

(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 $[e \text{ raised to the power of } (.2025 \times \text{the hospital's disproportionate patient percentage as determined under } \S 412.106(b)(5)), -1]$, 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.

[56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992, as amended at 58 FR 46339, Sept. 1, 1993; 69 FR 49250, Aug. 11, 2004; 71 FR 48140, Aug. 18, 2006]

§ 412.322 Indirect medical education adjustment factor.

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

(1) The hospital's number of full-time equivalent residents as determined under § 412.105(f).

(2) The hospital's average daily census is determined by dividing the total number of inpatient days in the acute inpatient area of the hospital by the number of days in the cost reporting period.

(3) The measurement of teaching activity is the ratio of the hospital's full-time equivalent residents to average daily census. This ratio cannot exceed 1.5.

(b) *Payment adjustment factor.* The indirect teaching adjustment factor equals $[e \text{ (raised to the power of } .2822 \times \text{the ratio of residents to average daily census)} - 1]$.

(c)-(d) [Reserved]

[56 FR 43449, Aug. 30, 1991, as amended at 63 FR 26357, May 12, 1998; 63 FR 41004, July 31, 1998; 72 FR 47412, Aug. 22, 2007; 74 FR 43998, Aug. 27, 2009]

DETERMINATION OF TRANSITION PERIOD
PAYMENT RATES FOR CAPITAL-RELATED COSTS

§ 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).

[56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992]

§ 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 period ending on or before December 31, 1990 as the base period to determine a hospital's hospital-specific rate.

(2) *New hospitals.* The base-year cost reporting period for a new hospital is its 12-month cost reporting period (or a combination of cost reporting periods covering at least 12 months) that begins at least 1 year after the hospital accepts its first patient.

(3) *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.

(ii) *Disposal of assets in the base year.* When a depreciable asset has been disposed of in the base year, only that portion of the gain or loss that is allocated to the base-year cost reporting period is reflected in the hospital-specific rate.

(iii) *Disposal of assets subsequent to the base year.* If an asset for which the Medicare program had recognized depreciation during the base year is disposed of subsequent to the base year, the hospital-specific rate will not be revised to recognize the portion of the gain or loss allocated to the base year.

(2) *Discharges.* For the purpose of determining a hospital's base period capital costs per discharge, a discharge includes discharges as defined in §412.4(a) and transfers as defined in §412.4(b)(2), adjusted by the transfer adjustment factor that is determined under paragraph (b)(3) of this section.

(3) *Transfer adjustment factor.* (i) For base year cost reporting periods ending on or before December 31, 1990, CMS uses the base year MEDPAR data received as of June 30, 1991 to develop an adjustment to discharges to account for transfers. CMS divides the length of stay for each transfer case by the geometric mean length of stay for the DRG (but in no case using a number greater than 1.0) and assigns each non-transfer case a value of 1.0. To determine the transfer adjustment factor, CMS adds together the adjusted discharges and divides the result by total discharges including transfers.

(ii) For base year cost reporting periods ending after December 31, 1990 but beginning before October 1, 1991, CMS determines a transfer adjustment factor as described in paragraph (b)(3)(i) of this section for a hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least 6 months after the close of the approved base year.

(iii) For base year cost reporting periods beginning on or after October 1, 1991, the intermediary determines the transfer adjustment factor in place of CMS as described in paragraph (b)(3)(i) of this section based on the most recent billing data available as of the date of the final determination of the hospital-specific rate.

(c) *Case-mix adjustment—(1) Determining transfer-adjusted case mix value. Step 1:* For base year cost reporting periods ending on or before December 31, 1990, CMS uses the base year MEDPAR data received as of June 30, 1991 to determine the hospital's transfer-adjusted case-mix value. For base year cost reporting periods ending after December 31, 1990 and beginning before October 1, 1991, CMS determines a transfer-adjusted case-mix value for a hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least 6 months after the close of the base year. For base year cost reporting periods beginning on or after October 1, 1991, the intermediary determines the transfer-adjusted case-mix value based on the most recent billing data available as of the date of the final determination of the hospital-specific rate. CMS or the intermediary, as appropriate,

multiplies the DRG weight for each case by one of the following factors:

(i) If the case is not a transfer, the factor equals 1.0.

(ii) If the case is a transfer, the factor equals the lesser of 1.0 or the ratio of the length of stay for the case divided by the geometric mean length of stay for the DRG.

Step 2: The products derived for all cases under Step 1 are added together and the result is divided by the adjusted discharges used to calculate the transfer adjustment factor determined under paragraph (b)(3) of this section.

(2) *Adjusting base period capital costs per discharge by the hospital's transfer-adjusted case-mix value.* The intermediary divides the base period capital costs per discharge for each hospital as determined in paragraph (b) of this section by the hospital's transfer-adjusted case mix value for the cost reporting period determined under paragraph (c)(1) of this section.

(d) *Updating to FY 1992.* The intermediary updates the case-mix adjusted base period costs per discharge to FY 1992 based on the national average increase in Medicare inpatient capital costs per discharge as estimated by CMS, excluding the portion of the increase in capital costs per discharge attributable to changes in case mix.

(e) *Hospital-specific rate.* The intermediary determines the hospital-specific rate each year by adjusting the amount determined under paragraph (d) of this section by the following factors:

(1) *Update factor.* After FY 1992, the intermediary updates the hospital-specific rate in accordance with § 412.308(c)(1).

