

## § 412.280

(f) *Administrator's decision.* (1) The Administrator may not receive or consider any new evidence and must issue a decision based only upon the record as it appeared before the MGCRB and comments submitted under paragraphs (b)(2), (b)(3), (b)(4), (c)(2), and (c)(3) of this section.

(2) The Administrator issues a decision in writing to the party with a copy to CMS—

(i) Not later than 90 days following receipt of the party's request for review, except the Administrator may, at his or her discretion, for good cause shown, toll such 90 days; or

(ii) Not later than 105 days following issuance of the MGCRB decision in the case of review at the discretion of the Administrator, except the Administrator may, at his or her discretion, for good cause shown, toll such 105 days.

(3) The Administrator's decision issued under § 412.278 (a) or (c) is the final Departmental decision, unless it is amended under § 412.278(g). The final Departmental decision is not subject to judicial review.

(4) The Administrator's decision is not subject to judicial review.

(g) *Amendment of Administrator decision*—(1) *Hospital's request for amendment.* The hospital may request the Administrator to amend the decision for the limited purpose of correcting mathematical or computational errors, or to correct the decision if the evidence that was considered in making the decision clearly shows on its face that an error was made. The following procedure is followed:

(i) The hospital's request for amendment must be received by the Administrator within 10 days after the date the Administrator issues a decision. The request for amendment must be in writing, with a copy to CMS.

(ii) The Administrator promptly reviews the hospital's request and amends the decision, if necessary, within 5 days following receipt of the hospital's request for amendment.

(2) *Discretionary review by the Administrator.* Within 15 days following the issuance of the Administrator's decision, the Administrator, at his or her discretion, may amend the decision to correct mathematical or computational errors, or to correct the decision

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if the evidence that was considered in making the decision clearly shows on its face that an error was made. The Administrator's amended decision is final and is not subject to judicial review.

[55 FR 36766, Sept. 6, 1990, as amended at 56 FR 25489, June 4, 1991; 57 FR 39826, Sept. 1, 1992; 68 FR 45471, Aug. 1, 2003; 70 FR 47487, Aug. 12, 2005; 85 FR 59023, Sept. 18, 2020; 86 FR 45520, Aug. 13, 2021]

### § 412.280 Representation.

(a) *General.* A party may be represented by legal counsel or by any other person appointed to act as its representative at any proceeding before the MGCRB or the Administrator.

(b) *Rights of a representative.* A representative appointed by a party may accept or give on behalf of the party any request or notice connected with any proceeding before the MGCRB or the Administrator. A representative is entitled to present evidence and argument as to facts and law in any MGCRB proceeding affecting the party represented and to obtain information to the same extent as the party represented. Notice of any action or decision sent to the representative of a party has the same effect as if it had been sent to the party itself.

## Subpart M—Prospective Payment System for Inpatient Hospital Capital Costs

SOURCE: 56 FR 43449, Aug. 30, 1991, unless otherwise noted.

### GENERAL PROVISIONS

#### § 412.300 Scope of subpart and definition.

(a) *Purpose.* This subpart implements section 1886(g)(1)(A) of the Act by establishing a prospective payment system for inpatient hospital capital-related costs. Under this system, payment is made on the basis described in § 412.304 through § 412.374 for inpatient hospital capital-related costs furnished by hospitals subject to the prospective payment system under subpart B of this part.

(b) *Definition.* For purposes of this subpart, a new hospital means a hospital that has operated (under previous

or present ownership) for less than 2 years. The following hospitals are not 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 has been in operation for more than 2 years but has participated in the Medicare program for less than 2 years.

(4) A hospital that changes its status from a hospital that is excluded from the prospective payment systems to a hospital that is subject to the capital prospective payment systems.

[56 FR 43449, Aug. 30, 1991, as amended at 57 FR 39827, Sept. 1, 1992]

#### §412.302 Introduction to capital costs.

(a) *New capital costs.* New capital costs are allowable Medicare inpatient hospital capital-related costs under subpart G of part 413 of this chapter that are related to assets that were first put in use for patient care after December 31, 1990 (except for such costs deemed to be old capital costs based on prior obligations as described in paragraph (c) of this section) and those allowable capital-related costs related to assets in use prior to December 31, 1990 that are excluded from the definition of old capital costs described in paragraphs (b) (2) through (5) of this section, or are betterment or improvement costs related to those old capital assets.

(b) *Old capital costs.* Except as provided in paragraph (c) of this section with respect to capital obligations that qualify for recognition as old capital, old capital costs are allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before December 31, 1990. However, for a new hospital as defined in §412.300(b), old capital costs are defined as those allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of the hospital's base year cost reporting period under

§412.328(a)(2). Old capital costs include the following:

(1) Allowable depreciation on assets based on the useful life guidelines used to determine depreciation expense in the hospital's base period.

(2) Allowable capital-related interest expense. Except as provided below, the amount of allowable capital-related interest expense that will be recognized as old capital is limited to the amount the hospital was legally obligated to pay as of December 31, 1990. Any allowable interest expense in excess of this limitation will be recognized as new capital.

(i) An increase in interest expense is recognized if the increase is due to periodic fluctuations of rates in variable interest rate loans or at the time of conversion from a variable rate loan to a fixed rate loan when no other changes in the terms of the loan are made.

(ii) If the terms of a debt instrument are revised after December 31, 1990, the amount of interest that will be recognized as old capital during the transition cannot exceed the amount that would have been recognized during the same period prior to the revision of the debt instrument.

(iii) If short-term financing was used to acquire old capital assets and the debt is extended or "rolled-over", a portion of the extended debt will be recognized as old capital. The portion will equal the ratio of the net book value as of the beginning of the applicable cost reporting period for depreciable assets that were in use in the base year, to the net book value as of the beginning of the base year cost reporting period for those assets. The net book value for the base year will not be adjusted to exclude assets that have been fully depreciated or removed from service since the base year. If the debt is related to specific assets, the ratio will be determined based on the values for those assets. The ratio will exclude assets that were acquired with other identifiable debt instruments. For purposes of this paragraph, short term financing is a debt that becomes due in no later than the earlier of 5 years or half of the average useful life of the assets to which the debt is related.

(iv) If old capital indebtedness is commingled with new capital debt, the allowable interest expense will be apportioned to old capital costs based on the ratio of the portion of the loan principal related to old capital indebtedness to the total loan principal.

(v) Investment income, excluding income from funded depreciation accounts, is used to reduce old capital interest expense based on the ratio of total old capital interest expense to total allowable interest expense in each cost reporting period.

(3) Allowable capital-related lease and rental costs for land and depreciable assets that were obligated as of December 31, 1990.

(i) Lease renewals up to the annual lease payment level obligated as of December 31, 1990 are recognized provided the same asset remains in use, the asset has a useful life of at least 3 years, and the annual lease payment is \$1,000 or more for each item or service.

(ii) If a hospital-owned asset is sold or given to another party and that same asset is then leased back by the hospital, the amount of allowable capital-related costs recognized as old capital costs is limited to the amount allowed for that asset in the last cost reporting period that it was owned by the hospital.

(iii) If an entire hospital is leased without assumption of the hospital's asset costs after December 31, 1990, the amount of allowable capital-related costs recognized as old capital costs is limited to the amount allowed for old capital costs in the base year or the last cost reporting period these costs were recognized under this subpart, whichever is later.

(4) The portion of allowable costs for other capital-related expenses (including but not limited to, taxes, insurance, license and royalty fees on depreciable assets) resulting from applying the ratio of the hospital's gross old asset value to total asset value in each cost reporting period.

(5) The appropriate portion of the capital-related costs of related organizations under § 413.17 that would be recognized as old capital costs if these costs had been incurred directly by the hospital.

(6) Obligated capital costs that are recognized as old capital costs in accordance with paragraph (c) of this section.

(7) If a hospital had nonreimbursable costs applicable to an old capital asset as of December 31, 1990 that subsequently become allowable inpatient capital-related costs, the allowable costs for such an asset that are attributable to inpatient hospital services are recognized as old capital costs if a portion of the asset was in use for inpatient hospital care on December 31, 1990 and the costs meet all other provisions for recognition of old capital costs contained in this section.

(c) *Obligated capital costs*—(1) *General rule*. Under the conditions described below, capital-related costs attributable to assets that are put in use after December 31, 1990 may be recognized as old capital costs. Any allowable capital-related costs for these assets that are not recognized as old capital costs are recognized as new capital costs.

(i) *Fixed assets*. The costs of capital-related items and services defined in subpart G of part 413 for which there was a contractual obligation entered into by a hospital or related party with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a fixed asset may be recognized as old capital costs if all the following conditions are met:

(A) The obligation must arise from a binding written agreement that was executed on or before December 31, 1990 and that obligates the hospital on or before December 31, 1990.

(B) The capital asset must be put in use for patient care before October 1, 1994 except as provided in paragraph (c)(1)(iv) of this section.

(C) The hospital notifies the intermediary of the existence of obligated capital costs as provided in paragraph (c)(1)(v) of this section.

(D) The amount that is recognized as old capital cost is limited to the lesser of the actual allowable costs when the asset is put in use or the estimated costs of the capital expenditure at the time it was obligated as provided in paragraph (c)(1)(vi) of this section.

(ii) *Moveable equipment*. Moveable equipment is recognized as old capital

only if all of the conditions specified in paragraphs (c)(1)(i) (B) through (D) of this section are met and one of the following conditions is met:

(A) There was a binding contractual agreement that was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990 for the lease or purchase of the item of equipment on or before December 31, 1990.

(B) There was a binding contractual agreement that was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990 for financing the acquisition of the equipment; the item of equipment costs at least \$100,000; and the item was specifically listed in an equipment purchase plan approved by the Board of Directors on or before December 31, 1990.

(iii) *Agreements not recognized.* Agreements for planning, design or feasibility that do not commit the hospital to undertake a project are not recognized as obligating capital expenditures for purposes of this subsection.

(iv) *Extension of deadline.* CMS may extend the deadline in paragraph (c)(1)(i)(B) of this section, under which an asset must be put in use for patient care before October 1, 1994, to no later than September 30, 1996 for extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include, but are not limited to, a construction strike or atypically severe weather that significantly delayed completion of a construction project. Normal construction delays do not constitute extraordinary circumstances.

(A) The hospital must submit its request for an extended deadline with documentation of the extraordinary circumstances by the later of January 1, 1993 or 180 days after the extraordinary circumstance.

(B) The intermediary reviews the request and verifies the hospital's documentation, and forwards the request to CMS within 60 days. Within 90 days, CMS notifies the intermediary of its decision and, if an extension is granted, of the revised deadline for putting the asset in use for patient care service.

(v) The hospital must submit to its intermediary the binding agreement

and supporting documents that relate to the obligated capital expenditure by the later of October 1, 1992, or within 90 days after the start of the hospital's first cost reporting period beginning on or after October 1, 1991. This documentation must include a project description (including details of any phased construction or financing) and an estimate of costs that were prepared no later than December 31, 1990.

(vi) *Cost limitation—(A) Leases, rentals or purchases.* The amount of obligated capital costs recognized as old capital costs cannot exceed the amount specified in the lease, rental, or purchase agreement. If moveable equipment is recognized as old capital under paragraph (c)(1)(ii)(B) of this section, the amount recognized as old capital costs cannot exceed the estimated cost identified in the equipment purchase plan approved by the hospital's Board of Directors.

(B) *Construction contracts.* The amount of obligated capital costs recognized as old capital costs cannot exceed the estimated construction costs for the project as of December 31, 1990. Additional costs will be recognized as old capital costs only if the additional costs are directly attributable to changes in life safety codes or other building requirements established by government ordinance that occurred after the project was obligated.

(C) *Financing costs.* The amount of obligated interest expense that will be recognized as old capital costs cannot exceed the amount for which the hospital was legally obligated as of December 31, 1990 or, in the case of financing that is arranged after December 31, 1990 for a capital acquisition that was legally obligated as of December 31, 1990, the amount specified in a detailed financing plan approved by the hospital's Board of Directors prior to January 1, 1991.

(vii) *Determining old capital costs.* (A) The intermediary determines whether the applicable criteria are met for recognition of obligated capital costs as old capital costs and the maximum allowable cost that will be recognized as old capital costs.

(B) The intermediary advises the hospital of its determination by the later of the end of the hospital's first cost

reporting period subject to the capital prospective payment system or 9 months after the receipt of the hospital's notification under paragraph (c)(1)(v) of this section.

(C) The actual amount that will be recognized as old capital costs is based on the lesser of the allowable costs for the asset when it is put into patient use or the amounts determined under paragraph (c)(1)(vi) of this section.

(viii) *Multi-phase project.* If the hospital has a multi-phase capital project, the provisions of paragraphs (c)(1) (i) through (vii) of this section apply independently to each phase of the project.

(2) *Lengthy certificate-of-need process.* (i) If a hospital does not meet the criteria under paragraph (c)(1)(i) or paragraph (c)(1)(ii) of this section, but meets all of the following criteria, the estimated cost for the project as of December 31, 1990 may be recognized as old capital costs:

(A) The hospital is required under State law to obtain preapproval of the capital project or acquisition by a designated State or local planning authority in the State in which it is located.

(B) The hospital filed an initial application for a certificate of need on or before December 31, 1989 that includes a detailed description of the project and its estimated cost and had not received approval or disapproval on or before September 30, 1990. If the hospital received conditional approval on or before September 30, 1990, the hospital's intermediary assesses the nature of the conditions. The hospital will be considered to have received approval for the project as of September 30, 1990 if the intermediary determines that the hospital received sufficient approval for the project to proceed without significant delay.

(C) The hospital expended the lesser of \$750,000 or 10 percent of the estimated cost of the project on or before December 31, 1990; and

(D) The hospital put the asset into patient use on or before the later of September 30, 1996 or 4 years from the date the certificate of need was approved.

(ii) The provisions of paragraphs (c)(1) (iv) through (viii) of this section apply to projects that meet the criteria in paragraph (c)(2)(i) of this section.

(3) *Construction in process.* (i) If a hospital that initiates construction on a capital project does not meet the requirements of paragraphs (c)(1)(i) or (ii) or (c)(2)(i) of this section, the project costs may be recognized as old capital costs if all the following conditions are met:

(A) The hospital received any required certificate of need approval on or before December 31, 1990.

(B) The hospital's Board of Directors formally authorized the project with a detailed description of its scope and costs on or before December 31, 1990.

(C) The estimated cost of the project as of December 31, 1990 exceeds 5 percent of the hospital's total patient revenues during its base year.

(D) The capitalized cost that had been incurred for the project as of December 31, 1990 exceeded the lesser of \$750,000 or 10 percent of the estimated project cost.

(E) The hospital began actual construction or renovation ("groundbreaking") on or before March 31, 1991.

(F) The project is completed before October 1, 1994.

(ii) The provisions of paragraphs (c)(1) (iv) through (viii) of this section apply to projects that meet the criteria in paragraph (c)(3)(i) of this section.

(d) *Consistency in cost reporting—(1) General rule.* For cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001, the hospital must follow consistent cost finding methods for classifying and allocating capital-related costs, except as otherwise provided in paragraph (d)(4) of this section.

(2) *Old capital costs.* Unless there is a change of ownership, the hospital must continue the same cost finding methods for old capital costs, including its practices for the direct assignment of capital-related costs and its cost allocation bases, that were in effect in the hospital's last cost reporting period ending on or before October 1, 1991. If there is a change of ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices.

(3) *New capital costs.* If a hospital desires to change its cost finding methods for new capital costs, the request for change must be made in writing to the intermediary prior to the beginning of the cost reporting period for which the change is to apply. The request must include justification as to why the change will result in more accurate and more appropriate cost finding. The intermediary will not approve the change unless it determines that there is reasonable justification for the change.

(4) Hospitals may elect the simplified cost allocation methodology under the terms and conditions provided in the instructions for CMS Form 2552.

[56 FR 43449, Aug. 30, 1991, as amended at 57 FR 3016, Jan. 27, 1992; 57 FR 39827, Sept. 1, 1992; 57 FR 46510, Oct. 9, 1992; 59 FR 45399, Sept. 1, 1994; 61 FR 46224, Aug. 30, 1996; 61 FR 51217, Oct. 1, 1996]

#### § 412.304 Implementation of the capital prospective payment system.

(a) *General rule.* As described in §§ 412.312 through 412.370, effective with cost reporting periods beginning on or after October 1, 1991, CMS pays an amount determined under the capital prospective payment system for each inpatient hospital discharge as defined in § 412.4. This amount is in addition to the amount payable under the prospective payment system for inpatient hospital operating costs as determined under subpart D of this part.

(b) *Cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001.* For cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, the capital payment amount is based on either a combination of payments for old capital costs and new capital costs or a fully prospective rate, as determined under § 412.324 through § 412.348.

(c) *Cost reporting periods beginning on or after October 1, 2001—*(1) *General.* Except as provided in paragraph (c)(2) of this section, for cost reporting periods beginning on or after October 1, 2001, the capital payment amount is based solely on the Federal rate determined under §§ 412.308(a) and (b) and updated under § 412.308(c).

(2) *Payment to new hospitals.* For cost reporting periods beginning on or after October 1, 2002—

(i) A new hospital, as defined under § 412.300(b), is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its cost report ending at least 2 years after the hospital accepts its first patient, unless the new hospital elects to be paid under the capital prospective payment system based on 100 percent of the Federal rate.

(A) If the new hospital elects to be paid based on 100 percent of the Federal rate, the new hospital must submit a written request to the fiscal intermediary by the later of December 1, 2002 or 60 days before the beginning of its cost reporting period.

(B) Once a new hospital elects to be paid based on 100 percent of the Federal rate, it may not revert to payment at 85 percent of its allowable Medicare inpatient hospital capital-related costs.

(ii) For the third year and subsequent years, the hospital is paid based on the Federal rate as described under § 412.312.

(d) *Interim payments.* Interim payments are made to the hospital as provided in § 412.116.

[56 FR 43449, Aug. 30, 1991, as amended at 67 FR 50113, Aug. 1, 2002; 70 FR 47487, Aug. 12, 2005]

#### BASIC METHODOLOGY FOR DETERMINING THE FEDERAL RATE FOR CAPITAL-RELATED COSTS

#### § 412.308 Determining and updating the Federal rate.

(a) *FY 1992 national average cost per discharge.* CMS determines the FY 1992 estimated national average cost per discharge by updating the discharge weighted national average Medicare inpatient hospital capital-related cost per discharge for FY 1989 by the estimated increase in Medicare inpatient hospital capital costs per discharge.

(b) *Standard Federal rate.* The standard Federal rate is used to determine the Federal rate for each fiscal year in accordance with the formula specified in paragraph (c) of this section.