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

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

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

(c) *CMS review.* The CMS 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, CMS 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 CMS by September 1, 2000, and satisfies any of the criteria set forth in paragraph (a) of this section, CMS will consider the filing date to be January 1, 2000.

(e) *Withdrawal of application.* A hospital may withdraw an application at any time prior to the date of CMS'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) *Hospitals other than rural referral centers.* Except as provided in paragraph (g)(2) of this section—

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

(ii) The hospital's cancellation of the classification is effective beginning with the next full cost reporting period.

(2) *Hospitals classified as rural referral centers.* For a hospital that was classified as a rural referral center under §412.96 based on rural reclassification under this section—

(i) A hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office not less than 120 days prior to the end of a Federal fiscal year and after being paid as rural for at least one 12-month cost reporting period.

(ii) The hospital's cancellation of the classification is not effective until it has been paid as rural for at least one 12-month cost reporting period, and not until the beginning of the Federal fiscal year following such 12-month cost reporting period.

(iii) The provisions of paragraphs (g)(2)(i) and (g)(2)(ii) of this section are effective for all written requests submitted by hospitals on or after October 1, 2007, to cancel rural reclassifications.

[65 FR 47048, Aug. 1, 2000, as amended at 69 FR 49244, Aug. 11, 2004; 69 FR 60252, Oct. 7, 2004; 70 FR 47486, Aug. 12, 2005; 72 FR 47411, Aug. 22, 2007; 74 FR 43997, Aug. 27, 2009; 79 FR 50353, Aug. 22, 2014]

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

(a) *Criteria for classification.* CMS provides an additional payment to a hospital for inpatient services provided to ESRD beneficiaries who receive a dialysis treatment during a hospital stay, if the hospital has established that ESRD beneficiary discharges, excluding discharges classified into MS–DRG 652 (Renal Failure), MS–DRG 682 (Renal Failure with MCC), MS–DRG 683 (Renal Failure with CC), MS–DRG 684 (Renal Failure without CC/MCC) and MS–DRG 685 (Admit for Renal Dialysis), where the beneficiary received dialysis services during the inpatient stay, constitute 10 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.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39824, Sept. 1, 1992; 69 FR 49244, Aug. 11, 2004; 73 FR 48755, Aug. 19, 2008]

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

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

(a) *Basic data.* CMS 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 under paragraph (b) of this section).

(i) Except for the special circumstances for Medicare GME affiliated groups, emergency Medicare GME affiliated groups, and new programs described in paragraphs (f)(1)(vi) and (f)(1)(vii) of this section for cost reporting periods beginning on or after October 1, 1997, and for the special circumstances for closed hospitals or closed programs described in paragraph (f)(1)(ix) of this section for cost reporting periods beginning on or after October 1, 2002, this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period after accounting for the cap on the number of allopathic and osteopathic full-time equivalent residents as described in paragraph (f)(1)(iv) of this section, and adding to the capped numerator any dental and podiatric full-time equivalent residents.

(ii)(A) For new programs started prior to October 1, 2012, the exception for new programs described in paragraph (f)(1)(vii) of this section applies to each new program individually for which the full-time equivalent cap may be adjusted based on the period of years equal to the minimum accredited length of each new program.

(B) For new programs started on or after October 1, 2012, the exception for new programs described in paragraph (f)(1)(vii) of this section applies to each new program individually during the cost reporting periods prior to the beginning of the applicable hospital's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started, for hospitals for which the full-time equivalent cap may be adjusted in accordance with § 413.79(e)(1) of this chapter, and prior to the beginning of the applicable hospital's cost reporting period that coincides with or follows the start of the sixth program year of the each individual new program started, for hospitals for which the full-time equivalent cap may be adjusted in accordance with § 413.79(e)(3) of this chapter.

(iii) The exception for closed hospitals and closed programs described in paragraph (f)(1)(ix) of this section applies only through the end of the first 12-month cost reporting period in which the receiving hospital trains the displaced full-time equivalent residents.

(iv) In the cost reporting period following the last year the receiving hospital's full-time equivalent cap is adjusted for the displaced resident(s), the resident-to-bed ratio cap in paragraph (a)(1) of this section is calculated as if the displaced full-time equivalent residents had not trained at the receiving hospital in the prior year.

(2) The hospital's DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment