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§ 412.50 Furnishing of inpatient hospital services directly or under arrangements.

(a) The applicable payments made under the prospective payment systems, as described in subparts H and M of this part, are payment in full for all inpatient hospital services, as defined in § 409.10 of this chapter. Inpatient hospital services do not include the following types of services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69 of this chapter.

(b) CMS does not pay any provider or supplier other than the hospital for services furnished to a beneficiary who is an inpatient, except for the services described in paragraphs (a)(1) through (a)(6) of this section.

(c) The hospital must furnish all necessary covered services to the beneficiary either directly or under arrangements (as defined in § 409.3 of this chapter).

[50 FR 12741, Mar. 29, 1985, as amended at 53 FR 38527, Sept. 30, 1988; 57 FR 39821, Sept. 1, 1992; 60 FR 63188, Dec. 8, 1995; 65 FR 18537, Apr. 7, 2000]

§ 412.52 Reporting and recordkeeping requirements.

All hospitals participating in the prospective payment systems must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 57 FR 39821, Sept. 1, 1992]

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Subpart D—Basic Methodology for Determining Prospective Payment Federal Rates for Inpatient Operating Costs

§ 412.60 DRG classification and weighting factors.

(a) *Diagnosis-related groups.* CMS establishes a classification of inpatient hospital discharges by Diagnosis-Related Groups (DRGs).

(b) *DRG weighting factors.* CMS assigns, for each DRG, an appropriate weighting factor that reflects the estimated relative cost of hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups, subject to a maximum ten percent reduction to the weighting factor for a DRG as compared to the weighting factor for the same DRG for the prior fiscal year.

(c) *Assignment of discharges to DRGs.* CMS establishes a methodology for classifying specific hospital discharges within DRGs which ensures that each hospital discharge is appropriately assigned to a single DRG based on essential data abstracted from the inpatient bill for that discharge.

(1) The classification of a particular discharge is based, as appropriate, on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status.

(2) Each discharge is assigned to only one DRG (related, except as provided in paragraph (c)(3) of this section, to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

(3) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill is returned to the hospital for validation and reverification. CMS's DRG classification system provides a DRG, and an appropriate weighting factor, for the group of cases for which the unrelated diagnosis and procedure are confirmed.

(d) *Review of DRG assignment.* (1) A hospital has 60 days after the date of the notice of the initial assignment of

a discharge to a DRG to request a review of that assignment. The hospital may submit additional information as a part of its request.

(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; 87 FR 49403, Aug. 10, 2022]

§ 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.

(4) For purposes of this section, any change in an MSA or NECMA designation is recognized on the October 1 following the effective date of the change.

(5) For discharges occurring on or after October 1, 1988, for hospitals that consist of two or more separately located inpatient hospital facilities the national adjusted prospective payment rate is based on the geographic location of the hospital facility at which the discharge occurs.

(c) *Updating previous standardized amounts.* (1) For discharges occurring in fiscal year 1985 through fiscal year 2003, CMS computes average standardized amounts for hospitals in urban areas and rural areas within the United States, and in urban areas and rural areas within each region. For discharges occurring in fiscal year 2004, CMS computes an average standardized amount for hospitals located in all areas.

(2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under § 412.62(g)—

(i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;

(ii) Adjusted by the estimated amount of Medicare payment for non-physician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;

(iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and

(iv) Adjusted for budget neutrality under paragraph (h) of this section.

(3) For fiscal year 1986 and thereafter, CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective adjusted average standardized amounts computed for the previous fiscal year—

(i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;

(ii) Adjusted by the estimated amount of Medicare payment for non-physician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and

(iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by CMS) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by CMS) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

(4) For fiscal years 1987 through 1990 CMS standardizes the average standardized amounts by excluding an estimate of the payments for hospitals that serve a disproportionate share of low-income patients.

(5) For fiscal years 1987 through 2004, CMS standardizes the average standardized amounts by excluding an estimate of indirect medical education payments.

(6) For fiscal years 1988 through 2003, CMS computes average standardized amounts for hospitals located in large urban areas, other urban areas, and rural areas. The term *large urban area* means an MSA with a population of more than 1,000,000 or an NECMA, with a population of more than 970,000 based on the most recent available population data published by the Census Bureau. For fiscal year 2004, CMS computes an average standardized amount for hospitals located in all areas.

(d) *Applicable percentage change for fiscal year 1986.* (1) The applicable percentage change for fiscal year 1986 is—

(i) For discharges occurring on or after October 1, 1985 and before May 1, 1986, zero percent; and

(ii) For discharges occurring on or after May 1, 1986, one-half of one percent.

(2) For purposes of determining the standardized amounts for discharges occurring on or after October 1, 1986, the applicable percentage increase for fiscal year 1986 is deemed to have been one-half of one percent.

(e) *Applicable percentage change for fiscal year 1987.* The applicable percentage change for fiscal year 1987 is 1.15 percent.

(f) *Applicable percentage change for fiscal year 1988.* (1) The applicable percentage change for fiscal year 1988 is—

(i) For discharges occurring on or after October 1, 1987 and before November 21, 1987, zero percent;

(ii) For discharges occurring on or after November 21, 1987 and before April 1, 1988, 2.7 percent; and

(iii) For discharges occurring on or after April 1, 1988 and before October 1, 1988—

(A) 3.0 percent for hospitals located in rural areas;

(B) 1.5 percent for hospitals located in large urban areas; and

(C) 1.0 percent for hospitals located in other urban areas.

(2) For purposes of determining the standardized amounts for discharges occurring on or after October 1, 1988 (for Federal fiscal year 1989), the applicable percentage change for fiscal year 1988 is deemed to have been—

(i) 3.0 percent for hospitals located in rural areas;

(ii) 1.5 percent for hospitals located in large urban areas; and

(iii) 1.0 percent for hospitals located in other urban areas.

(g) *Applicable percentage change for fiscal year 1989.* The applicable percentage change for fiscal year 1989 is the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter)—

(1) Minus 1.5 percentage points for hospitals located in rural areas;

(2) Minus 2.0 percentage points for hospitals in large urban areas; and

(3) Minus 2.5 percentage points for hospitals in other urban areas.

(h) *Applicable percentage change for fiscal year 1990.* (1) The applicable percentage change for fiscal year 1990 is—

(i) For discharges occurring on or after October 1, 1989 and before January 1, 1990, 5.5 percent; and

(ii) For discharges occurring on or after January 1, 1990 and before October 1, 1990—

(A) 9.72 percent for hospitals located in rural areas;

(B) 5.62 percent for hospitals located in large urban areas; and

(C) 4.97 percent for hospitals located in other urban areas.

(2) For purposes of determining the standardized amounts for discharges occurring on or after October 1, 1990, the applicable percentage change for fiscal year 1990 is deemed to have been the percentage change provided for in paragraph (h)(1)(ii) of this section.

(i) *Applicable percentage change for fiscal year 1991.* (1) The applicable percentage change for fiscal year 1991 is—

(i) For discharges occurring on or after October 1, 1990 and before October 21, 1990, 5.2 percent;

(ii) For discharges occurring on or after October 21, 1990 and before January 1, 1991, 0.0 percent; and

(iii) For discharges occurring on or after January 1, 1991 and before October 1, 1991—

(A) 4.5 percent for hospitals located in rural areas; and

(B) 3.2 percent for hospitals located in large urban areas and other urban areas.

(2) For purposes of determining the standardized amounts for discharges occurring on or after October 1, 1991, the applicable percentage change for fiscal year 1991 is deemed to have been the percentage change provided for in paragraph (i)(1)(iii) of this section.

(j) *Applicable percentage change for fiscal year 1992.* The applicable percentage change for fiscal year 1992 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a)(3) of this chapter)—

(1) Minus 0.6 percentage points for hospitals located in rural areas.

(2) Minus 1.6 percentage points for hospitals located in large urban areas and other urban areas.

(k) *Applicable percentage change for fiscal year 1993.* The applicable percentage change for fiscal year 1993 is the

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percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a)(3) of this chapter)—

(1) Minus 0.55 percentage points for hospitals located in rural areas.

(2) Minus 1.55 percentage points for hospitals located in large urban areas and other urban areas.

(l) *Applicable percentage change for fiscal year 1994.* The applicable percentage change for fiscal year 1994 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter)—

(1) Minus 1.0 percentage point for hospitals located in rural areas.

(2) Minus 2.5 percentage points for hospitals located in large urban areas and other urban areas.

(m) *Applicable percentage change for fiscal year 1995.* The applicable percentage change for fiscal year 1995 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter)—

(1) Plus, for hospitals located in rural areas, the percentage increase necessary so that the average standardized amounts computed under paragraph (c) through (i) of this section are equal to the average standardized amounts for hospitals located in an urban area other than a large urban area.

(2) Minus 2.5 percentage points for hospitals located in large urban areas and other urban areas.

(n) *Applicable percentage change for fiscal year 1996.* The applicable percentage change for fiscal year 1996 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter) minus 2.0 percentage points for all areas.

(o) *Applicable percentage change for fiscal year 1997.* The applicable percentage change for fiscal year 1997 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter) minus 0.5 percentage point for all areas.

(p) *Applicable percentage change for fiscal year 1998.* The applicable percentage change for fiscal year 1998 is 0 percent for hospitals in all areas.

(q) *Applicable percentage change for fiscal year 1999.* The applicable percentage change for fiscal year 1999 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) minus 1.9 percentage points for hospitals in all areas.

(r) *Applicable percentage change for fiscal year 2000.* The applicable percentage change for fiscal year 2000 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter) minus 1.8 percentage points for hospitals in all areas.

(s) *Applicable percentage change for fiscal year 2001.* The applicable percentage change for discharges occurring in fiscal year 2001 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas as follows:

(1) For discharges occurring on October 1, 2000 or before April 1, 2001 the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for sole community hospitals and the increase in the market basket index minus 1.1 percentage points for other hospitals in all areas; and

(2) For discharges occurring on April 1, 2001 or before October 1, 2001 the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for sole community hospitals and the increase in the market basket index plus 1.1 percentage points for other hospitals in all areas.

(t) *Applicable percentage change for fiscal years 2002 and 2003.* The applicable percentage change for fiscal years 2002 and 2003 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) minus 0.55 percentage points for hospitals in all areas.

(u) *Applicable percentage change for fiscal year 2004.* The applicable percentage change for fiscal year 2004 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas.

(v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure 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 fiscal year 1985) is not greater or less than 50 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1985 under the law 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.

(w) *Computing Federal rates for inpatient operating costs for hospitals located in large urban and other areas.* For each discharge classified within a DRG, CMS establishes for the fiscal year a national prospective payment rate and a regional prospective payment rate for inpatient operating costs, for each region, as follows:

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

(i) The adjusted average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in a large 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 an other area in the United States or that region respectively, the rate equals the product of—

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

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

(x) *Adjusting for different area wage levels.* (1) CMS adjusts the proportion

(as estimated by CMS from time to time) of Federal rates for inpatient operating costs 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 based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs. The wage index is updated annually.

(2)(i) CMS makes a midyear correction to the wage index for an area only if a hospital can show that—

(A) The intermediary or CMS made an error in tabulating its data; and

(B) The hospital could not have known about the error, or did not have the opportunity to correct the error, before the beginning of the Federal fiscal year.

(ii) A midyear correction to the wage index is effective prospectively from the date the change is made to the wage index.

(3) If a judicial decision reverses a CMS denial of a hospital's wage data revision request, CMS pays the hospital by applying a revised wage index that reflects the revised wage data as if CMS's decision had been favorable rather than unfavorable.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.63, see the List of CFR Sections Affected, which appears in the finding Aids section of the printed volume and at www.govinfo.gov.

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

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

(i) The term *region* means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area or a Metropolitan division (in the case where a Metropolitan Statistical Area is divided into Metropolitan Divisions), as defined by the Executive Office of Management and Budget; or

(B) For discharges occurring on or after October 1, 1983, and before October 1, 2007, the following New England counties 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.

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

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3)(i) For discharges occurring on or after October 1, 2004, a hospital that is 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 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. Qualifying counties are determined based upon OMB standards, using the most recent OMB standards for delineating statistical areas adopted by CMS.

(ii) For discharges occurring on or after October 1, 2007, hospitals in the following New England counties, if not already located in an urban area, are deemed to be located in 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.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.

(5) For hospitals that consist of two or more separately located inpatient hospital facilities, the national adjusted prospective payment rate is based on the geographic location of the hospital facility at which the discharge occurred.

(c) *Computing the standardized amount.* CMS computes an average standardized amount that is applicable to all hospitals located in all areas, updated by the applicable percentage increase specified in paragraph (d) of this section. CMS standardizes the average standardized amount by excluding an estimate of indirect medical education payments.

(d) *Applicable percentage change for fiscal year 2005 and for subsequent fiscal years.* (1) The applicable percentage change for updating the standardized amount for all hospitals in all areas is—

(i) For fiscal year 2005 through fiscal year 2009, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraph (d)(2) of this section.

(ii) For fiscal year 2010, for discharges—

(A) On or after October 1, 2009 and before April 1, 2010, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraph (d)(2) of this section; and

(B) On or after April 1, 2010 and before October 1, 2010, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraph (d)(2) of this section, less 0.25 percentage point.

(iii) For fiscal year 2011, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this subchapter) for prospective payment hospitals, subject to the provisions of paragraph (d)(2) of this section, less 0.25 percentage point.

(iv) For fiscal years 2012 and 2013, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraph (d)(2) of this section, less a multifactor productivity adjustment (as determined by CMS) and less 0.1 percentage point.

(v) For fiscal year 2014, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraph (d)(2) of this section, less a multifactor productivity adjustment (as determined by CMS) and less 0.3 percentage point.

(vi) For fiscal years 2015 and 2016, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraphs (d)(2) and (3) of this section, less a multifactor productivity adjustment (as determined by CMS) and less 0.2 percentage point.

(vii) For fiscal years 2017, 2018, and 2019, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraphs (d)(2) and (3) of this section, less a multifactor productivity adjustment (as determined by CMS) and less 0.75 percentage point.

(viii) For fiscal year 2020 and subsequent fiscal years, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraphs (d)(2) and (3) of this section, less a

multifactor productivity adjustment (as determined by CMS).

(2)(i) In the case of a “subsection (d) hospital,” as defined under section 1886(d)(1)(B) of the Act, that does not submit quality data on a quarterly basis to CMS, in the form and manner specified by CMS, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals is reduced—

(A) For fiscal years 2005 and 2006, by 0.4 percentage points; and

(B) For fiscal year 2007 through 2014, by 2 percentage points.

(C) For fiscal year 2015 and subsequent fiscal years, by one-fourth.

(ii) Any reduction pursuant to this paragraph (d)(2) will apply only to the fiscal year involved and will not be taken into account in computing the applicable percentage change for a subsequent fiscal year.

(3)(i) Beginning fiscal year 2015, in the case of a “subsection (d) hospital,” as defined under section 1886(d)(1)(B) of the Act, that is not a meaningful electronic health record (EHR) user as defined in part 495 of this chapter for the applicable EHR reporting period and does not receive an exception, three-fourths of the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals is reduced—

(A) For fiscal year 2015, by 33⅓ percent;

(B) For fiscal year 2016, by 66⅔ percent; and

(C) For fiscal year 2017 and subsequent fiscal years, by 100 percent.

(ii) Beginning fiscal year 2022, in the case of a “subsection (d) Puerto Rico hospital,” as defined under section 1886(d)(9)(A) of the Act, that is not a meaningful EHR user as defined in part 495 of this chapter for the applicable EHR reporting period and does not receive an exception, three-fourths of the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals is reduced—

(A) For fiscal year 2022, by 33⅓ percent;

(B) For fiscal year 2023, by 66⅔ percent; and

(C) For fiscal year 2024 and subsequent fiscal years, by 100 percent.

(4) *Exception*—(i) *General rules.* The Secretary may, on a case-by-case basis, exempt an eligible hospital that is not a qualifying eligible hospital from the application of the reduction under paragraph (d)(3) of this section if the Secretary determines that compliance with the requirement for being a meaningful EHR user would result in a significant hardship for the eligible hospital.

(ii) To be considered for an exception, a hospital must submit an application, in the manner specified by CMS, demonstrating that it meets one or more than one of the criteria specified in this paragraph (d)(4) of this section. These types of exceptions are subject to annual renewal, but in no case may a hospital be granted this type of exception for more than 5 years. (See § 495.4 for definitions of payment adjustment year, EHR reporting period, and meaningful EHR user.)

(A) During any 90-day period from the beginning of the fiscal year that is 2 years before the payment adjustment year to July 1 of the year before the payment adjustment year, or a later date specified by CMS, the hospital was located in an area without sufficient Internet access to comply with the meaningful use objectives requiring internet connectivity, and faced insurmountable barriers to obtaining such internet connectivity. Applications requesting this exception must be submitted by July 1 of the year before the applicable payment adjustment year, or a later date specified by CMS.

(B)(1) During the fiscal year that is 2 fiscal years before the payment adjustment year, the hospital that has previously demonstrated meaningful use faces extreme and uncontrollable circumstances that prevent it from becoming a meaningful EHR user. Applications requesting this exception must be submitted by July 1 of the year before the applicable payment adjustment year, or a later date specified by CMS.

(2) During the fiscal year preceding the payment adjustment year, the hospital that has not previously demonstrated meaningful use faces extreme and uncontrollable cir-

cumstances that prevent it from becoming a meaningful EHR user. Applications requesting this exception must be submitted by July 1 of the year before the applicable payment adjustment year, or a later date specified by CMS.

(C) The hospital is new in the payment adjustment year, and has not previously operated (under previous or present ownership). This exception expires beginning with the first Federal fiscal year that begins on or after the hospital has had at least one 12-month (or longer) cost reporting period after they accept their first Medicare covered patient. For purposes of this exception, the following hospitals are not considered new hospitals:

(1) A hospital that builds new or replacement facilities at the same or another location even if coincidental with a change of ownership, a change in management, or a lease arrangement.

(2) A hospital that closes and subsequently reopens.

(3) A hospital that changes its status from a CAH to a hospital that is subject to the Medicare hospital inpatient prospective payment systems.

(iii) *Exception for decertified EHR technology.* Beginning with the fiscal year 2019 payment adjustment year, the Secretary shall exempt an eligible hospital that is not a qualifying eligible hospital from the application of the reduction under paragraph (d)(3) of this section if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by the eligible hospital has been decertified under ONC's Health IT Certification Program. To be considered for an exception, an eligible hospital must submit an application, in the manner specified by CMS, demonstrating that the certified EHR technology was decertified during the 12-month period preceding the applicable EHR reporting period for the payment adjustment year, or during the applicable EHR reporting period for the payment adjustment year, and that the eligible hospital made a good faith effort to obtain another certified EHR technology for that EHR reporting period.

(See § 495.4 of this chapter for definitions of payment adjustment year, EHR reporting period, and meaningful EHR user.) Applications requesting this exception must be submitted by July 1 of the year before the applicable payment adjustment year, or a later date specified by CMS. This exception is subject to annual renewal, but in no case may an eligible hospital be granted an exception under paragraph (d)(4) of this section for more than 5 years.

(5) A State in which hospitals are paid for services under section 1814(b)(3) of the Act must—

(i) Adjust the payments to each eligible hospital in the State that is not a meaningful EHR user in a manner that is designed to result in an aggregate reduction in payments to hospitals in the State that is equivalent to the aggregate reduction that would have occurred if payments had been reduced to each eligible hospital in the State in a manner comparable to the reduction under paragraph (d)(3) of this section; and

(ii) Provide to the Secretary, by January 1, 2013, a report on the method that it proposes to employ in order to make the requisite payment adjustment described in paragraph (d)(5)(i) of this section.

(e) *Maintaining budget neutrality.* (1) CMS makes an adjustment to the standardized amount to ensure that—

(i) Changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to hospitals are not affected; and

(ii) Except as provided in paragraphs (e)(4) and (h)(4)(vii) of this section, the annual updates and adjustments to the wage index under paragraph (h) of this section are made in a manner that ensures that aggregate payments are not affected; and

(2) CMS also makes an adjustment to the rates to ensure that aggregate payments after implementation of reclassifications under subpart L of this part are equal to the aggregate prospective payments that would have been made in the absence of these provisions.

(3) To the extent CMS determines that changes to the DRG classification and recalibrations of the DRG relative weights for a previous year (or esti-

mates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in coding or classification of discharges that do not reflect real changes in case mix, CMS may adjust the standardized amount for subsequent fiscal years so as to eliminate the effect of such coding and classification changes.

(4) CMS makes an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the Balanced Budget Act of 1997 (Pub. L. 105-33) and, for discharges on or after October 1, 2004, and before October 1, 2018, the imputed floor under paragraph (h)(4) of this section are equal to the aggregate prospective payments that would have been made in the absence of such provisions as follows:

(i) Beginning October 1, 2008, such adjustment is transitioned from a nationwide to a statewide adjustment as follows:

(A) From October 1, 2008 through September 30, 2009, the wage index is a blend of 20 percent of a wage index with a statewide adjustment and 80 percent of a wage index with a nationwide adjustment.

(B) From October 1, 2009 through September 30, 2010, the wage index is a blend of 50 percent of a wage index with a statewide adjustment and 50 percent of a wage index with a nationwide adjustment.

(ii) Beginning October 1, 2010, such adjustment is a full nationwide adjustment.

(5) CMS makes an adjustment to the standardized amount to ensure that the reasonable cost based payments for allogeneic hematopoietic stem cell acquisition costs are made in a manner so that aggregate payments to hospitals are not affected.

(f) *Adjustment for outlier payments.* CMS reduces the adjusted average standardized amount determined under paragraph (c) through (e) of this section by a proportion equal to the proportion (estimated by CMS) to the total amount of payments based on DRG prospective payment rates that are additional payments for outlier cases under subpart F of this part.

(g) *Computing Federal rates for inpatient operating costs for hospitals located in all areas.* For each discharge classified within a DRG, CMS establishes for the fiscal year a national prospective payment rate for inpatient operating costs based on the standardized amount for the fiscal year and the weighting factor determined under § 412.60(b) for that DRG.

(h) *Adjusting for different area wage levels.* CMS adjusts the proportion of the Federal rate for inpatient operating costs that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs. The adjustment described in this paragraph (h) also takes into account the earnings and paid hours of employment by occupational category.

(1) The wage index is updated annually.

(2) CMS determines the proportion of the Federal rate that is attributable to wages and labor-related costs from time to time, employing a methodology that is described in the annual regulation updating the system of payment for inpatient hospital operating costs.

(3) For discharges occurring on or after October 1, 2004, CMS employs 62 percent as the proportion of the rate that is adjusted for the relative level of hospital wages and wage-related costs, unless employing that percentage would result in lower payments for the hospital than employing the proportion determined under the methodology described in paragraph (h)(2) of this section.

(4) For discharges on or after October 1, 2004 and before October 1, 2018, and for discharges on or after October 1, 2021, CMS establishes a minimum wage index for each all-urban State, as defined in paragraph (h)(5) of this section. This minimum wage index value is computed using the following methodology:

(i) CMS computes the ratio of the lowest-to-highest wage index for each all-urban State;

(ii) CMS computes the average of the ratios of the lowest-to-highest wage indexes of all the all-urban States;

(iii) For each all-urban State, CMS determines the higher of the State's own lowest-to-highest rate (as determined under paragraph (h)(4)(i) of this section) or the average lowest-to-highest rate (as determined under paragraph (h)(4)(ii) of this section);

(iv) For each State, CMS multiplies the rate determined under paragraph (h)(4)(iii) of this section by the highest wage index value in the State;

(v) The product determined under paragraph (h)(4)(iv) of this section is the minimum wage index value for the State, except as provided under paragraph (h)(4)(vi) of this section;

(vi) For discharges on or after October 1, 2012 and before October 1, 2018, and for discharges on or after October 1, 2021, the minimum wage index value for the State is the higher of the value determined under paragraph (h)(4)(iv) of this section or the value computed using the following alternative methodology:

(A) CMS estimates a percentage representing the average percentage increase in wage index for hospitals receiving the rural floor due to such floor.

(B) For each all-urban State, CMS makes a onetime determination of the lowest hospital wage index in the State (including all adjustments to the hospital's wage index, except for the rural floor, the rural floor budget neutrality, and the outmigration adjustment) and increases this wage index by the percentage determined under paragraph (h)(4)(vi)(A) of this section, the result of which establishes the alternative minimum wage index value for the State.

(vii) For discharges on or after October 1, 2021, the minimum wage index computed under this paragraph must not be applied in a budget neutral manner.

(5)(i) For purposes of paragraph (h)(4) of this section, for discharges on or after October 1, 2004 and before October 1, 2018, an all-urban State is a State with no rural areas, as defined in this

section, or a State in which there are no hospitals classified as rural. For purposes of this definition, a State with rural areas and with hospitals reclassified as rural under § 412.103 is not an all-urban State.

(ii) For purposes of paragraph (h)(4) of this section, for discharges on or after October 1, 2021, an all-urban State is a State with no rural areas, as defined in this section, or a State in which there are no hospitals classified as rural under section 1886 of the Act. For purposes of this definition, a hospital is classified as rural under section 1886 of the Act if it is assigned the State's rural area wage index value.

(6) If a new rural hospital that is subject to the hospital inpatient prospective payment system opens in a State that has an imputed rural floor and has rural areas, CMS uses the imputed floor as the hospital's wage index until the hospital's first cost report as an inpatient prospective payment system provider is contemporaneous with the cost reporting period being used to develop a given fiscal year's wage index.

(7) Beginning with fiscal year 2023, if CMS determines that a hospital's wage index value for a fiscal year would decrease by more than 5 percent as compared to the hospital's wage index value for the prior fiscal year, CMS limits the decrease to 5 percent for the fiscal year.

(i) *Adjusting the wage index to account for commuting patterns of hospital workers*—(1) *General criteria.* For discharges occurring on or after October 1, 2004, CMS adjusts the hospital wage index for hospitals located in qualifying counties to recognize the commuting patterns of hospital employees. A qualifying county is a county that meets all of the following criteria:

(i) Hospital employees in the county commute to work in an MSA (or MSAs) with a wage index (or wage indices) higher than the wage index of the MSA or rural statewide area in which the county is located.

(ii) At least 10 percent of the county's hospital employees commute to an MSA (or MSAs) with a higher wage index (or wage indices).

(iii) The 3-year average hourly wage of the hospital(s) in the county equals or exceeds the 3-year average hourly

wage of all hospitals in the MSA or rural statewide area in which the county is located.

(2) *Amount of adjustment.* A hospital located in a county that meets the criteria under paragraphs (i)(1)(i) through (i)(1)(iii) of this section will receive an increase in its wage index that is equal to a weighted average of the difference between the postreclassified wage index of the MSA (or MSAs) with the higher wage index (or wage indices) and the postreclassified wage index of the MSA or rural statewide area in which the qualifying county is located, weighted by the overall percentage of the hospital employees residing in the qualifying county who are employed in any MSA with a higher wage index.

(3) *Process for determining the adjustment.* (i) CMS will use the most accurate data available, as determined by CMS, to determine the out-migration percentage for each county.

(ii) CMS will include, in its annual proposed and final notices of updates to the hospital inpatient prospective payment system, a listing of qualifying counties and the hospitals that are eligible to receive the adjustment to their wage indexes for commuting hospital employees, and the wage index increase applicable to each qualifying county.

(iii) Any wage index adjustment made under this paragraph (i) is effective for a period of 3 fiscal years, except that hospitals in a qualifying county may elect to waive the application of the wage index adjustment. A hospital may waive the application of the wage index adjustment by notifying CMS in writing within 45 days of the date of public display of the annual notice of proposed rulemaking for the hospital inpatient prospective payment system at the Office of the Federal Register.

(iv) A hospital in a qualifying county that receives a wage index adjustment under this paragraph (i) is not eligible for reclassification under subpart L of this part or section 1886(d)(8) of the Act.

(j) *Wage index assignment for rural referral centers for FY 2005.* (1) CMS makes an exception to the wage index assignment of a rural referral center for FY 2005 if the rural referral center meets the following conditions:

(i) The rural referral center was reclassified for FY 2004 by the MGCRB to another MSA, but, upon applying to the MGCRB for FY 2005, was found to be ineligible for reclassification because its average hourly wage was less than 84 percent (but greater than 82 percent) of the average hourly wage of the hospitals geographically located in the MSA to which the rural referral center applied for reclassification for FY 2005.

(ii) The hospital may not qualify for any geographic reclassification under subpart L of this part, effective for discharges occurring on or after October 1, 2004.

(2) CMS will assign a rural referral center that meets the conditions of paragraph (j)(1) of this section the wage index value of the MSA to which it was reclassified by the MGCRB in FY 2004. The wage index assignment is applicable for discharges occurring during the 3-year period beginning October 1, 2004 and ending September 30, 2007.

(k) *Midyear corrections to the wage index.* (1) CMS makes a midyear correction to the wage index for an area only if a hospital can show that—

(i) The intermediary or CMS made an error in tabulating its data; and

(ii) The hospital could not have known about the error, or did not have the opportunity to correct the error, before the beginning of the Federal fiscal year.

(2)(i) Except as provided in paragraph (k)(2)(ii) of this section, a midyear correction to the wage index is effective prospectively from the date the change is made to the wage index.

(ii) Effective October 1, 2005, a change to the wage index may be made retroactively to the beginning of the Federal fiscal year, if, for the fiscal year in question, CMS determines all of the following—

(A) The fiscal intermediary or CMS made an error in tabulating data used for the wage index calculation;

(B) The hospital knew about the error in its wage data and requested the fiscal intermediary and CMS to correct the error both within the established schedule for requesting corrections to the wage data (which is at least before the beginning of the fiscal

year for the applicable update to the hospital inpatient prospective payment system) and using the established process; and

(C) CMS agreed before October 1 that the fiscal intermediary or CMS made an error in tabulating the hospital's wage data and the wage index should be corrected.

(1) *Judicial decision.* If a judicial decision reverses a CMS denial of a hospital's wage data revision request, CMS pays the hospital by applying a revised wage index that reflects the revised wage data as if CMS's decision had been favorable rather than unfavorable.

(m) *Adjusting the wage index to account for the Frontier State floor—*(1) *General criteria.* For discharges occurring on or after October 1, 2010, CMS adjusts the hospital wage index for hospitals located in qualifying States to recognize the wage index floor established for frontier States. A qualifying frontier State meets both of the following criteria:

(i) At least 50 percent of counties located within the State have a reported population density less than 6 persons per square mile.

(ii) The State does not receive a nonlabor-related share adjustment determined by the Secretary to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(2) *Amount of wage index adjustment.* A hospital located in a qualifying State will receive a wage index value not less than 1.00.

(3) *Process for determining and posting wage index adjustments.* (i) CMS uses the most recent Population Estimate data published by the U.S. Census Bureau to determine county definitions and population density. This analysis will be periodically revised, such as for updates to the decennial census data.

(ii) CMS will include a listing of qualifying frontier States and denote the hospitals receiving a wage index increase attributable to this provision in its annual updates to the hospital inpatient prospective payment system published in the FEDERAL REGISTER.

[69 FR 49242, Aug. 11, 2004]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.64, see the List of CFR Sections Affected, which appears in the

Finding Aids section of the printed volume and at www.govinfo.gov.

Subpart E—Determination of Transition Period Payment Rates for the Prospective Payment System for Inpatient Operating Costs

§ 412.70 General description.

For discharges occurring on or after April 1, 1988, and before October 1, 1996, payments to a hospital are based on the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region in which the hospital is located.

[57 FR 39822, Sept. 1, 1992, as amended at 58 FR 46338, Sept. 1, 1993]

§ 412.71 Determination of base-year inpatient operating costs.

(a) *Base-year costs.* (1) For each hospital, the intermediary will estimate the hospital's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1982 and before September 30, 1983.

(2) If the hospital's last cost reporting period ending before September 30, 1983 is for less than 12 months, the base period will be the hospital's most recent 12-month or longer cost reporting period ending before such short reporting period, with an appropriate adjustment for inflation. (The rules applicable to new hospitals are set forth in § 412.74.)

(b) *Modifications to base-year costs.* Prior to determining the hospital-specific rate, the intermediary will adjust the hospital's estimated base-year inpatient operating costs, as necessary, to include malpractice insurance costs in accordance with § 413.53(a)(1)(i) of this chapter, and exclude the following:

(1) Medical education costs as described in § 413.85 of this chapter.

(2) Capital-related costs as described in § 413.130 of this chapter.

(3) Kidney acquisition costs incurred by hospitals with approved kidney transplant programs as described in § 412.100. Kidney acquisition costs in

the base year are determined by multiplying the hospital's average kidney acquisition cost per kidney times the number of kidney transplants covered by Medicare Part A during the base period.

(4) Higher costs that were incurred for purposes of increasing base-year costs.

(5) One-time nonrecurring higher costs or revenue offsets that have the effect of distorting base-year costs as an appropriate basis for computing the hospital-specific rate.

(6) Higher costs that result from changes in hospital accounting principles initiated in the base year.

(7) The costs of qualified nonphysician anesthesiologists' services, as described in § 412.113(c).

(c) *Hospital's request for adjustment of base-year inpatient operating costs.* (1) Before the date it becomes subject to the prospective payment system for inpatient operating costs, a hospital may request the intermediary to further adjust its estimated base-period costs to take into account the following:

(i) Services paid for under Medicare Part B during the hospital's base year that will be paid for under prospective payments. The base-year costs may be increased to include estimated payments for certain services previously billed as physicians' services before the effective date of § 415.102(a) of this chapter, and estimated payments for nonphysicians' services that were not furnished either directly or under arrangements before October 1, 1983 (the effective date of § 405.310(m) of this chapter), but may not include the costs of anesthesiologists' services for which a physician employer continues to bill under § 405.553(b)(4) of this chapter.

(ii) The payment of FICA taxes during cost reporting periods subject to the prospective payment system, if the hospital had not paid such taxes for all its employees during its base period and will be required to participate effective January 1, 1984.

(2) If a hospital requests that its base-period costs be adjusted under paragraph (c)(1) of this section, it must timely provide the intermediary with sufficient documentation to justify the