

§ 412.107

3 years of available historical discharge data.

(2) Final payment determinations are made at the time of cost report settlement, based on the final determination of each hospital's eligibility for payment under this section.

[54 FR 36494, Sept. 1, 1989]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.106, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.govinfo.gov.

§ 412.107 Special treatment: Hospitals that receive an additional update for FYs 1998 and 1999.

(a) *Additional payment update.* A hospital that meets the criteria set forth in paragraph (b) of this section receives the following increase to its applicable percentage amount set forth in § 412.63 (p) and (q):

- (1) For FY 1998, 0.5 percent.
- (2) For FY 1999, 0.3 percent.

(b) *Criteria for classification.* A hospital is eligible for the additional payment update set forth in paragraph (a) of this section if it meets all of the following criteria:

(1) *Definition.* The hospital is not a Medicare-dependent, small rural hospital as defined in § 412.108(a) and does not receive any additional payment under the following provisions:

(i) The indirect medical education adjustment made under § 412.105.

(ii) The disproportionate share adjustment made under § 412.106.

(2) *State criteria.* The hospital is located in a State in which the aggregate payment made under § 412.112 (a) and (c) for hospitals described in paragraph (b)(1) of this section for their cost reporting periods beginning in FY 1995 is less than the allowable operating costs described in § 412.2(c) for those hospitals.

(3) *Hospital criteria.* The aggregate payment made to the hospital under § 412.112 (a) and (c) for the hospital's cost reporting period beginning in the fiscal year in which the additional payment update described in paragraph (a) of this section is made is less than the allowable operating cost described in § 412.2(c) for that hospital.

[62 FR 46030, Aug. 29, 1997]

42 CFR Ch. IV (10–1–24 Edition)

§ 412.108 Special treatment: Medicare-dependent, small rural hospitals.

(a) *Criteria for classification as a Medicare-dependent, small rural hospital—*

(1) *General considerations.* For cost reporting periods beginning on or after April 1, 1990, and ending before October 1, 1994, or for discharges occurring on or after October 1, 1997, and before January 1, 2025, a hospital is classified as a Medicare-dependent, small rural hospital if it meets all of the following conditions:

(i) It is located in a rural area (as defined in subpart D of this part) or it is located in a State with no rural area and satisfies any of the criteria under § 412.103(a)(1) or (3) or under § 412.103(a)(2) as of January 1, 2018.

(ii) The hospital has 100 or fewer beds as defined in § 412.105(b) during the cost reporting period.

(iii) The hospital is not also classified as a sole community hospital under § 412.92.

(iv) At least 60 percent of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits during the hospital's cost reporting period or periods as follows, subject to the provisions of paragraph (a)(1)(v) of this section:

(A) The hospital's cost reporting period ending on or after September 30, 1987 and before September 30, 1988.

(B) If the hospital does not have a cost reporting period that meets the criterion set forth in paragraph (a)(1)(iv)(A) of this section, the hospital's cost reporting period beginning on or after October 1, 1986, and before October 1, 1987.

(C) At least two of the last three most recent audited cost reporting periods for which the Secretary has a settled cost report.

(v) If the cost reporting period determined under paragraph (a)(1)(iv) of this section is for less than 12 months, the hospital's most recent 12-month or longer cost reporting period before the short period is used.

(2) *Counting days and discharges.* In counting inpatient days and discharges for purposes of meeting the criteria in paragraph (a)(1)(iii) of this section, only days and discharges from acute

care inpatient hospital stays are counted (including days and discharges from swing beds when used for acute care inpatient hospital services), but not including days and discharges from units excluded from the prospective payment system under §§412.25 through 412.30 or from newborn nursery units. For purposes of this section, a transfer as defined in §412.4(b) is considered to be a discharge.

(3) *Criteria for hospitals that have remote location(s).* For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at §413.65 of this chapter as a main campus and a remote location of a hospital, combined data from the main campus and its remote location(s) are required to demonstrate that the criteria in paragraphs (a)(1) and (2) of this section are met. For the location requirement specified in paragraph (a)(1)(i) of this section, the hospital must demonstrate that the main campus and its remote locations each independently satisfy this requirement.

(b) *Classification procedures.* (1) The MAC determines whether a hospital meets the criteria specified in paragraph (a) of this section.

(2) A hospital must submit a written request along with qualifying documentation to its fiscal intermediary to be considered for MDH status based on the criterion under paragraph (a)(1)(iii)(C) of this section.

(3) The MAC will make its determination and notify the hospital within 90 days from the date that it receives the hospital's request and all of the required documentation.

(4) For applications received on or before September 30, 2018, a determination of MDH status made by the MAC is effective 30 days after the date the MAC provides written notification to the hospital. For applications received on or after October 1, 2018, a determination of MDH status made by the MAC is effective as of the date the MAC receives the complete application. An approved MDH status determination remains in effect unless there

is a change in the circumstances under which the status was approved.

(i) An approved MDH must notify the MAC if any change occurs that is specified in paragraph (b)(4)(ii) of this section occurs. If CMS determines that an MDH failed to comply with this requirement, CMS will cancel the hospital's classification as an MDH effective with the date that the hospital no longer met the criteria for such status, consistent with the provisions of §405.1885 of this chapter.

(ii) An MDH must report the following to the MAC within 30 days of the event:

(A) The number of beds increases to more than 100.

(B) Its geographic classification changes.

(iii) An MDH must report to the MAC if it becomes aware of any change that would affect its classification as an MDH beyond the events listed in paragraph (b)(4)(ii) of this section within 30 days of the event. If CMS determines that an MDH has failed to comply with this requirement, CMS will cancel the hospital's classification as an MDH effective with the date the hospital became aware of the event that resulted in the MDH no longer meeting the criteria for such classification, consistent with the provisions of §405.1885 of this chapter.

(5) The MAC will evaluate on an ongoing basis, whether or not a hospital continues to qualify for MDH status. This evaluation includes an ongoing review to ensure that the hospital continues to meet all of the criteria specified in paragraph (a) of this section.

(6) If the MAC determines that a hospital no longer qualifies for MDH status, the change in status will become effective 30 days after the date the MAC provides written notification to the hospital.

(7) A hospital may reapply for MDH status following its disqualification only after it has completed another cost reporting period that has been audited and settled. The hospital must reapply for MDH status in writing to its MAC and submit the required documentation.

(8) If a hospital disagrees with an MAC's determination regarding the

hospital's initial or ongoing MDH status, the hospital may notify its MAC and submit other documentable evidence to support its claim that it meets the MDH qualifying criteria.

(9) The MAC's initial and ongoing determination is subject to review under subpart R of Part 405 of this chapter. The time required by the MAC to review the request is considered good cause for granting an extension of the time limit for the hospital to apply for that review.

(c) *Payment methodology.* A hospital that meets the criteria in paragraph (a) of this section is paid for its inpatient operating costs the sum of paragraphs (c)(1) and (c)(2) of this section.

(1) The Federal payment rate applicable to the hospital, as determined under subpart D of this part, subject to the regional floor defined in § 412.70(c)(6).

(2) The amount, if any, determined as follows:

(i) For discharges occurring during the first three 12-month cost reporting periods that begin on or after April 1, 1990, 100 percent of the amount that the Federal rate determined under paragraph (c)(1) of this section is exceeded by the higher of the following:

(A) The hospital-specific rate as determined under § 412.73.

(B) The hospital-specific rate as determined under § 412.75.

(ii) For discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, and for discharges occurring on or after October 1, 1997 and before October 1, 2006, 50 percent of the amount that the Federal rate determined under paragraph (c)(1) of this section is exceeded by the higher of the following:

(A) The hospital-specific rate as determined under § 412.73.

(B) The hospital-specific rate as determined under § 412.75.

(iii) For discharges occurring during cost reporting periods (or portions thereof) beginning on or after October 1, 2006, and before January 1, 2025, 75 percent of the amount that the Federal rate determined under paragraph (c)(1) of this section is exceeded by the highest of the following:

(A) The hospital-specific rate as determined under § 412.73.

(B) The hospital-specific rate as determined under § 412.75.

(C) The hospital-specific rate as determined under § 412.79.

(d) *Additional payments to hospitals experiencing a significant volume decrease.*

(1) CMS provides for a payment adjustment for a Medicare-dependent, small rural hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (d)(2) of this section, a more than 5 percent decrease in its total inpatient discharges as compared to its immediately preceding cost reporting period. If either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the MAC must convert the discharges to a monthly figure and multiply this figure by 12 to estimate the total number of discharges for a 12-month cost reporting period.

(2) To qualify for a payment adjustment on the basis of a decrease in discharges, a Medicare-dependent, small rural hospital must submit its request no later than 180 days after the date on the MAC's Notice of Amount of Program Reimbursement and it must—

(i) Submit to the MAC documentation demonstrating the size of the decrease in discharges and the resulting effect on per discharge costs; and

(ii) Show that the decrease is due to circumstances beyond the hospital's control.

(3) The MAC determines a lump sum adjustment amount in accordance with the methodology set forth in § 412.92(e)(3).

(i) In determining the adjustment amount, the MAC considers—

(A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;

(B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and

(C) The length of time the hospital has experienced a decrease in utilization.

(ii) The MAC makes its determination within 180 days from the date it

receives the hospital's request and all other necessary information.

(iii) The MAC determination is subject to review under subpart R of part 405 of this chapter. The time required by the MAC to review the request is considered good cause for granting an extension of the time limit for the hospital to apply for that review.

[55 FR 15175, Apr. 20, 1990; 55 FR 32088, Aug. 7, 1990]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §412.108, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.govinfo.gov.

§412.109 Special treatment: Essential access community hospitals (EACHs).

(a) *General rule.* For payment purposes, CMS treats as a sole community hospital any hospital that is located in a rural area as described in paragraph (b) of this section and that CMS designated as an EACH under section 1820(i)(1) of the Act as in effect on September 30, 1997, for as long as the hospital continues to comply with the terms, conditions, and limitations that were applicable at the time CMS designated the hospital as an EACH. The payment methodology for sole community hospitals is set forth at §412.92(d).

(b) *Location in a rural area.* For purposes of this section, a hospital is located in a rural area if it—

(1) Is located outside any area that is a Metropolitan Statistical Area as defined by the Office of Management and Budget or that has been recognized as urban under §412.62;

(2) Is not deemed to be located in an urban area under subpart D of this part.

(3) Is not classified as an urban hospital for purposes of the standardized payment amount by CMS or the Medicare Geographic Classification Review Board; or

(4) Is not located in a rural county that has been redesignated to an adjacent urban area under §412.232.

(c) *Adjustment to the hospital-specific rate for rural EACHs experiencing increased costs—*(1) *General rule.* CMS increases the applicable hospital-specific rate of an EACH that it treats as a sole community hospital if, during a cost

reporting period, the hospital experiences an increase in its Medicare inpatient operating costs per discharge that is directly attributable to activities related to its membership in a rural health network.

(2) *Request and documentation.* In order for a hospital to qualify for an increase in its hospital-specific rate, it must meet the following criteria:

(i) The hospital must submit its request to its intermediary no later than 180 days after the date on the intermediary's notice of program reimbursement.

(ii) The request must include documentation specifically identifying the increased costs resulting from the hospital's participation in a rural health network and show that the increased costs during the cost reporting period will result in increased costs in subsequent cost reporting periods that are not already accounted for under the prospective payment system payment.

(iii) The hospital must show that the cost increases are incremental costs that would not have been incurred in the absence of the hospital's membership in a rural health network.

(iv) The hospital must show that the cost increases do not include amounts for start-up and one-time, nonrecurring costs attributable to its membership in a rural health network.

(3) *Intermediary recommendation.* The intermediary forwards the following material to CMS within 60 days of receipt from the hospital:

(i) The hospital's documentation and the intermediary's verification of that documentation.

(ii) The intermediary's analysis and recommendation of the request.

(iii) The hospital's Medicare cost report for the year in which the increase in costs occurred and the prior year.

(4) *CMS determination.* CMS determines, within 120 days of receiving all necessary information from the intermediary, whether an increase in the hospital-specific rate is warranted and, if it is, the amount of the increase. CMS grants an adjustment only if a hospital's Medicare inpatient operating costs per discharge exceed the hospital's hospital-specific rate. The adjusted hospital-specific rate cannot exceed the hospital's Medicare inpatient