

Federal fiscal year. The hospital's cancellation of the classification is effective beginning with the next Federal fiscal year.

(4) *Cancellation of rural reclassification on or after October 1, 2021.* For all written requests submitted by hospitals on or after October 1, 2021, to cancel rural reclassifications, a hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office not less than 1 calendar year after the effective date of the rural reclassification and not less than 120 days prior to the end of a Federal fiscal year. The hospital's cancellation of the classification is effective beginning with the next Federal fiscal year.

(5) *Special rule for hospitals that opt to receive county out-migration adjustment.* A rural reclassification will be considered canceled effective for the next Federal fiscal year when a hospital, by submitting a request to CMS within 45 days of the date of public display of the proposed rule for the next Federal fiscal year at the Office of the Federal Register, opts to accept and receives its county out-migration wage index adjustment determined under section 1886(d)(13) of the Act in lieu of its geographic reclassification described under section 1886(d)(8)(B) of the Act.

[65 FR 47048, Aug. 1, 2000, as amended at 69 FR 49244, Aug. 11, 2004; 69 FR 60252, Oct. 7, 2004; 70 FR 47486, Aug. 12, 2005; 72 FR 47411, Aug. 22, 2007; 74 FR 43997, Aug. 27, 2009; 79 FR 50353, Aug. 22, 2014; 81 FR 57267, Aug. 22, 2016; 83 FR 41703, Aug. 17, 2018; 84 FR 42613, Aug. 16, 2019; 86 FR 45519, Aug. 13, 2021; 87 FR 49403, Aug. 10, 2022; 88 FR 59332, Aug. 28, 2023; 89 FR 69911, Aug. 28, 2024]

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

(a) *Criteria for classification.* CMS provides an additional payment to a hospital for inpatient services provided to ESRD beneficiaries who receive a dialysis treatment during a hospital stay, if the hospital has established that ESRD beneficiary discharges, excluding discharges classified into any of the following MS-DRGs, where the beneficiary received dialysis services during the inpatient stay, constitute 10 percent or more of its total Medicare discharges:

(1) MS-DRG 019 (Simultaneous Pancreas/Kidney Transplant with Hemodialysis).

(2) MS-DRGs 650 and 651 (Kidney Transplant with Hemodialysis with MCC, without MCC, respectively).

(3) MS-DRGs 682, 683, and 684 (Renal Failure with MCC, with CC, without CC/MCC, respectively).

(b) *Additional payment.* A hospital that meets the criteria of paragraph (a) of this section is paid an additional payment for each ESRD beneficiary discharge except those excluded under paragraph (a) of this section.

(1) The payment is based on the estimated weekly cost of dialysis and the average length of stay of ESRD beneficiaries for the hospital.

(2)(i) Effective for cost reporting periods beginning before October 1, 2024, the estimated weekly cost of dialysis is the average number of dialysis sessions furnished per week during the 12-month period that ended June 30, 1983, multiplied by the average cost of dialysis for the same period.

(ii) Effective for cost reporting periods beginning on or after October 1, 2024, the estimated weekly cost of dialysis is calculated as 3 dialysis sessions per week multiplied by the applicable ESRD prospective payment system (PPS) base rate (as defined in 42 CFR 413.171) that corresponds with the fiscal year in which the cost reporting period begins.

(3) The average cost of dialysis used for purposes of determining the estimated weekly cost of dialysis for cost reporting periods beginning before October 1, 2024, includes only those costs determined to be directly related to the renal dialysis services. (These costs include salary, employee health and welfare, drugs, supplies, and laboratory services.)

(4) Effective for cost reporting periods beginning before October 1, 2024, the average cost of dialysis is reviewed and adjusted, if appropriate, at the time the composite rate reimbursement for outpatient dialysis is reviewed.

(5) The payment to a hospital equals the average length of stay of ESRD beneficiaries in the hospital, expressed

as a ratio to one week, times the estimated weekly cost of dialysis multiplied by the number of ESRD beneficiary discharges except for those excluded under paragraph (a) of this section. This payment is made only on the Federal portion of the payment rate.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39824, Sept. 1, 1992; 69 FR 49244, Aug. 11, 2004; 73 FR 48755, Aug. 19, 2008; 85 FR 59021, Sept. 18, 2020; 89 FR 69911, Aug. 28, 2024]

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

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

(a) *Basic data.* CMS determines the following for each hospital:

(1) The hospital's ratio of full-time equivalent residents (except as limited under paragraph (f) of this section) to the number of beds (as determined under paragraph (b) of this section).

(i) Except for the special circumstances for Medicare GME affiliated groups, emergency Medicare GME affiliated groups, and new programs described in paragraphs (f)(1)(vi) and (f)(1)(vii) of this section for cost reporting periods beginning on or after October 1, 1997, and for the special circumstances for closed hospitals or closed programs described in paragraph (f)(1)(ix) of this section for cost reporting periods beginning on or after October 1, 2002, and for Rural Track Programs within their 5-year cap building period described in paragraph (f)(1)(x)(B) in cost reporting periods beginning on or after October 1, 2022, this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period after accounting for the cap on the number of allopathic and osteopathic full-time equivalent residents as described in paragraph (f)(1)(iv) of this section, and adding to the capped numerator any dental and podiatric full-time equivalent residents.

(ii)(A) For new programs started prior to October 1, 2012, the exception for new programs described in paragraph (f)(1)(vii) of this section applies to each new program individually for which the full-time equivalent cap may

be adjusted based on the period of years equal to the minimum accredited length of each new program.

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

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

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

(2) The hospital's DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs, excluding outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made under the provisions of § 412.106.

(b) *Determination of the number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting