole community hospital is effective at the start of the cost reporting period for which it sought exemption from the cost limits.

(B) If the hospital’s application for sole community hospital status was filed on or after October 1, 1983, the effective date is 30 days after the date of HCFA’s original written notification of denial.

(iii) When a hospital is granted retroactive approval of sole community hospital status by a court order or a PRRB decision and the hospital wishes its sole community hospital status terminated before the date of the court order or PRRB determination, it must submit written notice to the HCFA regional office within 90 days of the court order or PRRB decision. A written request received after the 90-day period is effective no later than 30 days after the request is submitted.

(iv) A hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after 30 days after the date of HCFA’s approval of the classification.

(3) Duration of classification. An approved classification as a sole community hospital remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved.

(4) Cancellation of classification. (i) A hospital may at any time request cancellation of its classification as a sole
community hospital, and be paid at rates determined under subparts D and E of this part, as appropriate.

(ii) The cancellation becomes effective no later than 30 days after the date the hospital submits its request.

(iii) If a hospital requests that its sole community hospital classification be cancelled, it may not be reclassified as a sole community hospital unless it meets the following conditions:

A) At least one full year has passed since the effective date of its cancellation.

B) The hospital meets the qualifying criteria set forth in paragraph (a) of this section in effect at the time it re-applies.

(5) Automatic classification as a sole community hospital. A hospital that has been granted an exemption from the hospital cost limits before October 1, 1983, or whose request for the exemption was received by the appropriate intermediary before October 1, 1983, and was subsequently approved, is automatically classified as a sole community hospital unless that classification has been cancelled under paragraph (b)(3) of this section, or there is a change in the circumstances under which the classification was approved.

(c) Terminology. As used in this section—

(1) The term miles means the shortest distance in miles measured over improved roads. An improved road for this purpose is any road which is maintained by a local, State, or Federal government entity and which is available for use by the general public.

(2) The term like hospital means a hospital furnishing short-term, acute care. HCFA will not evaluate comparability of specialty services in making determinations on classifications as sole community hospitals.

(3) The term service area means the area from which a hospital draws at least 75 percent of its inpatients during the most recent 12-month cost reporting period ending before it applies for classification as a sole community hospital.

(d) Determining prospective payment rates for inpatient operating costs for sole community hospitals. (1) General rule. For cost reporting periods beginning on or after April 1, 1990, a sole community hospital is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period:

(i) The Federal payment rate applicable to the hospitals as determined under §412.63.

(ii) The hospital-specific rate as determined under §412.73.

(iii) The hospital-specific rate as determined under §412.75.

(iv) For cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate as determined under §412.77 (calculated under the transition schedule set forth in paragraph (d)(2) of this section), if the sole community hospital was paid for its cost reporting period beginning during 1999 on the basis of the hospital-specific rate specified in paragraph (d)(1)(ii) or (d)(1)(iii) of this section, unless the hospital elects otherwise under §412.77(a)(1).

(2) Transition of FY 1996 hospital-specific rate. The intermediary calculates the hospital-specific rate determined on the basis of the fiscal year 1996 base period rate as follows:

(i) For Federal fiscal year 2001, the hospital-specific rate is the sum of 75 percent of the greater of the hospital-specific rates specified in paragraph (d)(1)(ii) or (d)(1)(iii) of this section, plus 25 percent of the hospital-specific rate specified in paragraph (d)(1)(iv) of this section.

(ii) For Federal fiscal year 2002, the hospital-specific rate is the sum of 50 percent of the greater of the hospital-specific rates specified in paragraph (d)(1)(ii) or (d)(1)(iii) of this section plus 50 percent of the hospital-specific rate specified in paragraph (d)(1)(iv) of this section.

(iii) For Federal fiscal year 2003, the hospital-specific rate is the sum of 25 percent of the greater of the hospital-specific rates specified in paragraph (d)(1)(ii) or (d)(1)(iii) of this section plus 75 percent of the hospital-specific rate specified in paragraph (d)(1)(iv) of this section.

(iv) For Federal fiscal year 2004 and any subsequent fiscal years, the hospital-specific rate is 100 percent of the hospital-specific rate specified in paragraph (d)(1)(iv) of this section.
§ 412.96 Special treatment: Referral centers.

(a) Criteria for classification as a referral center: Basic rule. HCFA classifies a hospital as a referral center only if the hospital is a Medicare participating acute care hospital and meets the applicable criteria of paragraph (b) or (c) of this section.

(b) Criteria for cost reporting periods beginning on or after October 1, 1983. The hospital meets either of the following criteria:

(1) The hospital is located in a rural area (as defined in §412.63(b)) and has the following number of beds, as determined under the provisions of §412.105(b), available for use:

(i) Effective for discharges occurring before April 1, 1988, the hospital has 500 or more beds.

(ii) Effective for discharges occurring on or after April 1, 1988, the hospital has 500 or more beds.
Health Care Financing Administration, HHS § 412.96

has 275 or more beds during its most recently completed cost reporting period unless the hospital submits written documentation with its application that its bed count has changed since the close of its most recently completed cost reporting period for one or more of the following reasons:

(A) Merger of two or more hospitals.
(B) Reopening of acute care beds previously closed for renovation.
(C) Transfer to the prospective payment system of acute care beds previously classified as part of an excluded unit.
(D) Expansion of acute care beds available for use and permanently maintained for lodging inpatients, excluding beds in corridors and other temporary beds.

(2) The hospital shows that—

(i) At least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the staff of the hospital; and
(ii) At least 60 percent of the hospital’s Medicare patients live more than 25 miles from the hospital, and at least 60 percent of all the services that the hospital furnishes to Medicare beneficiaries are furnished to beneficiaries who live more than 25 miles from the hospital.

(c) Alternative criteria. For cost reporting periods beginning on or after October 1, 1985, a hospital that does not meet the criteria of paragraph (b) of this section is classified as a referral center if it is located in a rural area (as defined in §412.62(f)) and meets the criteria specified in paragraphs (c)(1) and (c)(2) of this section and at least one of the three criteria specified in paragraphs (c)(3), (c)(4), and (c)(5) of this section.

(1) Case-mix index. HCFA sets forth national and regional case-mix index values in each year’s annual notice of prospective payment rates published under §412.8(b). The methodology HCFA uses to calculate these criteria is described in paragraph (h) of this section. Except as provided in paragraph (c)(2)(ii) of this section for an osteopathic hospital, for the hospital’s most recently completed cost reporting period, its number of discharges (not including discharges from units excluded from the prospective payment system under subpart B of this part or from newborn units) is at least equal to—

(A) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the national or regional case-mix index value; or
(B) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1986, 5,000 discharges or, if less, the median number of discharges for urban hospitals located in each region.

(2) Number of discharges. (i) HCFA sets forth the national and regional numbers of discharges in each year’s annual notice of prospective payment rates published under §412.8(b). The methodology HCFA uses to calculate these criteria is described in paragraph (h) of this section. Except as provided in paragraph (c)(2)(ii) of this section for an osteopathic hospital, for the hospital’s most recently completed cost reporting period, its number of discharges (not including discharges from units excluded from the prospective payment system under subpart B of this part or from newborn units) is at least equal to—

(A) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the number of discharges under either the national or regional criterion; or
(B) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1986, 5,000 discharges or, if less, the median number of discharges for urban hospitals located in each region.

375
(ii) For cost reporting periods beginning on or after January 1, 1986, an osteopathic hospital, recognized by the American Osteopathic Healthcare Association (or any successor organization), that is located in a rural area must have at least 3,000 discharges during its most recently completed cost reporting period to meet the number of discharges criterion. The 3,000 discharges benchmark is also used in evaluating an osteopathic hospital for purposes of the triennial review.

(3) Medical staff. More than 50 percent of the hospital’s active medical staff are specialists who meet one of the following conditions:

(i) Are certified as specialists by one of the Member Boards of the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists.

(ii) Have completed the current training requirements for admission to the certification examination of one of the Member Boards of the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists.

(iii) Have successfully completed a residency program in a medical specialty accredited by the Accreditation Council of Graduate Medical Education or the American Osteopathic Association.

(4) Source of inpatients. At least 60 percent of all its discharges are for inpatients who reside more than 25 miles from the hospital.

(5) Volume of referrals. At least 40 percent of all inpatients treated at the hospital are referred from other hospitals or from physicians not on the hospital’s staff.

(d) Payment to rural referral centers. Effective for discharges occurring on or after April 1, 1988, and before October 1, 1994, a hospital that is located in a rural area and meets the criteria of paragraphs (b)(1), (b)(2) or (c) of this section is paid prospective payments for inpatient operating costs per discharge based on the applicable other urban payment rates as determined in accordance with §412.63, as adjusted by the hospital’s area wage index value.

(2) The cancellation becomes effective no later than 30 days after the date the hospital submits its request.

(3) If a hospital requests that its referral center status be canceled, it may not be reclassified as a referral center unless it meets the qualifying criteria set forth in paragraph (a) of this section in effect at the time it reapplies.

(h) Methodology for calculating case-mix index criteria. HCFA calculates the national and regional case-mix index value criteria as described in paragraphs (g)(1) through (g)(4) of this section.

(1) Updating process. HCFA updates the national and regional case-mix index standards using the latest available data from hospitals subject to the prospective payment system for the Federal fiscal year.

