

Finding Aids section of the printed volume and at [www.govinfo.gov](http://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

## § 412.72

## 42 CFR Ch. IV (10–1–24 Edition)

adjustment, and adequate data to compute the adjusted costs. The intermediary decides whether to use part or all of the data on the basis of audit, survey and other information available.

(d) *Intermediary's determination.* The intermediary uses the best data available at the time in estimating each hospital's base-year costs and the modifications to those costs authorized by paragraphs (b) and (c) of this section. The intermediary's estimate of base-year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided in § 412.72.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 52 FR 33057, Sept. 1, 1987; 57 FR 33897, July 31, 1992; 57 FR 39822, Sept. 1, 1992; 59 FR 45398, Sept. 1, 1994; 60 FR 63188, Dec. 8, 1995; 86 FR 73510, Dec. 27, 2021]

### § 412.72 Modification of base-year costs.

(a) *Bases for modification of base-year costs.* Base-year costs as determined under § 412.71(d) may be modified under the following circumstances:

(1) *Inadvertent omissions.* (i) A hospital that becomes subject to the prospective payment system beginning on or after October 1, 1983 and before November 16, 1983 has until November 15, 1983 to request its intermediary to re-estimate its base-period costs to take into account inadvertent omissions in its previous submissions to the intermediary related to changes made by the prospective payment legislation for purposes of estimating the base-period costs.

(ii) The intermediary may also initiate changes to the estimation—

(A) For any reason before the date the hospital becomes subject to prospective payment; and

(B) Before November 16, 1983, for corrections to take into account inadvertent omissions in the hospital's previous submissions related to changes made by the prospective payment legislation for purposes of estimating the base-period costs.

(iii) Such omissions pertain to adjustments to exclude capital-related costs and the direct medical education

costs of approved educational activities and to adjustments specified in § 412.71(c).

(iv) The intermediary must notify the provider of any change to the hospital-specific amount as a result of the provider's request within 30 days of receipt of the additional data.

(v) Any change to base-period costs made under this paragraph (a)(1) will be made effective retroactively, beginning with the first day of the affected hospital's fiscal year.

(2) *Correction of mathematical errors of calculations.* (i) The hospital must report mathematical errors of calculations to the intermediary within 90 days of the intermediary's notification to the hospital of the hospital's payments rates.

(ii) The intermediary may also identify such errors and initiate their correction during this period.

(iii) The intermediary will either make an appropriate adjustment or notify the hospital that no adjustment is warranted within 30 days of receipt of the hospital's report of an error.

(iv) Corrections of errors of calculation will be effective with the first day of the hospital's first cost reporting period subject to the prospective payment system.

(3) *Recognition of additional costs.* (i) The intermediary may adjust base-period costs to take into account additional costs recognized as allowable costs for the hospital's base year as the result of any of the following:

(A) A reopening and revision of the hospital's base-year notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(B) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(C) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(D) An administrative or judicial review decision under §405.1831, §405.1871, or §405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(ii) The intermediary will recalculate the hospital's base-year costs, incorporating the additional costs recognized as allowable for the hospital's base year. Adjustments to base-year costs to take into account these additional costs—

(A) Will be effective with the first day of the hospital's first cost reporting period beginning on or after the date of the revision, order or finding, or review decision; and

(B) Will not be used to recalculate the hospital-specific portion as determined for fiscal years beginning before the date of the revision, order or finding, or review decision.

(4) *Successful appeal.* The intermediary may modify base-year costs to take into account a successful appeal relating to modifications to base-year costs that were made under §412.71(b). If a hospital successfully contests a modification to base-year costs—

(i) The intermediary will recalculate the hospital's base-year costs to reflect the modification determined appropriate as a result of the appeal; and

(ii) Such adjustments will be effective retroactively to the time of the intermediary's initial estimation of base-year costs.

(5) *Unlawfully claimed costs.* The intermediary may modify base-year costs to exclude costs that were unlawfully claimed as determined as a result of criminal conviction, imposition of a civil judgment under the False Claims Act (31 U.S.C. 3729–3731), or a proceeding for exclusion from the Medicare program. In addition to adjusting base-year costs, CMS will recover both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates. The amount to be recovered will be computed on the basis of the final reso-

lution of the amount of the inappropriate base-year costs.

(b) *Right to administrative and judicial review.* (1) An intermediary's estimation of a hospital's base-year costs, and modifications, made for purposes of determining the hospital-specific rate, are subject to administrative and judicial review. Review will be available to a hospital upon receipt of its notice of amount of program reimbursement following the close of its cost reporting period, but only with respect to whether the intermediary followed the provisions of §§412.71 and 412.72. (Sections 405.1803 and 405.1807 of this chapter set forth the rules for intermediary determinations and notice of amount of program reimbursement and the effect of those determinations.)

(2) In any administrative or judicial review of whether the intermediary used the best data available at the time, as required by §412.71(d), an intermediary's estimation will be revised on the basis of this review only if the estimation was unreasonable and clearly erroneous in light of the data available at the time the estimation was made.

(3) Specifically excluded from administrative or judicial review are any issues based on data, information, or arguments not presented to the intermediary at the time of the estimation.

#### **§412.73 Determination of the hospital-specific rate based on a Federal fiscal year 1982 base period.**

(a) *Costs on a per discharge basis.* The intermediary will determine the hospital's estimated adjusted base-year operating cost per discharge by dividing the total adjusted operating costs by the number of discharges in the base period.

(b) *Case-mix adjustment.* The intermediary will divide the adjusted base-year costs by the hospital's 1981 case-mix index. If the hospital's case-mix index is statistically unreliable (as determined by CMS), the hospital's base-year costs will be divided by the lower of the following:

(1) The hospital's estimated case-mix index.

(2) The average case-mix index for the appropriate classifications of all

## § 412.73

## 42 CFR Ch. IV (10–1–24 Edition)

hospitals subject to cost limits established under § 413.30 of this chapter for cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983.

(c) *Updating base-year costs*—(1) *For Federal fiscal year 1984.* The case-mix adjusted base-year cost per discharge will be updated by the applicable updating factor, that is, the rate-of-increase percentage determined under § 413.40(c)(3) of this chapter, as adjusted for budget neutrality.

(2) *For Federal fiscal year 1985.* The amount determined under paragraph (c)(1) of this section will be updated by the applicable updating factor, as adjusted for budget neutrality.

(3) *For Federal fiscal year 1986.* (i) The amount determined under paragraph (c)(2) of this section is updated by—

(A) Zero percent for the first seven months of the hospital's cost reporting period; and

(B) One-half of one percent for the remaining five months of the hospital's cost reporting period.

(ii) For purposes of determining the updated base-year costs for cost reporting periods beginning in Federal fiscal year 1987 (that is, on or after October 1, 1986 and before October 1, 1987), the update factor for the previous cost reporting period is deemed to have been one-half of one percent.

(4) *For Federal fiscal year 1987.* The amount determined under paragraph (c)(3)(ii) of this section is updated by 1.15 percent.

(5) *For Federal fiscal year 1988.* (i) For purposes of determining the prospective payment rates for sole community hospitals under § 412.92(d) for cost reporting periods beginning in Federal fiscal year 1988 (that is, on or after October 1, 1987 and before October 1, 1988), the base-year cost per discharge is updated as follows:

(A) For the first 51 days of the hospital's cost reporting period, by zero percent.

(B) For the next 132 days of the hospital's cost reporting period, by 2.7 percent.

(C) For the remainder of the hospital's cost reporting period, by—

(1) 3.0 percent for hospitals located in rural areas;

(2) 1.5 percent for hospitals located in large urban areas; and

(3) 1.0 percent for hospitals located in other urban areas.

(ii) For purposes of determining the updated base-year costs for cost reporting periods beginning in Federal fiscal year 1989 (that is, beginning on or after October 1, 1988 and before October 1, 1989), the update factor for the cost reporting period beginning during federal Fiscal year 1988 is deemed to have been—

(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.

(6) *For Federal fiscal year 1989.* For cost reporting periods beginning in Federal fiscal year 1989, the update factor is determined using the methodology set forth in § 412.63(g).

(7) *For Federal fiscal year 1990.* (i) Except as described in paragraph (c)(7)(ii) of this section, for cost reporting periods beginning in Federal fiscal year 1990, the base-period cost per discharge is updated as follows:

(A) For cost reporting periods beginning on or after October 1, 1989 and before January 1, 1990, by 5.5 percent for discharges occurring before January 1, 1990 and by the factors set forth in paragraph (c)(7)(i)(B) of this section for discharges occurring on or after January 1, 1990.

(B) For cost reporting periods beginning on or after January 1, 1990 and before October 1, 1990, by—

(1) 9.72 percent for hospitals located in rural areas;

(2) 5.62 percent for hospitals located in large urban areas; and

(3) 4.97 percent for hospitals located in other urban areas.

(ii) For discharges occurring on or after October 21, 1990 and before January 1, 1991, the base-period cost per discharge, updated as set forth in paragraph (c)(7)(i) of this section, is reduced by 5.5 percent.

(iii) For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 1991 (that is, beginning on or after October 1, 1990 and before October 1, 1991), the update factor for the

cost reporting period beginning during Federal fiscal year 1990 is deemed to have been the percentage change provided for in paragraph (c)(7)(i)(B) of this section.

(8) *For Federal fiscal year 1991.* (i) Except as described in paragraph (c)(8)(ii) of this section, for cost reporting periods beginning in Federal fiscal year 1991, the base-period cost per discharge is updated by 5.2 percent.

(ii) For discharges occurring on or after October 21, 1990 and before January 1, 1991, the base-period cost per discharge is updated by 0.0 percent.

(iii) For purposes of determining the updated base period costs for cost reporting periods beginning in Federal fiscal year 1992, the update factor for the cost reporting period beginning during Federal fiscal year 1991 is deemed to have been the percentage change provided for in paragraph (c)(8)(i) of this section.

(9) *For Federal fiscal years 1992 and 1993.* For Federal fiscal years 1992 and 1993, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in §413.40(a) of this chapter).

(10) *For Federal fiscal year 1994.* For Federal fiscal year 1994, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in §413.40(a) of the chapter) minus 2.3 percentage points. For purposes of determining the hospital-specific rate for Federal fiscal year 1994 and subsequent years, this update factor is adjusted to take into account the portion of the 12-month cost reporting period beginning during Federal fiscal year 1993 that occurs in Federal fiscal year 1994.

(11) *For Federal fiscal year 1995.* For Federal fiscal year 1995, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in §413.40(a) of this chapter) minus 2.2 percentage points.

(12) *For Federal fiscal years 1996 through 2000.* For Federal fiscal years 1996 through 2000, the update factor is the applicable percentage change for other prospective payment hospitals in each respective year as set forth in §§412.63(n) through (r).

(13) *For Federal fiscal year 2001.* For Federal fiscal year 2001, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in §413.40(a) of this chapter).

(14) *For Federal fiscal year 2002.* For Federal fiscal year 2002, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in §413.40(a) of this chapter) minus 1.1 percentage points.

(15) *For Federal fiscal year 2003 through Federal fiscal year 2009.* For Federal fiscal year 2003 through Federal fiscal year 2009, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in §413.40(a) of this chapter).

(16) *For Federal fiscal year 2010 and subsequent years.* For Federal fiscal year 2010 and subsequent years, the update factor is the percentage increase specified in §412.64(d).

(d) *Budget neutrality—(1) Federal fiscal year 1984.* For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984, CMS adjusts the target rate percentage used under paragraph (c)(1) of this section. This adjustment is based on a factor actuarially estimated to ensure that the estimated amount of aggregate Medicare payments based on the hospital-specific portion of the transition payment rates is neither greater nor less than 75 percent of the amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1984 under the law in effect before April 20, 1983.

(2) *Federal fiscal year 1985.* For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1985, CMS adjusts the target rate percentage used under paragraph (c)(2) of this section. This adjustment is based on a factor actuarially estimated to ensure that the estimated amount of aggregate Medicare payment based on the hospital-specific portion of the transition payment rates is neither greater nor less than 50 percent of the amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1985

## § 412.75

## 42 CFR Ch. IV (10–1–24 Edition)

under the Social Security Act as in effect on April 19, 1983.

(e) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(f) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 16787, May 6, 1986; 51 FR 34793, Sept. 30, 1986; 51 FR 42234, Nov. 24, 1986; 52 FR 33057, Sept. 1, 1987; 53 FR 38528, Sept. 30, 1988; 55 FR 15173, Apr. 20, 1990; 56 FR 573, Jan. 7, 1991; 57 FR 39822, Sept. 1, 1992; 58 FR 46338, Sept. 1, 1993; 59 FR 1658, Jan. 12, 1994; 59 FR 32383, June 23, 1994; 65 FR 47106, Aug. 1, 2000; 70 FR 47485, Aug. 12, 2005; 75 FR 50413, Aug. 16, 2010]

### § 412.75 Determination of the hospital-specific rate for inpatient operating costs based on a Federal fiscal year 1987 base period.

(a) *Base-period costs*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, for each hospital, the intermediary determines 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, 1987 and before September 30, 1988.

(2) *Exceptions.* (i) If the hospital's last cost reporting period ending before September 30, 1988 is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short period report.

(ii) If the hospital does not have a cost reporting period ending on or after September 30, 1987 and before September 30, 1988 and does have a cost reporting period beginning on or after October 1, 1986 and before October 1, 1987, that cost reporting period is the base period unless the cost reporting period is for less than 12 months. In that case, the base period is the hospital's most recent 12-month or longer

cost reporting period ending before the short cost reporting period.

(b) *Costs on a per discharge basis.* The intermediary determines the hospital's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as defined in § 412.4(b) is considered to be a discharge.

(c) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the hospital's case-mix index for the base period.

(d) *Updating base-period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 1988, the update factor is determined using the methodology set forth in §§ 412.73(c)(15) and 412.73(c)(16).

(e) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(f) *Notice of hospital-specific rate.* The intermediary furnishes the hospital a notice of its hospital-specific rate, which contains a statement of the hospital's Medicare part A allowable inpatient operating costs, number of Medicare discharges, and case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 1987 base period.

(g) *Right to administrative and judicial review.* An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to a hospital upon receipt of the notice of the hospital-specific rate. This notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of part 405 of this chapter, governing provider reimbursement determinations and appeals.

(h) *Modification of hospital-specific rate.* (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or

judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the hospital's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the hospital's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under §§ 405.1831, 405.1871, or 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (h) (1) and (2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

(i) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate

payments to section 1886(d) hospitals are not affected.

[55 FR 15173, Apr. 20, 1990, as amended at 55 FR 36069, Sept. 4, 1990; 55 FR 39775, Sept. 2, 1990; 56 FR 573, Jan. 7, 1991; 55 FR 46887, Nov. 7, 1990; 57 FR 39822, Sept. 1, 1992; 58 FR 46338, Sept. 1, 1993; 65 FR 47106, Aug. 1, 2000; 70 FR 47485, Aug. 12, 2005; 75 FR 50414, Aug. 16, 2010]

**§ 412.76 Recovery of excess transition period payment amounts resulting from unlawful claims.**

If a hospital's base-year costs, as estimated for purposes of determining the hospital-specific portion, are determined, by criminal conviction or imposition of a civil money penalty or assessment, to include costs that were unlawfully claimed, the hospital's base-period costs are adjusted to remove the effect of the excess costs, and CMS recovers both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39822, Sept. 1, 1992. Redesignated at 65 FR 47106, Aug. 1, 2000, and further redesignated at 73 FR 48754, Aug. 19, 2008]

**§ 412.77 Determination of the hospital-specific rate for inpatient operating costs for sole community hospitals based on a Federal fiscal year 1996 base period.**

(a) *Applicability.* (1) This section applies to a hospital that has been designated as a sole community hospital, as described in § 412.92. If the 1996 hospital-specific rate exceeds the rate that would otherwise apply, that is, either the Federal rate under § 412.64 (or under § 412.63 for periods prior to FY 2005) or the hospital-specific rates for either FY 1982 under § 412.73 or FY 1987 under § 412.75, this 1996 rate will be used in the payment formula set forth in § 412.92(d)(1).

(2) This section applies only to cost reporting periods beginning on or after October 1, 2000.

(3) The formula for determining the hospital-specific costs for hospitals described under paragraph (a)(1) of this section is set forth in paragraph (f) of this section.

(b) *Based costs for hospitals subject to fiscal year 1996 rebasing—(1) General rule.*

Except as provided in paragraph (b)(2) of this section, for each hospital eligible under paragraph (a) of this section, the intermediary determines 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, 1996 and before September 30, 1997, and computes the hospital-specific rate for purposes of determining prospective payment rates for inpatient operating costs as determined under § 412.92(d).

(2) *Exceptions.* (i) If the hospital's last cost reporting period ending before September 30, 1997 is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short period report.

(ii) If the hospital does not have a cost reporting period ending on or after September 30, 1996 and before September 30, 1997, and does have a cost reporting period beginning on or after October 1, 1995 and before October 1, 1996, that cost reporting period is the base period unless the cost reporting period is for less than 12 months. If that cost reporting period is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short cost reporting period. If a hospital has no cost reporting period beginning in fiscal year 1996, the hospital will not have a hospital-specific rate based on fiscal year 1996.

(c) *Costs on a per discharge basis.* The intermediary determines the hospital's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as defined in § 412.4(b) is considered to be a discharge.

(d) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the hospital's case-mix index for the base period.

(e) *Updating base-period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 1996, the update factor is determined using

the methodology set forth in § 412.73(c)(12) through (c)(16).

(f) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(g) *Notice of hospital-specific rates.* The intermediary furnishes a hospital eligible for rebasing a notice of the hospital-specific rate as computed in accordance with this section. The notice will contain a statement of the hospital's Medicare Part A allowable inpatient operating costs, the number of Medicare discharges, and the case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 1996 base period.

(h) *Right to administrative and judicial review.* An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to a hospital upon receipt of the notice of the hospital-specific rate. This notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of part 405 of this chapter.

(i) *Modification of hospital-specific rate.* (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the hospital's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for the recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the hospital's base-period notice of amount of program reimbursement under

§§ 405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under § 405.1831, § 405.1871, or § 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (i)(1) and (i)(2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

(j) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.

[65 FR 47106, Aug. 1, 2000, as amended at 66 FR 32192, June 13, 2001; 70 FR 47485, Aug. 12, 2005; 75 FR 50414, Aug. 16, 2010]

**§ 412.78 Determination of the hospital-specific rate for inpatient operating costs for sole community hospitals based on a Federal fiscal year 2006 base period.**

(a) *Applicability.* (1) This section applies to a hospital that has been designated as a sole community hospital, as described in § 412.92. If the 2006 hospital-specific rate exceeds the rate that would otherwise apply, that is, either the Federal rate under § 412.64 or the hospital-specific rates for either FY

1982 under § 412.73, FY 1987 under § 412.75 or FY 1996 under § 412.77, this 2006 rate will be used in the payment formula set forth in § 412.92(d)(1).

(2) This section applies only to cost reporting periods beginning on or after January 1, 2009.

(3) The formula for determining the hospital-specific costs for hospitals described under paragraph (a)(1) of this section is set forth in paragraph (f) of this section.

(b) *Based costs for hospitals subject to fiscal year 2006 rebasing—(1) General rule.* Except as provided in paragraph (b)(2) of this section, for each hospital eligible under paragraph (a) of this section, the intermediary determines 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, 2006, and before September 30, 2007, and computes the hospital-specific rate for purposes of determining prospective payment rates for inpatient operating costs as determined under § 412.92(d).

(2) *Exceptions.* (i) If the hospital's last cost reporting period ending before September 30, 2007 is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short period report.

(ii) If the hospital does not have a cost reporting period ending on or after September 30, 2006 and before September 30, 2007, and does have a cost reporting period beginning on or after October 1, 2005 and before October 1, 2006, that cost reporting period is the base period unless the cost reporting period is for less than 12 months. If that cost reporting period is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short cost reporting period. If a hospital has no cost reporting period beginning in fiscal year 2006, the hospital will not have a hospital-specific rate based on fiscal year 2006.

(c) *Costs on a per discharge basis.* The intermediary determines the hospital's average base-period operating cost per

## § 412.79

## 42 CFR Ch. IV (10–1–24 Edition)

discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as defined in § 412.4(b) is considered to be a discharge.

(d) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the hospital's case-mix index for the base period.

(e) *Updating base-period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 2006, the update factor is determined using the methodology set forth in §§ 412.73(c)(15) and 412.73(c)(16).

(f) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(g) *Notice of hospital-specific rates.* The intermediary furnishes a hospital eligible for rebasing a notice of the hospital-specific rate as computed in accordance with this section. The notice will contain a statement of the hospital's Medicare Part A allowable inpatient operating costs, the number of Medicare discharges, and the case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 2006 base period.

(h) *Right to administrative and judicial review.* An intermediary's determination under this section of the hospital-specific rate for a hospital is subject to administrative and judicial review in accordance with § 412.77(h).

(i) *Modification of hospital-specific rate.* The intermediary recalculates the hospital-specific rate determined under this section in the manner set forth in § 412.77(i).

(j) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate determined under this section in the manner set forth in § 412.77(j).

### **§ 412.79 Determination of the hospital-specific rate for inpatient operating costs for Medicare-dependent, small rural hospitals based on a Federal fiscal year 2002 base period.**

(a) *Base-period costs—(1) General rule.* Except as provided in paragraph (a)(2) of this section, for each MDH, the intermediary determines the MDH's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period beginning on or after October 1, 2001, and before October 1, 2002.

(2) *Exceptions.* (i) If the MDH's last cost reporting period beginning before October 1, 2002, is for less than 12 months, the base period is the MDH's most recent 12-month or longer cost reporting period beginning before that short cost reporting period.

(ii) If the MDH does not have a cost reporting period beginning on or after October 1, 2001, and before October 1, 2002, and does have a cost reporting period beginning on or after October 1, 2000, and before October 1, 2001, that cost reporting period is the base period unless the cost reporting is for less than 12 months. In that case, the base period is the MDH's most recent 12-month or longer cost reporting period beginning before that short cost reporting period.

(b) *Costs on a per discharge basis.* The intermediary determines the MDH's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as described in § 412.4(b) is considered to be a discharge.

(c) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the MDH's case-mix index for the base period.

(d) *Updating base period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 2002, the update factor is determined using the methodology set forth in § 412.73(c)(14) through (c)(16).

(e) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG

[73 FR 48754, Aug. 19, 2008, as amended at 75 FR 50414, Aug. 16, 2010]

weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(f) *Notice of hospital-specific rate.* The intermediary furnishes the MDH a notice of its hospital-specific rate which contains a statement of the hospital's Medicare Part A allowable inpatient operating costs, number of Medicare discharges, and case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 2002 base period.

(g) *Right to administrative and judicial review.* An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to an MDH upon receipt of the notice of the hospital-specific rate. The notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of part 405 of this chapter, governing provider reimbursement determinations and appeals.

(h) *Modification of hospital-specific rate.* (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the MDH's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the MDH's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a

matter at issue in the MDH's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under § 405.1831, § 405.1871, or § 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (h)(1) and (2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

(i) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.

[71 FR 48137, Aug. 18, 2006, as amended at 75 FR 50414, Aug. 16, 2010]

### **Subpart F—Payments for Outlier Cases, Special Treatment Payment for New Technology, and Payment Adjustment for Certain Replaced Devices**

#### **PAYMENT FOR OUTLIER CASES**

#### **§ 412.80 Outlier cases: General provisions.**

(a) *Basic rule*—(1) *Discharges occurring on or after October 1, 1994 and before October 1, 1997.* For discharges occurring on or after October 1, 1994, and before October 1, 1997, except as provided in paragraph (b) of this section concerning transferring hospitals, CMS provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital