Centers for Medicare & Medicaid Services, HHS § 412.322

§ 412.320 Disproportionate share adjustment factor.

(a) Criteria for classification. A hospital is classified as a “disproportionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with §412.105(b), and serves low-income patients as determined under §412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital’s location, for the purpose of receiving payment, under §412.63(a).

(ii) For discharges occurring on or after October 1, 2004, and before October 1, 2006, for an urban hospital that is reclassified as rural as set forth in §412.103, the geographic classification is rural.

(b) Payment adjustment factor. (1) If a hospital meets the criteria in paragraph (a)(1) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals $e^{\cdot2025 \times \text{hospital’s disproportionate patient percentage as determined under } \text{§412.106(b)(5)}}, -1$, where $e$ is the natural antilog of 1.

(2) If a hospital meets the criteria in §412.106(c)(2) for purposes of hospital inpatient operating prospective payments, the disproportionate share adjustment factor is the factor that results from deeming the hospital to have the same disproportionate share patient percentage that would yield its operating disproportionate share adjustment.

§ 412.324 General description.

(a) Hospitals under Medicare in FY 1991. During the ten-year transition period, payments to a hospital with a hospital-specific rate below the Federal rate are based on the fully prospective payment methodology under §412.340 or for a hospital with a hospital-specific rate above the Federal rate, the hold-harmless payment methodology under §412.344.

(b) New hospitals. (1) A new hospital, as defined under §412.300(b), is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its cost reporting period ending at least 2 years after the hospital accepts its first patient.

(2) For the third year through the remainder of the transition period, the hospital is paid based on the fully prospective payment methodology or the hold-harmless payment methodology using the base period determined under §412.328(a)(2).

(3) If the hospital is paid under the hold-harmless methodology described in §412.344, the hold-harmless payment for old capital costs described in §412.344(a)(1) is payable for up to and including 8 years and may continue beyond the first cost reporting period beginning on or after October 1, 2000.

(c) Hospitals with 52–53 week fiscal years ending September 25 through September 29. For purposes of this subpart, a hospital with a 52–53 week fiscal year period beginning September 26 through September 30, 1992 is deemed to have the same beginning date for all cost reporting periods beginning before October 1, 2000 (unless the hospital later changes its cost reporting period).

§ 412.328 Determining and updating the hospital-specific rate.

(a) Base-year cost reporting period—(1) Last 12 month cost reporting period ending on or before December 31, 1990. For each hospital, the intermediary uses the hospital’s latest 12-month or longer cost reporting periods covering at least 12 months that begins at least 1 year after the hospital accepts its first patient.

(2) Other hospitals. For other than a new hospital as defined in §412.300(b), if a hospital does not have a 12-month cost reporting period or does not have adequate Medicare utilization to file a cost report in a period ending on or before December 31, 1990, the hospital-specific rate is based on the hospital’s old capital costs (per discharge) in its first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) ending after December 31, 1990.

(b) Base-year costs per discharge—(1) Base period allowable inpatient capital costs per discharge. (i) Determination. The intermediary determines the base period allowable inpatient capital costs per discharge for the hospital by dividing the hospital’s total allowable Medicare inpatient hospital capital-related cost in the base period by the number of Medicare discharges in the base period.