(2) Source of data. In making the calculations described in paragraph (g)(1) of this section, HCFA uses all inpatient hospital bills received for discharges subject to prospective payment during the Federal fiscal year being monitored.

(3) Effective date. HCFA sets forth the national and regional criteria in the annual notice of prospective payment rates published under §412.8(b). These criteria are used to determine if a hospital qualifies for referral center status for cost reporting periods beginning on or after October 1 of the Federal fiscal year to which the notice applies.

(4) Applicability of criteria to HCFA review of referral center status. For purposes of the triennial HCFA review of a referral center’s status as described in paragraph (f) of this section, the referral center’s case-mix index value for a Federal fiscal year is evaluated using the appropriate case-mix value criteria published in the annual notice of prospective payment rates.

(i) Methodology for calculating number of discharges criteria. For purposes of determining compliance with the national or regional number of discharges criterion under paragraph (c)(2) of this
Health Care Financing Administration, HHS § 412.102

section, HCFA calculates the criteria as follows:

(1) Updating process. HCFA updates the national and regional number of discharges using the latest available data for levels of admissions or discharges or both.

(2) Source of data. In making the calculations described in paragraph (h)(1) of this section, HCFA uses the most recent hospital admissions or discharge data available.

(3) Annual notice. HCFA sets forth the national and regional criteria in the annual notice of prospective payment rates published under §412.8(b). These criteria are compared to an applying hospital's number of discharges for its most recently completed cost reporting period in determining if the hospital qualifies for referral center status for cost reporting periods beginning on or after October 1 of the Federal fiscal year to which the notice applies.

(4) Applicability of criteria to HCFA review of referral center status. For purposes of the triennial review of a referral center's status as described in paragraph (f) of this section, the referral center's number of discharges for its most recently completed cost reporting period is evaluated using the appropriate discharge criteria published in the annual notice of prospective payment rates.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For Federal Register citations affecting §412.96, see the List of Sections Affected in the Finding Aids section of this volume.

§ 412.98 [Reserved]

§ 412.100 Special treatment: Renal transplantation centers.

(a) Adjustments for renal transplantation centers. (1) HCFA adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part for hospitals approved as renal transplantation centers (described at §§405.2170 and 405.2171 of this chapter) to remove the estimated net expenses associated with kidney acquisition.

(2) Kidney acquisition costs are treated apart from the prospective payment rate for inpatient operating costs, and payment to the hospital is adjusted in each reporting period to reflect an amount necessary to compensate the hospital for reasonable expenses of kidney acquisition.

(b) Costs of kidney acquisition. Expenses recognized under this section include costs of acquiring a kidney, from a live donor or a cadaver, irrespective of whether the kidney was obtained by the hospital or through an organ procurement agency. These costs include—

(1) Tissue typing, including tissue typing furnished by independent laboratories;

(2) Donor and recipient evaluation;

(3) Other costs associated with excising kidneys, such as donor general routine and special care services;

(4) Operating room and other inpatient ancillary services applicable to the donor;

(5) Preservation and perfusion costs;

(6) Charges for registration of recipient with a kidney transplant registry;

(7) Surgeons' fees for excising cadaver kidneys;

(8) Transportation;

(9) Costs of kidneys acquired from other providers or kidney procurement organizations;

(10) Hospital costs normally classified as outpatient costs applicable to kidney excisions (services include donor and donee tissue typing, work-up, and related services furnished prior to admission);

(11) Costs of services applicable to kidney excisions which are rendered by residents and interns not in approved teaching programs; and

(12) All pre-admission physicians services, such as laboratory, electroencephalography, and surgeon fees for cadaver excisions, applicable to kidney excisions including the costs of physicians services.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39824, Sept. 1, 1992]

§ 412.102 Special treatment: Hospitals located in areas that are reclassified from urban to rural as a result of a geographic redesignation.

Effective on or after October 1, 1983, a hospital reclassified as rural, as defined in §412.62(f), may receive an adjustment to its rural Federal payment amount for operating costs for two successive fiscal years.

377
§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) General criteria. A prospective payment hospital that is located in an urban area (as defined in §412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

(1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at http://www.nal.usda.gov/orph or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in §412.96, or as a sole community hospital as set forth in §412.92, if the hospital were located in a rural area.

(b) Application requirements. (1) Written application. A hospital seeking reclassification under this section must submit a complete application in writing to HCFA in accordance with paragraphs (b)(2) and (b)(3) of this section.

(2) Contents of application. An application is complete if it contains an explanation of how the hospital meets the condition that constitutes the basis of the request for reclassification set forth in paragraph (a) of this section, including data and documentation necessary to support the request.

(3) Mailing of application. An application must be mailed to the HCFA Regional Office by the requesting hospital and may not be submitted by facsimile or other electronic means.

(4) Notification by HCFA. Within 5 business days after receiving the hospital’s application, the HCFA Regional Office will send the hospital a letter acknowledging receipt, with a copy to the HCFA Central Office.

(5) Filing date. The filing date of the application is the date HCFA receives the application.

(c) HCFA review. The HCFA Regional Office will review the application and notify the hospital of its approval or disapproval of the request within 60 days of the filing date.

(d) Effective dates of reclassification. (1) Except as specified in paragraph (d)(2) of this section, HCFA will consider a hospital that satisfies any of the criteria set forth in paragraph (a) of this section as being located in the rural area of the State in which the hospital is located as of that filing date.

(2) If a hospital’s complete application is received in HCFA by September 1, 2000, and satisfies any of the criteria set forth in paragraph (a) of this section, HCFA will consider the filing date to be January 1, 2000.
Health Care Financing Administration, HHS

§ 412.105

(e) Withdrawal of application. A hospital may withdraw an application at any time prior to the date of HCFA's decision as set forth in paragraph (c) of this section.

(f) Duration of classification. An approved reclassification under this section remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved.

(g) Cancellation of classification. (1) A hospital may cancel its rural reclassification by submitting a written request to the HCFA Regional Office not less than 120 days prior to the end of its current cost reporting period.

(2) The hospital's cancellation of the classification is effective beginning with the hospital's next full cost reporting period following the date of its request for cancellation.

§ 412.104 Special treatment: Hospitals with high percentage of ESRD discharges.

(a) Criteria for classification. Effective with cost reporting periods that begin on or after October 1, 1984, HCFA provides an additional payment to a hospital for inpatient dialysis provided to ESRD beneficiaries if the hospital has established that ESRD beneficiary discharges, excluding discharges classified into DRG No. 302 (Kidney Transplant), DRG No. 316 (Renal Failure) or DRG No. 317 (Admit for Renal Dialysis), constitute ten percent or more of its total Medicare discharges.

(b) Additional payment. A hospital that meets the criteria of paragraph (a) of this section is paid an additional payment for each ESRD beneficiary discharge except those excluded under paragraph (a) of this section.

(1) The payment is based on the estimated weekly cost of dialysis and the average length of stay of ESRD beneficiaries for the hospital.

(2) The estimated weekly cost of dialysis is the average number of dialysis sessions furnished per week during the 12-month period that ended June 30, 1983 multiplied by the average cost of dialysis for the same period.

(3) The average cost of dialysis includes only those costs determined to be directly related to the dialysis service. (These costs include salary, employee health and welfare, drugs, supplies, and laboratory services.)

(4) The average cost of dialysis is reviewed and adjusted, if appropriate, at the time the composite rate reimbursement for outpatient dialysis is reviewed.

(5) The payment to a hospital equals the average length of stay of ESRD beneficiaries in the hospital, expressed as a ratio to one week, times the estimated weekly cost of dialysis multiplied by the number of ESRD beneficiary discharges except for those excluded under paragraph (a) of this section. This payment is made only on the Federal portion of the payment rate.

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

HCFA makes an additional payment to hospitals for indirect medical education costs using the following procedures:

(a) Basic data. HCFA determines the following for each hospital:

(1) The hospital's ratio of full-time equivalent residents, except as limited under paragraph (f) of this section, to the number of beds (as determined in paragraph (b) of this section). Except for the special circumstances for affiliated groups and new programs described in paragraphs (f)(1)(vi) and (f)(1)(vii) of this section, for a hospital's cost reporting periods beginning on or after October 1, 1997, this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period.

(2) The hospital's DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs, excluding outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made under the provisions of §412.106.

(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, not including beds or bassinets in
§ 412.105

42 CFR Ch. IV (10–1–00 Edition)

the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

(c) Measurement for teaching activity. The factor representing the effect of teaching activity on inpatient operating costs equals .405 for discharges occurring on or after May 1, 1986.

(d) Determination of education adjustment factor. Each hospital's education adjustment factor is calculated as follows:

(1) Step one. A factor representing the sum of 1.00 plus the hospital's ratio of full-time equivalent residents to beds, as determined under paragraph (a)(1) of this section, is raised to an exponential power equal to the factor set forth in paragraph (c) of this section.

(2) Step two. The factor derived from step one is reduced by 1.00.

(3) Step three. The factor derived from completing steps one and two is multiplied by ‘c’, and where ‘c’ is equal to the following:

(i) For discharges occurring on or after October 1, 1988, and before October 1, 1997, 1.89.

(ii) For discharges occurring during fiscal year 1998, 1.72.

(iii) For discharges occurring during fiscal year 1999, 1.6.

(iv) For discharges occurring during fiscal year 2000, 1.47.

(A) Each hospital receives an amount that is equal in the aggregate to the difference between the amount of payments made to the hospital if “c” equaled 1.6, rather than 1.47.

(B) The payment of this amount will not affect any other payments, determinations, or budget neutrality adjustments.

(ii) In order to be counted, the resident must be enrolled in an approved teaching program. An approved teaching program is one that meets one of the following requirements:

(A) Is approved by one of the national organizations listed in § 415.200(a) of this chapter.

(B) May count towards certification of the participant in a specialty or sub-specialty listed in the current edition of either of the following publications:

(1) The Directory of Graduate Medical Education Programs published by the American Medical Association.

(2) The Annual Report and Reference Handbook published by the American Board of Medical Specialties.

(C) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(D) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

(iii) In order to be counted, the resident must be assigned to one of the following areas:

(A) The portion of the hospital subject to the prospective payment system.

(B) The outpatient department of the hospital.

(C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under
an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth at §413.86(f)(4) are met.

(iii) Full-time equivalent status is based on the total time necessary to fill a residency slot. No individual may be counted as more than one full-time equivalent. If a resident is assigned to more than one hospital, the resident counts as a partial full-time equivalent based on the proportion of time worked in any of the areas of the hospital listed in paragraph (f)(1)(ii) of this section, to the total time worked by the resident. A part-time resident or one working in an area of the hospital other than those listed under paragraph (f)(1)(ii) of this section (such as a free-standing family practice center or an excluded hospital unit) would be counted as a partial full-time equivalent based on the proportion of time assigned to an area of the hospital listed in paragraph (f)(1)(ii) of this section, compared to the total time necessary to fill a full-time internship or residency slot.

(iv) Effective for discharges occurring on or after October 1, 1997, the total number of FTE residents in the fields of allopathic and osteopathic medicine in either a hospital or a non-hospital setting that meets the criteria listed in paragraph (f)(1)(ii) of this section may not exceed the number of such FTE residents in the hospital (or, in the case of a hospital located in a rural area, effective for discharges occurring on or after April 1, 2000, 130 percent of that number) with respect to the hospital’s most recent cost reporting period ending on or before December 31, 1996.

(v) For a hospital’s cost reporting periods beginning on or after October 1, 1997, and before October 1, 1998, the total number of full-time equivalent residents for payment purposes is equal to the average of the actual full-time equivalent resident counts (subject to the requirements set forth in paragraphs (f)(1)(i)(C) and (f)(1)(i)(iv) of this section) for the cost reporting period and the preceding two cost reporting periods.

(vi) Hospitals that are part of the same affiliated group (as described in §413.86(b)) may elect to apply the limit at paragraph (f)(1)(iv) of this section on an aggregate basis.

(vii) If a hospital establishes a new medical residency training program, as defined in §413.86(g)(9) of this subchapter, the hospital’s full-time equivalent cap may be adjusted in accordance with the provisions of §§413.86(g)(6)(i) through (iv) of this subchapter.

(viii) A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on or after January 1, 1995 and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its full-time equivalent cap in accordance with the provisions of §413.86(g)(7) of this subchapter.

(ix) A hospital may receive a temporary adjustment to its full-time equivalent cap to reflect residents added because of another hospital’s closure if the hospital meets the criteria specified in §413.86(g)(8) of this subchapter.

(x) Effective for discharges occurring on or after April 1, 2000, an urban hospital that establishes a new residency program (as defined in §413.86(g)(12) 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 provisions of §§413.86(g)(11) of this subchapter.

(xi) Effective for discharges occurring on or after November 29, 1999, a hospital may receive an adjustment to its FTE cap of up to three additional FTEs to the extent that the additional residents would have been counted as
§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(a) General considerations. (1) The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital’s location.

(i) The number of beds in a hospital is determined in accordance with § 412.105(b).

(ii) The number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others.

(iii) The hospital’s location, in an urban or rural area, is determined in accordance with the definitions in § 412.62(f).

(2) The payment adjustment is applied to the hospital’s DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs, excluding outlier payments for inpatient operating costs under subpart F of this part and additional payments made under the provisions of § 412.105.

(b) Determination of a hospital’s disproportionate patient percentage. (1) General rule. A hospital’s disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

(2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital’s cost reporting period begins, HCFA—

(i) Determines the number of covered patient days that—

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;
(ii) Adds the results for the whole period; and
(iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of patient days that—
(A) Are associated with discharges that occur during that period; and
(B) Are furnished to patients entitled to Medicare Part A.

(3) First computation: Cost reporting period. If a hospital prefers that HCFA use its cost reporting period instead of the Federal fiscal year, it must furnish to HCFA, through its intermediary, a written request including the hospital’s name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital’s official Medicare Part A/SSI percentage for that period.

(4) Second computation. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital’s patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
(i) A patient is deemed eligible for Medicaid on a given day if the patient is eligible for medical assistance under an approved State Medicaid plan on such day, regardless of whether particular items or services were covered or paid under the State plan.
(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.
(iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

(5) Disproportionate patient percentage. The intermediary adds the results of the first computation made under either paragraph (b)(2) or (b)(3) of this section and the second computation made under paragraph (b)(4) of this section and expresses that sum as a percentage. This is the hospital’s disproportionate patient percentage, and is used in paragraph (c) of this section.

(c) Criteria for classification. A hospital is classified as a “disproportionate share” hospital under any of the following circumstances:
(1) The hospital’s disproportionate patient percentage, as determined under paragraph (b)(5) of this section, is at least equal to one of the following:
(i) 15 percent, if the hospital is located in an urban area and has 100 or more beds, or is located in a rural area and has 500 or more beds.
(ii) 30 percent, if the hospital is located in a rural area and either has more than 100 beds and fewer than 500 beds or is classified as a sole community hospital under §412.92 of this subpart.
(iii) 40 percent, if the hospital is located in an urban area and has fewer than 100 beds.
(iv) 45 percent, if the hospital is located in a rural area and has 100 or fewer beds.

(2) The hospital is located in an urban area, has 100 or more beds, and can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients.

(d) Payment adjustment. (1) Method of adjustment. Subject to the reduction factor set forth in paragraph (e) of this section, if a hospital serves a disproportionate number of low-income patients, its DRG revenues for inpatient operating costs are increased by an adjustment factor as specified in paragraph (d)(2) of this section.

(2) Payment adjustment factors. (i) If the hospital meets the criteria of paragraph (c)(1)(i) of this section, the payment adjustment factor is equal to one of the following:
(A) If the hospital’s disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is as follows:
(1) For discharges occurring on or after April 1, 1990, and before January 1, 1991, 5.62 percent plus 65 percent of the difference between 20.2 percent and the hospital’s disproportionate patient percentage.

(2) For discharges occurring on or after January 1, 1991, and before October 1, 1993, 5.62 percent plus 70 percent of the difference between 20.2 percent and the hospital’s disproportionate patient percentage.

(3) For discharges occurring on or after October 1, 1993, and before October 1, 1994, 5.88 percent plus 80 percent of the difference between 20.2 percent and the hospital’s disproportionate patient percentage.

(4) For discharges occurring on or after October 1, 1994, 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital’s disproportionate patient percentage.

(B) If the hospital’s disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is as follows:

(1) For discharges occurring on or after April 1, 1990, and before October 1, 1993, 2.5 percent plus 60 percent of the difference between 15 percent and the hospital’s disproportionate patient percentage.

(2) For discharges occurring on or after October 1, 1993, 2.5 percent plus 65 percent of the difference between 15 percent and the hospital’s disproportionate patient percentage.

(ii) If the hospital meets the criteria of paragraph (c)(1)(ii) of this section, the payment adjustment factor is equal to one of the following:

(A) If the hospital is classified as a rural referral center, the payment adjustment factor is 4 percent plus 60 percent of the difference between the hospital’s disproportionate patient percentage and 30 percent.

(B) If the hospital is classified as a sole community hospital, the payment adjustment factor is 10 percent.

(C) If the hospital is classified as both a rural referral center and a sole community hospital, the payment adjustment factor is the greater of 10 percent or 4 percent plus 60 percent of the difference between the hospital’s disproportionate patient percentage and 30 percent.

(D) If the hospital is not classified as either a sole community hospital or a referral center, the payment adjustment factor is 4 percent.

(iii) If the hospital meets the criteria of paragraph (c)(1)(iii) of this section, the payment adjustment factor is equal to 5 percent.

(iv) If the hospital meets the criteria of paragraph (c)(1)(iv) of this section, the payment adjustment factor is 4 percent.

(v) If the hospital meets the criteria of paragraph (c)(2) of this section, the payment adjustment factor is as follows:

(A) 30 percent for discharges occurring on or after April 1, 1990 and before October 1, 1991.

(B) 35 percent for discharges occurring on or after October 1, 1991.

(e) Reduction in payments for FYs 1998 through 2002. The amounts otherwise payable to a hospital under paragraph (d) of this section are reduced by the following:

(1) For FY 1998, 1 percent.

(2) For FY 1999, 2 percent.

(3) For FY 2000, 3 percent.

