

lump sum adjustment amount equal to the difference between the hospital's fixed Medicare inpatient operating costs and the hospital's total MS-DRG revenue based on MS-DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105) multiplied by the ratio of the hospital's fixed inpatient operating costs to its total inpatient operating costs.

(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.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.92, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.gpo.gov.

§ 412.96 Special treatment: Referral centers.

(a) *Criteria for classification as a referral center: Basic rule.* CMS classifies a hospital as a referral center only if the hospital is a Medicare participating acute care hospital and meets the applicable criteria of paragraph (b) or (c) of this section.

(b) *Criteria for cost reporting periods beginning on or after October 1, 1983.* The

hospital meets either of the following criteria:

(1) The hospital is located in a rural area (as defined in subpart D of this part) and has the following number of beds, as determined under the provisions of § 412.105(b) available for use:

(i) Effective for discharges occurring before April 1, 1988, the hospital has 500 or more beds.

(ii) Effective for discharges occurring on or after April 1, 1988, the hospital has 275 or more beds during its most recently completed cost reporting period unless the hospital submits written documentation with its application that its bed count has changed since the close of its most recently completed cost reporting period for one or more of the following reasons:

(A) Merger of two or more hospitals.

(B) Reopening of acute care beds previously closed for renovation.

(C) Transfer to the prospective payment system of acute care beds previously classified as part of an excluded unit.

(D) Expansion of acute care beds available for use and permanently maintained for lodging inpatients, excluding beds in corridors and other temporary beds.

(2) The hospital shows that—(i) At least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the staff of the hospital; and

(ii) At least 60 percent of the hospital's Medicare patients live more than 25 miles from the hospital, and at least 60 percent of all the services that the hospital furnishes to Medicare beneficiaries are furnished to beneficiaries who live more than 25 miles from the hospital.

(c) *Alternative criteria.* For cost reporting periods beginning on or after October 1, 1985, a hospital that does not meet the criteria of paragraph (b) of this section is classified as a referral center if it is located in a rural area (as defined in subpart D of this part) and meets the criteria specified in paragraphs (c)(1) and (c)(2) of this section and at least one of the three criteria specified in paragraphs (c)(3), (c)(4), and (c)(5) of this section.

(1) *Case-mix index.* CMS sets forth national and regional case-mix index values in each year's annual notice of prospective payment rates published under § 412.8(b). The methodology CMS uses to calculate these criteria is described in paragraph (h) of this section. The case-mix index value to be used for an individual hospital in the determination of whether it meets the case-mix index criteria is that calculated by CMS from the hospital's own billing records for Medicare discharges as processed by the fiscal intermediary and submitted to CMS. The hospital's case-mix index for discharges (not including discharges from units excluded from the prospective payment system under subpart B of this part) during the same Federal fiscal year used to compute the case mix index values under paragraph (h) of this section must be at least equal to—

(i) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the national or regional case-mix index value; or

(ii) For hospitals applying for rural referral center status for cost-reporting periods beginning on or after October 1, 1986, the national case-mix index value as established by CMS or the median case-mix index value for urban hospitals located in each region. In calculating the median case-mix index for each region, CMS excludes the case-mix indexes of hospitals receiving indirect medical education payments as provided in § 412.105.

(2) *Number of discharges.* (i) CMS sets forth the national and regional number of discharges in each year's annual notice of prospective payment rates published under § 412.8(b). The methodology CMS uses to calculate these criteria is described in paragraph (i) of this section. Except as provided in paragraph (c)(2)(ii) of this section for an osteopathic hospital, for the hospital's cost reporting period that began during the same fiscal year as the cost reporting periods used to compute the regional median discharges under paragraph (i) of this section, its number of discharges (not including discharges from units excluded from the prospective payments system under subpart B

of this part or from newborn units) is at least equal to—

(A) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the number of discharges under either the national or regional criterion; or

(B) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1986, 5,000 discharges or, if less, the median number of discharges for urban hospitals located in each region.

(ii) For cost reporting periods beginning on or after January 1, 1986, an osteopathic hospital, recognized by the American Osteopathic Healthcare Association (or any successor organization), that is located in a rural area must have at least 3,000 discharges during its cost reporting period that began during the same fiscal year as the cost reporting periods used to compute the regional median discharges under paragraph (i) of this section to meet the number of discharges criterion. A hospital applying for rural referral center status under the number of discharges criterion in this paragraph must demonstrate its status as an osteopathic hospital.

(iii) If the hospital's cost reporting period that began during the same fiscal year as the cost reporting periods used to compute the regional median discharges under paragraph (i) of this section is for less than 12 months or longer than 12 months, the hospital's number of discharges for that cost reporting period will be annualized to estimate the total number of discharges for a 12-month cost reporting period.

(3) *Medical staff.* More than 50 percent of the hospital's active medical staff are specialists who meet one of the following conditions:

(i) Are certified as specialists by one of the Member Boards of the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists.

(ii) Have completed the current training requirements for admission to the certification examination of one of the Member Boards of the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists.

(iii) Have successfully completed a residency program in a medical specialty accredited by the Accreditation Council of Graduate Medical Education or the American Osteopathic Association.

(4) *Source of inpatients.* At least 60 percent of all its discharges are for inpatients who reside more than 25 miles from the hospital.

(5) *Volume of referrals.* At least 40 percent of all inpatients treated at the hospital are referred from other hospitals or from physicians not on the hospital's staff.

(d) *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 specified in paragraphs (b)(1) and (2) and (c)(1) through (5) of this section are met. For the rural location criteria specified in paragraphs (b)(1) and (c) of this section and the mileage criteria specified in paragraphs (b)(2)(ii) and (c)(4) of this section, the hospital must demonstrate that the main campus and its remote locations each independently satisfy those requirements.

(e) *Payment to rural referral centers.* Effective for discharges occurring on or after April 1, 1988, and before October 1, 1994, a hospital that is located in a rural area and meets the criteria of paragraphs (b)(1), (b)(2) or (c) of this section is paid prospective payments for inpatient operating costs per discharge based on the applicable other urban payment rates as determined in accordance with §412.63, as adjusted by the hospital's area wage index.

(f) [Reserved]

(g) *Hospital cancellation of referral center status.* (1) A hospital may at any time request cancellation of its status as a referral center and be paid prospective payments per discharge based on the applicable rural rate, as determined in accordance with subpart D of this part.

(2) The cancellation becomes effective no later than 30 days after the date the hospital submits its request.

(3) If a hospital requests that its referral center status be canceled, it may not be reclassified as a referral center unless it meets the qualifying criteria set forth in paragraph (a) of this section in effect at the time it reapplies.

(4) A hospital that submits a written request on or after October 1, 2007, to cancel its reclassification under §412.103(g) is deemed to have cancelled its status as a rural referral center effective on the same date the cancellation under §412.103(g) takes effect. The provision of this paragraph (g)(4) applies to hospitals that qualify as rural referral centers under §412.96 based on rural status acquired under §412.103.

(h) *Methodology for calculating case-mix index criteria.* CMS calculates the national and regional case-mix index value criteria as described in paragraphs (h)(1) through (h)(4) of this section.

(1) *Updating process.* CMS updates the national and regional case-mix index standards using the best available data from hospitals subject to the prospective payment system for the Federal fiscal year.

(2) *Source of data.* In making the calculations described in paragraph (h)(1) of this section, CMS uses all inpatient hospital bills received for discharges subject to prospective payment during the Federal fiscal year being monitored.

(3) *Effective date.* CMS sets forth the national and regional criteria in the annual notice of prospective payment rates published under §412.8(b). These criteria are used to determine if a hospital qualifies for referral center status for cost reporting periods beginning on or after October 1 of the Federal fiscal year to which the notice applies.

(i) *Methodology for calculating number of discharges criteria.* For purposes of determining compliance with the national or regional number of discharges criterion under paragraph (c)(2) of this section, CMS calculates the criteria as follows:

(1) *Updating process.* CMS updates the national and regional number of discharges using the best available data

§ 412.98

for levels of admissions or discharges or both.

(2) *Source of data.* In making the calculations described in paragraph (i)(1) of this section, CMS uses the best available hospital admissions or discharge data.

(3) *Annual notice.* CMS sets forth the national and regional criteria in the annual notice of prospective payment rates published under § 412.8(b). These criteria are compared to an applying hospital's number of discharges for the same cost reporting period used to develop the regional criteria in this section in determining if the hospital qualifies for referral center status for cost reporting periods beginning on or after October 1 of the Federal fiscal year to which the notice applies.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.96, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.govinfo.gov.

§ 412.98 [Reserved]

§ 412.100 Special treatment: Kidney transplant programs.

(a) *Adjustments for kidney transplant programs.* (1) CMS adjusts the inpatient prospective payment system (IPPS) rates for inpatient operating costs determined under subparts D and E of this part for hospitals with approved kidney transplant programs (discussed at § 482.104 of this chapter) to remove the net costs associated with kidney acquisition.

(2)(i) Payment for Medicare kidney acquisition costs, as set forth in subpart L of part 413 of this chapter, is made on a reasonable cost basis apart from the prospective payment rate for inpatient operating costs.

(ii) IPPS payment to the hospital is adjusted in each cost reporting period to reflect an amount necessary to compensate the hospital for reasonable costs of Medicare kidney acquisition.

(b) Costs of kidney acquisition. Kidney acquisition costs include allowable costs incurred in the acquisition of a kidney from a living or a deceased donor by the hospital, or from a deceased donor by an organ procurement

42 CFR Ch. IV (10–1–24 Edition)

organization. These costs are listed in § 413.402(b) of this chapter.

[86 FR 73511, Dec. 27, 2021, as amended at 87 FR 72286, Nov. 23, 2022]

§ 412.101 Special treatment: Inpatient hospital payment adjustment for low-volume hospitals.

(a) *Definitions.* Beginning in FY 2011, the terms used in this section are defined as follows:

Medicare discharges means discharge of inpatients entitled to Medicare Part A, including discharges associated with individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare and also discharges of individuals enrolled in a MA organization under Medicare Part C.

Road miles means “miles” as defined in § 412.92(c)(1).

(b) *General considerations.* (1) CMS provides an additional payment to a qualifying hospital for the higher incremental costs associated with a low volume of discharges. The amount of any additional payment for a qualifying hospital is calculated in accordance with paragraph (c) of this section.

(2) In order to qualify for this adjustment, a hospital must meet the following criteria, subject to the provisions of paragraph (e) of this section:

(i) For FY 2005 through FY 2010, the portion of FY 2025 beginning on January 1, 2025 and subsequent fiscal years, a hospital must have fewer than 200 total discharges, which includes Medicare and non-Medicare discharges, during the fiscal year, based on the hospital's most recently submitted cost report, and be located more than 25 road miles (as defined in paragraph (a) of this section) from the nearest “subsection (d)” (section 1886(d) of the Act) hospital.

(ii) For FY 2011 through FY 2018, a hospital must have fewer than 1,600 Medicare discharges, as defined in paragraph (a) of this section, during the fiscal year, based on the hospital's Medicare discharges from the most recently available MedPAR data as determined by CMS, and be located more than 15 road miles, as defined in paragraph (a) of this section, from the nearest “subsection (d)” (section 1886(d) of the Act) hospital.