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 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 and FY 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.

(iii) For FY 2019 through FY 2024, a hospital must have fewer than 3,800 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 15 road miles (as defined in paragraph (a) of this section) from the nearest ''subsection (d)'' (section 1886(d) of the Act) hospital.

(3) In order to qualify for the adjustment, a hospital must provide its fiscal intermediary or Medicare administrative contractor with sufficient evidence that it meets the distance requirement specified under paragraph (b)(2) of this section. The fiscal intermediary or Medicare administrative contractor will base its determination of whether the distance requirement is satisfied upon the evidence presented by the hospital and other relevant evidence, such as maps, mapping software, and inquiries to State and local police, transportation officials, or other government officials.

(c) *Determination of the adjustment amount.* The low-volume adjustment for hospitals that qualify under paragraph (b) of this section is as follows for the applicable fiscal year:

(1) For FY 2005 through FY 2010 and FY 2025 and subsequent fiscal years, the adjustment is an additional 25 percent for each Medicare discharge.

(2) For FY 2011 through FY 2018, the adjustment is as follows:

(i) For low-volume hospitals with 200 or fewer Medicare discharges (as defined in paragraph (a) of this section), the adjustment is an additional 25 percent for each Medicare discharge.

(ii) For low-volume hospitals with Medicare discharges (as defined in paragraph (a) of this section) of more than 200 and fewer than 1,600, the adjustment for each Medicare discharge is an additional percent calculated using the formula [(4/14)—(number of Medicare discharges/5600)]. The ''number of Medicare discharges'' is determined as described in paragraph (b)(2)(ii) of this section.

(3) For FY 2019 through FY 2024, the adjustment is as follows:

(i) For low-volume hospitals with 500 or fewer total discharges, which includes Medicare and non-Medicare discharges, during the fiscal year, based on the hospital's most recently submitted cost report, the adjustment is an additional 25 percent for each Medicare discharge.

(ii) For low-volume hospitals with more than 500 and fewer than 3,800 total discharges, which includes Medicare and non-Medicare discharges, during the fiscal year, based on the hospital's most recently submitted cost report, the adjustment for each Medicare discharge is an additional percent calculated using the formula [(95/330)−(number of total discharges/13,200)]. ''Total discharges'' is determined as described in paragraph (b)(2)(iii) of this section.

(d) *Eligibility of new hospitals for the adjustment.* For FYs 2005 through 2010 and FY 2019 and subsequent fiscal years, a new hospital will be eligible for a low-volume adjustment under this section once it has submitted a cost report for a cost reporting period that indicates that it meets discharge requirements during the applicable fiscal year and has provided its Medicare administrative contractor with sufficient evidence that it meets the distance requirement, as specified in paragraph (b)(2) of this section.

(e) *Special treatment regarding hospitals operated by the Indian Health Service (IHS) or a Tribe.* (1) For discharges occurring in FY 2018 and subsequent fiscal years—

(i) A hospital operated by the IHS or a Tribe will be considered to meet the applicable mileage criterion specified under paragraph (b)(2) of this section if it is located more than the specified number of road miles from the nearest subsection (d) hospital operated by the IHS or a Tribe.

(ii) A hospital, other than a hospital operated by the IHS or a Tribe, will be considered to meet the applicable mileage criterion specified under paragraph (b)(2) of this section if it is located more than the specified number of road miles from the nearest subsection (d) hospital other than a subsection (d) hospital operated by the IHS or a Tribe.

(2) Subject to the requirements set forth in §405.1885 of this chapter, a hospital may request the application of the policy described in paragraph (e)(1) of this section for discharges occurring in FY 2011 through FY 2017.

[75 FR 50414, Aug. 16, 2010, as amended at 78 FR 50965, Aug. 19, 2013; 49 FR 15030, Mar. 18, 2014; 79 FR 50352, Aug. 22, 2014; 80 FR 49767, Aug. 17, 2015; 82 FR 38511, Aug. 14, 2017; 83 FR 41702, Aug. 17, 2018; 84 FR 42613, Aug. 16, 2019; 88 FR 59332, Aug. 28, 2023]

§412.102 Special treatment: Hospitals located in areas that are changing from urban to rural as a result of a geographic redesignation.

An urban hospital that was part of an MSA, but was redesignated as rural as a result of the most recent OMB standards for delineating statistical areas adopted by CMS, may receive an adjustment to its rural Federal payment amount for operating costs for 2 successive fiscal years as provided in paragraphs (a) and (b) of this section.

(a) *First year adjustment.* (1) Effective on or after October 1, 1983 and before October 1, 2014, the hospital's rural average standardized amount and disproportionate share payments as described in §412.106 are adjusted on the