

## § 412.110

operating costs per discharge for the cost reporting period.

(d) *Termination of EACH designation.* If CMS determines that a hospital no longer complies with the terms, conditions, and limitations that were applicable at the time CMS designated the hospital as an EACH, CMS will terminate the EACH designation of the hospital, effective with discharges occurring on or after 30 days after the date of the determination.

(e) *Review of CMS determination.* A determination by CMS that a hospital's EACH designation should be terminated, is subject to review under part 405, subpart R of this chapter, including the time limits for filing requests for hearings as specified in §§ 405.1811(a) and 405.1841(a)(1) and (b) of this chapter.

[58 FR 30669, May 26, 1993, as amended at 59 FR 45398, Sept. 1, 1994; 60 FR 45848, Sept. 1, 1995; 61 FR 21972, May 13, 1996; 62 FR 46030, Aug. 29, 1997; 70 FR 47486, Aug. 12, 2005]

## Subpart H—Payments to Hospitals Under the Prospective Payment Systems

### § 412.110 Total Medicare payment.

Under the prospective payment systems, Medicare's total payment for inpatient hospital services furnished to a Medicare beneficiary by a hospital will equal the sum of the payments listed in §§ 412.112 through 412.115, reduced by the amounts specified in § 412.120.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39824, Sept. 1, 1992]

### § 412.112 Payments determined on a per case basis.

A hospital is paid the following amounts on a per case basis:

(a) The appropriate prospective payment rate for inpatient operating costs for each discharge as determined in accordance with subparts D, E, and G of this part.

(b) Effective for cost reporting periods beginning on or after October 1, 1991, the appropriate prospective payment rate for capital-related costs for each discharge as determined in accordance with subpart M of this part.

(c) The appropriate outlier payment amounts determined under subpart F of this part.

(d) Additional payments for new medical services and technologies determined under subpart F of this part.

[56 FR 43448, Aug. 30, 1991, as amended at 57 FR 39824, Sept. 1, 1992; 68 FR 45470, Aug. 1, 2003]

### § 412.113 Other payments.

(a) *Capital-related costs—(1) Payment.* Subject to the reductions described in paragraph (a)(2) of this section, payment for capital-related costs (as described in § 413.130 of this chapter) for cost reporting periods beginning before October 1, 1991 is determined on a reasonable cost basis.

(2) *Reduction to capital-related payments.* (i) Except for sole community hospitals as defined in § 412.92, the amount of capital-related payments for cost-reporting periods beginning before October 1, 1991 (including a return on equity capital as provided under § 413.157 of this chapter) is reduced by—

(A) Three and one-half percent for payments attributable to portions of cost reporting periods occurring during Federal FY 1987;

(B) Seven percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1988 and before January 1, 1988;

(C) Twelve percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) in fiscal year 1988 occurring on or after January 1, 1988;

(D) Fifteen percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989 and beginning on or after January 1, 1990 and ending on or before September 30, 1991; and

(E) Ten percent for payments attributable to portions of cost-reporting periods occurring on or after October 1, 1991 and before the beginning of the hospital's first cost-reporting period beginning on or after October 1, 1991.

(ii) If a hospital's cost reporting period encompasses more than one Federal fiscal year, the reductions to capital-related payments are determined on a prorated monthly basis.

(3) For cost-reporting periods beginning on or after October 1, 1991, a hospital with a hospital-specific rate above the Federal capital rate is paid a hold-harmless payment for old capital determined in accordance with subpart M of this part.

(b) *Direct medical education costs.* (1) Payment for the direct medical education costs of interns and residents in approved programs for cost reporting periods beginning prior to July 1, 1985, and for approved education activities of nurses and paramedical health professionals is made as described in §413.85 of this chapter.

(2) For cost reporting periods beginning on or after July 1, 1985, payment for the direct medical education costs of interns and residents in approved programs is made as described in §§413.75 through 413.83 of this subchapter.

(3) Except as provided in §413.75(c) of this subchapter, for cost reporting periods during the prospective payment transition period, the costs of medical education must be determined in a manner that is consistent with the treatment of these costs for purposes of determining the hospital-specific portion of the payment rate as provided in subpart E of this part.

