

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.

(e)–(f) [Reserved]

(g) *Hospital cancellation of referral center status.* (1) A hospital may at any time request cancellation of its status as a referral center and be paid prospective payments per discharge based on the applicable rural rate, as determined in accordance with subpart D of this part.

(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.

(4) A hospital that submits a written request on or after October 1, 2007, to cancel its reclassification under § 412.103(g) is deemed to have cancelled its status as a rural referral center effective on the same date the cancellation under § 412.103(g) takes effect. The provision of this paragraph (g)(4) applies to hospitals that qualify as rural referral centers under § 412.96 based on rural status acquired under § 412.103.

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

(1) *Updating process.* CMS 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 (h)(1) of this section, CMS uses all inpatient hospital bills received for discharges subject to prospective payment during the Federal fiscal year being monitored.

(3) *Effective date.* CMS 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.

(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 section, CMS calculates the criteria as follows:

(1) *Updating process.* CMS 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 (i)(1) of this section, CMS uses the most recent hospital admissions or discharge data available.

(3) *Annual notice.* CMS 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 the same cost reporting period used to develop the regional criteria in this section 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.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.96, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.fdsys.gov.

§ 412.98 [Reserved]

§ 412.100 Special treatment: Renal transplantation centers.

(a) *Adjustments for renal transplantation centers.* (1) CMS 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

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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 beneficiary 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 beneficiary 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]

§412.101 Special treatment: Inpatient hospital payment adjustment for low-volume hospitals.

(a) *Definitions.* Beginning in FY 2011, the terms used in this section are defined as follows:

Medicare discharges means discharge of inpatients entitled to Medicare Part A, including discharges associated with

individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare and also discharges of individuals enrolled in a MA organization under Medicare Part C.

Road miles means “miles” as defined in §412.92(c)(1).

(b) *General considerations.* (1) CMS provides an additional payment to a qualifying hospital for the higher incremental costs associated with a low volume of discharges. The amount of any additional payment for a qualifying hospital is calculated in accordance with paragraph (c) of this section.

(2) In order to qualify for this adjustment, a hospital must meet the following criteria:

(i) For FY 2005 through FY 2010 and the portion of FY 2015 beginning on April 1, 2015, and subsequent fiscal years, a hospital must have fewer than 200 total discharges, which includes Medicare and non-Medicare discharges, during the fiscal year, based on the hospital's most recently submitted cost report, and be located more than 25 road miles (as defined in paragraph (a) of this section) from the nearest “subsection (d)” (section 1886(d) of the Act) hospital.

(ii) For FY 2011 through FY 2014, and the portion of FY 2015 before April 1, 2015, a hospital must have fewer than 1,600 Medicare discharges, as defined in paragraph (a) of this section, during the fiscal year, based on the hospital's Medicare discharges from the most recently available MedPAR data as determined by CMS, and be located more than 15 road miles, as defined in paragraph (a) of this section, from the nearest “subsection (d)” (section 1886(d) of the Act) hospital.

(3) In order to qualify for the adjustment, a hospital must provide its fiscal intermediary or Medicare administrative contractor with sufficient evidence that it meets the distance requirement specified under paragraph (b)(2) of this section. The fiscal intermediary or Medicare administrative contractor will base its determination of whether the distance requirement is satisfied upon the evidence presented by the hospital and other relevant evidence, such as maps, mapping software, and inquiries to State and local police,