(2) *Exceptions payment adjustment factor.* For FY 1992 through FY 2001, the intermediary reduces the updated amount determined in paragraph (d) of this section by an adjustment factor equal to the estimated additional payments for capital-related costs for exceptions under § 412.348, determined as a proportion of the total amount of payments under the hospital-specific rate and Federal rate.

(3) *Budget neutrality adjustment factor.* For FY 1992 through FY 1995, the intermediary adjusts the updated amount determined in paragraph (d) of this sec-

tion by a budget neutrality adjustment factor determined under § 412.352.

(4) *Payment for transfer cases.* Effective FY 1996, the intermediary reduces the updated amount determined in paragraph (d) of this section by 0.28 percent to account for the effect of the revised policy for payment of transfers under § 412.4(d).

(5) *Reduction of rate: FY 1998.* Effective FY 1998, the unadjusted hospital-specific rate as in effect on September 30, 1997 described in paragraph (e)(1) of this section is reduced by 15.68 percent.

(6) *Reduction of rate: FY 1998 through FY 2002.* For discharges occurring on or after October 1, 1997 through September 30, 2002, the unadjusted hospital-specific rate in effect on September 30, 1997, described in paragraph (e)(1) of this section is further reduced by 2.1 percent.

(f) *Redetermination of hospital-specific rate—(1) General.* (i) Upon request by a hospital, the intermediary redetermines the hospital-specific rate to reflect an increase in old capital costs as determined in a cost reporting period subsequent to the base year. An increase in Medicare old capital cost per discharge that is related solely to a decline in utilization is not recognized as an increase in old capital costs for purposes of this section. New capital costs are excluded from the redetermination of the hospital-specific rate.

(ii) The hospital may request redetermination for any cost reporting period beginning subsequent to the base period but no later than the later of the hospital's cost reporting period beginning in FY 1994 or the cost reporting period beginning after obligated capital that is recognized as old capital under § 412.302(b) is put in use.

(iii) The hospital must request a redetermination in writing no later than the date the cost report must be filed with the hospital's intermediary for the first cost reporting period beginning on or after October 1, 1991 or the cost reporting period that will serve as the new base period, whichever is later. The hospital's redetermination request must include the cost report for the new base period and an estimate of the revised hospital-specific rate indicating that the new rate exceeds the

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hospital's current hospital-specific rate.

(2) *Determination of old capital costs.* The intermediary determines the hospital's old capital costs for the subsequent cost reporting period that will serve as the new base period. The intermediary includes the costs of obligated capital that are recognized as old capital costs under §412.302(b), excludes the costs of assets disposed of subsequent to the initial base year, and reflects changes in allowable old capital costs occurring subsequent to the initial base period.

(3) *Redetermined hospital-specific rate.* The intermediary redetermines the hospital-specific rate based on the old capital costs that are determined under paragraph (f)(2) of this section for the new base period. The intermediary—

(i) Divides the hospital's old capital costs for the new base period by the number of Medicare discharges in that cost reporting period (consistent with paragraph (b) of this section);

(ii) Divides the old capital costs per discharge by the hospital's transfer adjusted case-mix value for the new base period (consistent with paragraph (c) of this section);

(iii) Applies an update factor, if appropriate, to account for inflation occurring subsequent to the new base year, an exceptions payment adjustment factor, and a budget neutrality adjustment factor (consistent with paragraphs (d) and (e) of this section).

(4) *Denial by intermediary.* If the intermediary determines, after audit, that the revised hospital-specific rate is lower than the current hospital-specific rate, it advises the hospital that its request is denied and explains the basis for the denial.

(5) *Implementation date.* The redetermined hospital-specific rate applies to discharges occurring on or after the beginning date of the new base period.

(g) *Review and revision of the hospital-specific rate—*(1) *Interim determination.* The intermediary makes an interim determination of the hospital-specific rate based on the best data available and notifies the hospital at least 30 days before the beginning of the hospital's first cost reporting period beginning on or after October 1, 1991.

(2) *Final determination.* (i) The intermediary makes a final determination of the hospital-specific rate based on the final settlement of the base period cost report.

(ii) The final determination of the hospital-specific rate is effective retroactively to the beginning of the hospital's first cost reporting period beginning on or after October 1, 1991 or, in the case of a redetermination of the hospital-specific rate under §412.328(f), to the beginning of the new base period.

(iii) The final determination of the hospital-specific rate is subject to administrative and judicial review in accordance with subpart R of part 405 of this chapter, governing provider reimbursement determinations and appeals.

(iv) The intermediary adjusts the hospital-specific rate to reflect any revisions that result from administrative or judicial review of the final determination of hospital-specific rate. The revised determination is effective retroactively to the same extent as in paragraph (g)(2)(ii) of this section.

[56 FR 43449, Aug. 30, 1991; 57 FR 3016, 3017, Jan. 27, 1992; 57 FR 39828, Sept. 1, 1992; 60 FR 45849, Sept. 1, 1995; 62 FR 46031, Aug. 29, 1997]

§412.331 Determining hospital-specific rates in cases of hospital merger, consolidation, or dissolution.

(a) *New hospital merger or consolidation.* If, after a new hospital accepts its first patient but before the end of its base year, it merges with one or more existing hospitals, and two or more separately located hospital campuses are maintained, the hospital-specific rate and payment determination for the merged entity are determined as follows—

(1) *Post-merger base year payment methodology.* The new campus is paid based on reasonable costs until the end of its base year. The existing campus remains on its previous payment methodology until the end of the new campus' base year. Effective with the first cost reporting period beginning after the end of the new campus' base year, the intermediary determines a hospital-specific rate applicable to the new campus in accordance with §412.328, and then determines a revised hospital-specific rate for the merged