(4) For FY 2001, 3 percent.

(5) For FY 2002, 4 percent.

(6) For FYs 2003 and thereafter, 0 percent.


(a) Additional payment update. A hospital that meets the criteria set forth in paragraph (b) of this section receives the following increase to its applicable percentage amount set forth in §412.63 (p) and (q):

(1) For FY 1998, 0.5 percent.

(2) For FY 1999, 0.3 percent.

(b) Criteria for classification. A hospital is eligible for the additional payment update set forth in paragraph (a) of this section if it meets all of the following criteria:
(1) **Definition.** The hospital is not a Medicare-dependent, small rural hospital as defined in §412.108(a) and does not receive any additional payment under the following provisions:

(i) The indirect medical education adjustment made under §412.105.

(ii) The disproportionate share adjustment made under §412.106.

(2) **State criteria.** The hospital is located in a State in which the aggregate payment made under §412.112 (a) and (c) for hospitals described in paragraph (b)(1) of this section for their cost reporting periods beginning in FY 1995 is less than the allowable operating costs described in §412.2(c) for those hospitals.

(3) **Hospital criteria.** The aggregate payment made to the hospital under §412.112 (a) and (c) for the hospital’s cost reporting period beginning in the fiscal year in which the additional payment update described in paragraph (a) of this section is made is less than the allowable operating cost described in §412.2(c) for that hospital.


§ 412.108 Special treatment: Medicare-dependent, small rural hospitals.

(a) **Criteria for classification as a Medicare-dependent, small rural hospital.**

(1) **General considerations.** For cost reporting periods beginning on or after April 1, 1990 and ending before October 1, 1994, or beginning on or after October 1, 1997 and ending before October 1, 2006, a hospital is classified as a Medicare-dependent, small rural hospital if it is located in a rural area (as defined in §412.63(b)) and meets all of the following conditions:

(i) The hospital has 100 or fewer beds as defined in §412.105(b) during the cost reporting period.

(ii) The hospital is not also classified as a sole community hospital under §412.92.

(iii) At least 60 percent of the hospital’s inpatient days or discharges were attributable to individuals receiving Medicare part A benefits during the hospital’s cost reporting period as follows, subject to the provisions of paragraph (a)(1)(iv) of this section:

(A) The hospital’s cost reporting period ending on or after September 30, 1987 and before September 30, 1988.

(B) If the hospital does not have a cost reporting period that meets the criterion set forth in paragraph (a)(1)(iii)(A) of this section, the hospital’s cost reporting period beginning on or after October 1, 1986, and before October 1, 1987.

(iv) If the cost reporting period determined under paragraph (a)(1)(iii) of this section is for less than 12 months, the hospital’s most recent 12-month or longer cost reporting period before the short period is used.

(2) **Counting inpatient days and discharges.** In counting inpatient days and discharges for purposes of meeting the criteria in paragraph (a)(1)(iii) of this section, only days and discharges from acute care inpatient hospital stays are counted (including days and discharges from swing beds when used for acute care inpatient hospital services), but not including days and discharges from units excluded from the prospective payment system under §§ 412.25 through 412.30 or from newborn nursery units. For purposes of this section, a transfer as defined in §412.4(b) is considered to be a discharge.

(b) **Classification procedures.** The fiscal intermediary determines whether a hospital meets the criteria in paragraph (a) of this section. If a hospital disagrees with an intermediary’s decision, it should notify its intermediary and submit documentable evidence that it meets the criteria.

(c) **Payment methodology.** A hospital that meets the criteria in paragraph (a) of this section is paid for its inpatient operating costs the sum of paragraphs (c)(1) and (c)(2) of this section.

(1) The Federal payment rate applicable to the hospital as determined under §412.63, subject to the regional floor defined in §412.70(c)(6).

(2) The amount, if any, determined as follows:

(i) For discharges occurring during the first three 12-month cost reporting periods that begin on or after April 1, 1990, 100 percent of the amount that the Federal rate determined under paragraph (c)(1) of this section is exceeded by the higher of the following:

(A) The hospital-specific rate as determined under §412.73.

(B) The hospital-specific rate as determined under §412.75.
§ 412.109 Special treatment: Essential access community hospitals (EACHs).

(a) General rule. For payment purposes, HCFA treats as a sole community hospital any hospital that is located in a rural area as described in paragraph (b) of this section and that HCFA designated as an EACH under section 1820(i)(1) of the Act as in effect on September 30, 1997, for as long as the hospital continues to comply with the terms, conditions, and limitations that were applicable at the time HCFA designated the hospital as an EACH. The payment methodology for sole community hospitals is set forth at §412.92(d).

(b) Location in a rural area. For purposes of this section, a hospital is located in a rural area if it—

(ii) For discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, and for discharges occurring on or after October 1, 1997 and before October 1, 2006, 50 percent of the amount that the Federal rate determined under paragraph (c)(1) of this section is exceeded by the higher of the following:

(A) The hospital-specific rate as determined under §412.73.

(B) The hospital-specific rate as determined under §412.75.

(d) Additional payments to hospitals experiencing a significant volume decrease.

(1) HCFA provides for a payment adjustment for a Medicare-dependent, small rural hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (d)(2) of this section, a more than 5 percent decrease in its total inpatient discharges as compared to its immediately preceding cost reporting period. If either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the intermediary must convert the discharges to a monthly figure and multiply this figure by 12 to estimate the total number of discharges for a 12-month cost reporting period.

(2) To qualify for a payment adjustment on the basis of a decrease in discharges, a Medicare-dependent, small rural hospital must submit its request no later than 180 days after the date on the intermediary’s Notice of Amount of Program Reimbursement and it must—

(i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges and the resulting effect on per discharge costs, and

(ii) Show that the decrease is due to circumstances beyond the hospital’s control.

(3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital’s Medicare inpatient operating costs and the hospital’s total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs hospitals that serve a disproportionate share of low-income patients as determined under §412.106 and for indirect medical education costs as determined under §412.105.

(i) In determining the adjustment amount, the intermediary considers—

(A) The individual hospital’s needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;

(B) The hospital’s fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and

(C) The length of time the hospital has experienced a decrease in utilization.

(ii) The intermediary makes its determination within 180 days from the date it receives the hospital’s request and all other necessary information.

(iii) The intermediary determination is subject to review under subpart R of part 405 of this chapter.

§ 412.110 Total Medicare payment.

Under the prospective payment systems, Medicare's total payment for inpatient hospital services furnished to a Medicare beneficiary by a hospital will equal the sum of the payments listed in

(1) Is located outside any area that is a Metropolitan Statistical Area as defined by the Office of Management and Budget or that has been recognized as urban under §412.62;

(2) Is not deemed to be located in an urban area under §412.63;

(3) Is not classified as an urban hospital for purposes of the standardized payment amount by HCFA or the Medicare Geographic Classification Review Board; or

(4) Is not located in a rural county that has been redesignated to an adjacent urban area under §412.232.

(c) Adjustment to the hospital-specific rate for rural EACH's experiencing increased costs.

(1) General rule. HCFA increases the applicable hospital-specific rate of an EACH that it treats as a sole community hospital if, during a cost reporting period, the hospital experiences an increase in its Medicare inpatient operating costs per discharge that is directly attributable to activities related to its membership in a rural health network.

(2) Request and documentation. In order for a hospital to qualify for an increase in its hospital-specific rate, it must meet the following criteria:

(i) The hospital must submit its request to its intermediary no later than 180 days after the date on the intermediary's notice of program reimbursement.

(ii) The request must include documentation specifically identifying the increased costs resulting from the hospital's participation in a rural health network and show that the increased costs during the cost reporting period will result in increased costs in subsequent cost reporting periods that are not already accounted for under the prospective payment system payment.

(iii) The hospital must show that the cost increases are incremental costs that would not have been incurred in the absence of the hospital's membership in a rural health network.

(iv) The hospital must show that the cost increases do not include amounts for start-up and one-time, nonrecurring costs attributable to its membership in a rural health network.

(3) Intermediary recommendation. The intermediary forwards the following material to HCFA within 60 days of receipt from the hospital:

(i) The hospital's documentation and the intermediary's verification of that documentation.

(ii) The intermediary's analysis and recommendation of the request.

(iii) The hospital's Medicare cost report for the year in which the increase in costs occurred and the prior year.

(4) HCFA determination. HCFA determines, within 120 days of receiving all necessary information from the intermediary, whether an increase in the hospital-specific rate is warranted and, if it is, the amount of the increase.

HCFA grants an adjustment only if a hospital's Medicare inpatient operating costs per discharge exceed the hospital's hospital-specific rate. The adjusted hospital-specific rate cannot exceed the hospital's Medicare inpatient operating costs per discharge for the cost reporting period.

(d) Termination of EACH designation.

If HCFA determines that a hospital no longer complies with the terms, conditions, and limitations that were applicable at the time HCFA designated the hospital as an EACH, HCFA will terminate the EACH designation of the hospital, effective with discharges occurring on or after 30 days after the date of the determination.

(e) Review of HCFA determination. A determination by HCFA that a hospital's EACH designation should be terminated, is subject to review under part 405, subpart R of this chapter, including the time limits for filing requests for hearings as specified in §§405.1811(a) and 405.1841(a)(1) and (b) of this chapter.