(c) *Anesthesia services furnished by hospital or CAH employed nonphysician anesthetists or obtained under arrangements.* (1) For cost reporting periods beginning on or after October 1, 1984 through any part of a cost reporting period occurring before January 1, 1989, payment is determined on a reasonable cost basis for anesthesia services provided in the hospital or CAH by qualified nonphysician anesthetists (certified registered nurse anesthetists and anesthesiologist's assistants) employed by the hospital or CAH or obtained under arrangements.

(2)(i) For cost reporting periods, or any part of a cost reporting period, beginning on or after January 1, 1989, through any part of a cost reporting period occurring before January 1, 1990, payment is determined on a reasonable cost basis for anesthesia services provided in a hospital or CAH by qualified nonphysician anesthetists employed by the hospital or CAH or obtained under arrangement, if the hospital or CAH

demonstrates to its intermediary prior to April 1, 1989 that it meets the following criteria:

(A) The hospital or CAH is located in a rural area as defined in §412.62(f) and is not deemed to be located in an urban area under the provisions of §412.64(b)(3). Effective December 2, 2010, the hospital or CAH is either located in a rural area as defined at §412.62(f) and is not deemed to be located in an urban area under the provisions of §412.64(b)(3) or the hospital or CAH has reclassified as rural under the provisions at §412.103.

(B) The hospital or CAH must have employed or contracted with a qualified nonphysician anesthetist, as defined in §410.69 of this chapter, as of January 1, 1988 to perform anesthesia services in that hospital or CAH. The hospital or CAH may employ or contract with more than one anesthetist; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.

(C) The hospital or CAH must provide data for its entire patient population to demonstrate that, during calendar year 1987, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 250 procedures. For purposes of this section, a *surgical procedure requiring anesthesia services* means a surgical procedure in which the anesthesia is administered and monitored by a qualified nonphysician anesthetist, a physician other than the primary surgeon, or an intern or resident.

(D) Each qualified nonphysician anesthetist employed by or under contract with the hospital or CAH has agreed in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.

(ii) To maintain its eligibility for reasonable cost payment under paragraph (c)(2)(i) of this section in calendar years after 1989, a qualified hospital or CAH must demonstrate prior to January 1 of each respective year that for the prior year its volume of surgical procedures requiring anesthesia service did not exceed 500 procedures; or, effective October 1, 2002, did not exceed 800 procedures.

(iii) A hospital or CAH that did not qualify for reasonable cost payment for nonphysician anesthesiologist services furnished in calendar year 1989 can qualify in subsequent years if it meets the criteria in paragraphs (c)(2)(i)(A), (B), and (D) of this section, and demonstrates to its intermediary prior to the start of the calendar year that it met these criteria. The hospital or CAH must provide data for its entire patient population to demonstrate that, during calendar year 1987 and the year immediately preceding its election of reasonable cost payment, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 500 procedures, or, effective October 1, 2002, did not exceed 800 procedures.

(iv) For administrative purposes for the calendar years after 1990, the volume of surgical procedures for the immediately preceding year is the sum of the surgical procedures for the nine month period ending September 30, annualized for the twelve month period.

(d) *Organ acquisition.* Payment for organ acquisition costs as specified in part 413, subpart L, incurred by hospitals with approved transplant programs is made on a reasonable cost basis.

(e) *Allogeneic hematopoietic stem cell acquisition.* For cost reporting periods beginning on or after October 1, 2020, in the case of a subsection (d) hospital that furnishes an allogeneic hematopoietic stem cell transplant to an individual, payment to such hospital for hematopoietic stem cell acquisition costs is made on a reasonable cost basis.

(1) An allogeneic hematopoietic stem cell transplant is the intravenous infusion of hematopoietic cells derived from bone marrow, peripheral blood stem cells, or cord blood, but not including embryonic stem cells, of a donor to an individual that are or may be used to restore hematopoietic function in such individual having an inherited or acquired deficiency or defect.

(2) Allogeneic hematopoietic stem cell acquisition costs recognized under this paragraph (e) are costs of acquiring

hematopoietic stem cells from a donor. These costs are as follows:

(i) Registry fees from a national donor registry described in 42 U.S.C. 274k, if applicable, for stem cells from an unrelated donor.

(ii) Tissue typing of donor and recipient.

(iii) Donor evaluation.

(iv) Physician pre-admission/pre-procedure donor evaluation services.

(v) Costs associated with the collection procedure (for example, general routine and special care services, procedure/operating room and other ancillary services, apheresis services), and transportation costs of stem cells if the recipient hospital incurred or paid such costs.

(vi) Post-operative/post-procedure evaluation of donor.

(vii) Preparation and processing of stem cells derived from bone marrow, peripheral blood stem cells, or cord blood (but not including embryonic stem cells).

(3) A subsection (d) hospital that furnishes inpatient allogeneic hematopoietic stem cell transplants is required to hold all allogeneic hematopoietic stem cell acquisition charges and bill them to Medicare using the appropriate revenue code, when the transplant occurs.

(4) A subsection (d) hospital must maintain an itemized statement that identifies, for all costs defined in paragraph (e)(2) of this section, the services furnished in collecting hematopoietic stem cells including all invoices or statements for purchased services for all donors and their service charges. Records must be for the person receiving the services (donor or recipient; for all donor sources, the hospital must identify the prospective recipient), and the recipient's Medicare beneficiary identification number.

(f) *Additional resource costs of domestic National Institute for Occupational Safety and Health approved surgical N95 respirators.* (1) For cost reporting periods beginning on or after January 1, 2023, a payment adjustment to a hospital for the additional resource costs of domestic National Institute for Occupational Safety and Health approved surgical N95 respirators is made as described in paragraph (f)(2) of this section.

(2) The payment adjustment is based on the estimated difference in the reasonable cost incurred by the hospital for domestic National Institute for Occupational Safety and Health approved surgical N95 respirators purchased during the cost reporting period as compared to other National Institute for Occupational Safety and Health approved surgical N95 respirators purchased during the cost reporting period.

(g) *Additional resource costs of establishing and maintaining access to buffer stocks of essential medicines.* (1) Essential medicines are the 86 medicines prioritized in the report Essential Medicines Supply Chain and Manufacturing Resilience Assessment developed by the U.S. Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response and published in May of 2022, and any subsequent revisions to that list of medicines. A buffer stock of essential medicines for a hospital is a supply, for no less than a 6-month period of one or more essential medicines.

(2) The additional resource costs of establishing and maintaining access to a buffer stock of essential medicines for a hospital are the additional resource costs incurred by the hospital to directly hold a buffer stock of essential medicines for its patients or arrange contractually for such a buffer stock to be held by another entity for use by the hospital for its patients. The additional resource costs of establishing and maintaining access to a buffer stock of essential medicines does not include the resource costs of the essential medicines themselves.

(3) For cost reporting periods beginning on or after October 1, 2024, a payment adjustment to a small, independent hospital for the additional resource costs of establishing and maintaining access to buffer stocks of essential medicines is made as described in paragraph (g)(4) of this section. For purposes of this section, a small, independent hospital is a hospital with 100 or fewer beds as defined in §412.105(b) during the cost reporting period that is not part of a chain organization, defined as a group of two or more health care facilities which are owned, leased,

or through any other device, controlled by one organization.

(4) The payment adjustment is based on the estimated reasonable cost incurred by the hospital for establishing and maintaining access to buffer stocks of essential medicines during the cost reporting period.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting §412.113, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at [www.govinfo.gov](http://www.govinfo.gov).

#### §412.115 Additional payments.

(a) *Bad debts.* An additional payment is made to each hospital in accordance with §413.89 of this chapter for bad debts attributable to deductible and co-insurance amounts related to covered services received by beneficiaries.

(b) *Administration of blood clotting factor.* For discharges occurring on or after June 19, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997, an additional payment is made to a hospital for each unit of blood clotting factor furnished to a Medicare inpatient who is a hemophiliac. For discharges occurring on or after October 1, 2005, the additional payment is made based on the average sales price methodology specified in subpart K, part 414 of this chapter and the furnishing fee specified in §410.63 of this subchapter.

(c) *QIO reimbursement for cost of sending requested patient records to the QIO.* An additional payment is made to a hospital in accordance with §476.78 of this chapter for the costs of sending requested patient records to the QIO in electronic format, by facsimile, or by photocopying and mailing.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 55 FR 15175, Apr. 20, 1990; 56 FR 43448, Aug. 30, 1991; 57 FR 39825, Sept. 1, 1992; 57 FR 47787, Oct. 20, 1992; 58 FR 46339, Sept. 1, 1993; 62 FR 46030, Aug. 29, 1997; 68 FR 67960, Dec. 5, 2003; 70 FR 47486, Aug. 12, 2005; 85 FR 59022, Sept. 18, 2020]

#### §412.116 Method of payment.

(a) *General rules.* (1) Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge