(2) The intermediary reviews the hospital's request and any additional information and decides whether a change in the DRG assignment is appropriate. If the intermediary decides that a higher-weighted DRG should be assigned, the case will be reviewed by the appropriate QIO as specified in § 466.71(c)(2) of this chapter.

(3) Following the 60-day period described in paragraph (d)(1) of this section, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

(e) *Revision of DRG classification and weighting factors.* Beginning with discharges in fiscal year 1988, CMS adjusts the classifications and weighting factors established under paragraphs (a) and (b) of this section at least annually to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources.

[50 FR 12741, Mar. 29, 1985, as amended at 52 FR 33057, Sept. 1, 1987; 57 FR 39821, Sept. 1, 1992; 59 FR 45397, Sept. 1, 1994]

§ 412.62 Federal rates for inpatient operating costs for fiscal year 1984.

(a) *General rule.* CMS determines national adjusted DRG prospective payment rates for operating costs, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system under subpart B of this part, and determines regional adjusted DRG prospective payment rates for inpatient operating costs for such discharges in each region, for which payment may be made under Medicare Part A. Such rates are determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as described in paragraphs (b) through (k) of this section.

(b) *Determining allowable individual hospital inpatient operating costs.* CMS determines the Medicare allowable operating costs per discharge of inpatient hospital services for each hospital in the data base for the most recent cost reporting period for which data are available.

(c) *Updating for fiscal year 1984.* CMS updates each amount determined under paragraph (b) of this section for fiscal year 1984 by—

(1) Updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under paragraph (b) of this section and fiscal year 1983; and

(2) Projecting for fiscal year 1984 by the applicable percentage increase in the hospital market basket for fiscal year 1984.

(d) *Standardizing amounts.* CMS standardizes the amount updated under paragraph (c) of this section for each hospital by—

(1) Adjusting for area variations in case mix among hospitals;

(2) Excluding an estimate of indirect medical education costs;

(3) Adjusting for area variations in hospital wage levels; and

(4) Adjusting for the effects of a higher cost of living for hospitals located in Alaska and Hawaii.

(e) *Computing urban and rural averages.* CMS computes an average of the standardized amounts determined under paragraph (d) of this section for urban and rural hospitals in the United States and for urban and rural hospitals in each region.

(f) *Geographic classifications.* (1) For purposes of paragraph (e) of this section, the following definitions apply:

(i) The term *region* means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes.

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21, 42 U.S.C. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(iii) The term *rural area* means any area outside an urban area.

(iv) The phrase *hospital reclassified as rural* means a hospital located in a county that was part of an MSA or NECMA, as defined by the Executive Office of Management and Budget, but is not part of an MSA or NECMA as a result of an Executive Office of Management and Budget redesignation occurring after April 20, 1983.

(2) For hospitals within an MSA or NECMA that crosses census division boundaries, the following provisions apply:

(i) The MSA or NECMA is deemed to belong to the census division in which most of the hospitals within the MSA or NECMA are located.

(ii) If a hospital would receive a lower Federal rate because most of the hospitals are located in a census division with a lower Federal rate than the rate applicable to the census division in which the hospital is located, the payment rate will not be reduced for the hospital's cost reporting period beginning before October 1, 1984.

(iii) If an equal number of hospitals within the MSA or NECMA are located in each census division, such hospitals are deemed to be in the census division with the higher Federal rate.

(g) *Adjusting the average standardized amounts.* CMS adjusts each of the average standardized amounts determined under paragraphs (c), (d), and (e) of this section by factors representing CMS's estimates of the following:

(1) The amount of payment that would have been made under Medicare Part B for nonphysician services to hospital inpatients during the first cost reporting period subject to prospective payment were it not for the fact that such services must be furnished either directly by hospitals or under arrangements in order for any Medicare payment to be made after September 30, 1983 (the effective date of § 405.310(m) of this chapter).

(2) The amount of FICA taxes that would be incurred during the first cost reporting period subject to the prospective payment system, by hospitals that had not incurred such taxes for any or all of their employees during the base period described in paragraph (c) of this section.

(h) *Reducing for value of outlier payments.* CMS reduces each of the adjusted average standardized amounts determined under paragraphs (c) through (g) of this section by a proportion equal to the proportion (estimated by CMS) of the total amount of payments based on DRG prospective payment rates that are additional payments for outlier cases under subpart F of this part.

(i) *Maintaining budget neutrality.* (1) CMS adjusts each of the reduced standardized amounts determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) is not greater or less than 25 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1984 under the Social Security Act as in effect on April 19, 1983.

(2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.

(j) *Computing Federal rates for inpatient operating costs for urban and rural hospitals in the United States and in each region.* For each discharge classified within a DRG, CMS establishes a national prospective payment rate for inpatient operating costs and a regional prospective payment rate for inpatient operating costs for each region, as follows:

(1) For hospitals located in an urban area in the United States or in that region respectively, the rate equals the product of—

(i) The adjusted average standardized amount (computed under paragraphs (c) through (i) of this section) for hospitals located in an urban area in the United States or in that region; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(2) For hospitals located in a rural area in the United States or in that region respectively, the rate equals the product of—

(i) The adjusted average standardized amount (computed under paragraphs (c) through (i) of this section) for hospitals located in a rural area in the United States or that region; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(k) *Adjusting for different area wage levels.* CMS adjusts the proportion (as estimated by CMS from time to time) of Federal rates computed under paragraph (j) of this section that are attributable to wages and labor-related costs, for area differences in hospital wage levels by a factor (established by CMS) reflecting the relative hospital wage level in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (f) of this section) of the hospital compared to the national average hospital wage level.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 53 FR 38527, Sept. 30, 1988; 57 FR 39821, Sept. 1, 1992; 58 FR 46337, Sept. 1, 1993]

§ 412.63 Federal rates for inpatient operating costs for Federal fiscal years 1984 through 2004.

(a) *General rule.* (1) CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal years 1985 through 2004 involving inpatient hospital service of a hospital in the United States, subject to the PPS, and determines a regional adjusted PPS rate for operating costs for such discharges in each region for which payment may be made under Medicare Part A.

(2) Each such rate is determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as described under paragraphs (b) through (u) of this section.

(b) *Geographic classifications.* Effective for fiscal years 1985 through 2004, the following rules apply.

(1) For purposes of this section, the definitions set forth in § 412.62(f) apply, except that, effective January 1, 2000, a hospital reclassified as rural may mean a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.

(2) For hospitals within an MSA or NECMA that crosses census division boundaries, the following provisions apply:

(i) The MSA or NECMA is deemed to belong to the census division in which most of the hospitals within the MSA or NECMA are located.

(ii) A hospital that met the conditions specified in § 412.62(f)(2)(ii) and therefore did not receive a lower Federal rate that would have applied for cost reporting periods beginning before October 1, 1984, receives the lower Federal rate applicable to all hospitals in the MSA or NECMA in which it is located effective with the hospital's cost reporting period that begins on or after October 1, 1984.

(iii) The higher Federal rate is payable to all hospitals in the MSA or NECMA if an equal number of hospitals within the MSA or NECMA are located in each census division.

(3) For discharges occurring on or after October 1, 1988, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs or NECMAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs or NECMAs. These EOMB standards are set forth in the notice of final standards for classification of MSAs published in the FEDERAL REGISTER on January 3, 1980 (45 FR 956), and available from CMS, East High Rise Building, room 132, 6325 Security Boulevard, Baltimore, Maryland 21207.