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an initial adverse review determination, whether or not the physician further appeals the initial adverse review determination.

(c) *Notices and appeals.* If payment is denied for nonassignment-related claims because the services are found to be not reasonable and necessary, a notice of denial will be sent to both the physician and the beneficiary. The physician who does not accept assignment will have the same rights as a physician who submits claims on an assignment-related basis, as detailed in subpart H of part 405 and subpart B of part 473, to appeal the determination, and will be subject to the same time limitations.

(d) *When a refund is not required.* A refund of any amounts collected for services not reasonable and necessary is not required if—

(1) The physician did not know, and could not reasonably have been expected to know, that Medicare would not pay for the service; or

(2) Before the service was provided—

(i) The physician informed the beneficiary, or someone acting on the beneficiary's behalf, in writing that the physician believed Medicare was likely to deny payment for the specific service; and

(ii) The beneficiary (or someone eligible to sign for the beneficiary under §424.36(b) of this chapter) signed a statement agreeing to pay for that service.

(e) *Criteria for determining that a physician knew that services were excluded as not reasonable and necessary.* A physician will be determined to have known that furnished services were excluded from coverage as not reasonable and necessary if one or more of the conditions in §411.406 of this subpart are met.

(f) *Acceptable evidence of prior notice to a beneficiary that Medicare was likely to deny payment for a particular service.* To qualify for waiver of the refund requirement under paragraph (d)(2) of this section, the physician must inform the beneficiary (or person acting on his or her behalf) that the physician believes Medicare is likely to deny payment.

(1) The notice must—

(i) Be in writing, using approved notice language;

(ii) Cite the particular service or services for which payment is likely to be denied; and

(iii) Cite the physician's reasons for believing Medicare payment will be denied.

(2) The notice is not acceptable evidence if—

(i) The physician routinely gives this notice to all beneficiaries for whom he or she furnishes services; or

(ii) The notice is no more than a statement to the effect that there is a possibility that Medicare may not pay for the service.

(g) *Applicability of sanctions to physicians who fail to make refunds under this section.* A physician who knowingly and willfully fails to make refunds as required by this section may be subject to sanctions as provided for in chapter V, parts 1001, 1002, and 1003 of this title.

[55 FR 24568, June 18, 1990; 55 FR 35142, 35143, Aug. 28, 1990]

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AUTHORITY: 42 U.S.C. 1302 and 1395hh.

SOURCE: 50 FR 12741, Mar. 29, 1985, unless otherwise noted.

Subpart A—General Provisions

§ 412.1 Scope of part.

(a) *Purpose.* (1) This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983, and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991.

(i) Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis.

(ii) Payment for other costs related to inpatient hospital services is made on a reasonable cost basis as follows:

(A) Organ acquisition costs incurred by hospitals with approved organ transplant programs.

(B) The costs of qualified nonphysician anesthetist's services, as described in § 412.113(c).

(C) Direct costs of approved nursing and allied health educational programs.

(D) Costs related to hematopoietic stem cell acquisition for the purpose of an allogeneic hematopoietic stem cell transplant as described in § 412.113(e).

(iii) Payment for the direct costs of graduate medical education is made on a per resident amount basis in accordance with §§ 413.75 through 413.83 of this chapter.

(iv) Additional payments are made for outlier cases, bad debts, indirect medical education costs, for serving a disproportionate share of low-income patients, for the additional resource costs of domestic National Institute for Occupational Safety and Health approved surgical N95 respirators, and for the additional resource costs for small,

independent hospitals to establish and maintain access to buffer stocks of essential medicines.

(v) Under either prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating or capital-related costs incurred in furnishing inpatient services, and the hospital is at risk for inpatient operating or inpatient capital-related costs that exceed its payment rate.

(2) This part implements section 124 of Public Law 106–113 by establishing a per diem prospective payment system for the inpatient operating and capital costs of hospital inpatient services furnished to Medicare beneficiaries by a psychiatric facility that meets the conditions of subpart N of this part.

(3) This part implements section 1886(j) of the Act by establishing a prospective payment system for the inpatient operating and capital costs of inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meets the conditions of §412.604.

(4) This part implements the following regarding long-term care hospitals—

(i) Section 123 of Public Law 106–113, which provides for the establishment of a prospective payment system for the costs of inpatient hospital services furnished to Medicare beneficiaries by long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Act, for cost reporting periods beginning on or after October 1, 2002.

(ii) The provisions of section 307(b) of Public Law 106–554, which state that the Secretary shall examine and may provide for appropriate adjustments to the long-term care hospital prospective payment system, including adjustments to diagnosis-related group (DRG) weights, area wage adjustments, geographic reclassification, outlier adjustments, updates, and disproportionate share adjustments consistent with section 1886(d)(5)(F) of the Act.

(iii) Section 114 of Public Law 110–173, which contains several provisions regarding long-term care hospitals, including the—

(A) Amendment of section 1886 of the Act to add a new subsection (m) that references section 123 of Public Law 106–113 and section 307(b) of Public Law 106–554 for the establishment and implementation of a prospective payment system for payments under title XVIII for inpatient hospital services furnished by a long-term care hospital described in section 1886(d)(1)(B)(iv) of the Act.

(B) Revision of the standard Federal rate for RY 2008.

(5) This part implements section 1886(q) of the Act, which provides that, effective for discharges from an ''applicable hospital'' beginning on or after October 1, 2012, payments to those hospitals under section 1886(d) of the Act will be reduced to account for certain excess readmissions, under the Hospital Readmissions Reduction Program. This reduction will be made through an adjustment to the hospital's base operating DRG payment amounts under the prospective payment system for inpatient operating costs.

(6) This part implements section 1886(o)(1)(B) of the Act, which directs the Secretary to begin to make value-based incentive payments under the Hospital Value-Based Purchasing Program to hospitals for discharges occurring on or after October 1, 2012, through an adjustment to the base operating DRG payment amounts under the prospective payment system for inpatient operating costs.

(7) This part implements section 1866(k) of the Act, which directs hospitals described in section 1886(d)(1)(B)(v) of the Act to submit data on quality measures to the Secretary.

(b) *Summary of content.* (1) This subpart describes the basis of payment for inpatient hospital services under the prospective payment systems specified in paragraph (a)(1) of this section and sets forth the general basis of these systems.

(2) Subpart B of this part sets forth all of the following:

(i)(A) The classifications of hospitals that are included in and excluded from the prospective payment systems specified in paragraph (a)(1) of this section.

(B) Requirements governing the inclusion or exclusion of hospitals in the systems as a result of changes in their classification.

(ii) Requirements for the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program.

(3) Subpart C sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment systems specified in paragraph (a)(1) of this section.

(4) Subpart D sets forth the basic methodology by which prospective payment rates for inpatient operating costs are determined under the prospective payment system specified in paragraph (a)(1) of this section.

(5) Subpart E describes the transition ratesetting methods that are used to determine transition payment rates for inpatient operating costs during the first 4 years of the prospective payment system specified in paragraph (a)(1) of this section.

(6) Subpart F sets forth the methodology for determining payments for outlier cases under the prospective payment system specified in paragraph (a)(1) of this section.

(7) Subpart G sets forth rules for special treatment of certain facilities under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(8) Subpart H describes the types, amounts, and methods of payment to hospitals under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(9) Subpart K describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs is implemented for hospitals located in Puerto Rico.

(10) Subpart L sets forth the procedures and criteria concerning applications from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation under the prospective payment systems specified in paragraph (a)(1) of this section.

(11) Subpart M describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient capital-related costs is implemented effective with reporting periods beginning on or after October 1, 1991.

(12) Subpart N describes the prospective payment system specified in paragraph (a)(2) of this section for inpatient psychiatric facilities and sets forth the general methodology for paying the operating and capital-related costs of inpatient hospital services furnished by inpatient psychiatric facilities effective with cost reporting periods beginning on or after January 1, 2005.

(13) Subpart O of this part describes the prospective payment system specified in paragraph (a)(4) of this section for long-term care hospitals and sets forth the general methodology for paying for the operating and capital-related costs of inpatient hospital services furnished by long-term care hospitals, effective with cost reporting periods beginning on or after October 1, 2002.

(14) Subpart P describes the prospective payment system specified in paragraph (a)(3) of this section for rehabilitation hospitals and rehabilitation units and sets forth the general methodology for paying for the operating and capital-related costs of inpatient hospital services furnished by rehabilitation hospitals and rehabilitation units effective with cost reporting periods beginning on or after January 1, 2002.

[66 FR 41385, Aug. 7, 2001, as amended at 67 FR 56048, Aug. 30, 2002; 69 FR 66976, Nov. 15, 2004; 70 FR 47484, Aug. 12, 2005; 73 FR 24879, May 6, 2008; 77 FR 53673, Aug. 31, 2012; 85 FR 59020, Sept. 18, 2020; 86 FR 45518, Aug. 13, 2021; 86 FR 73510, Dec. 27, 2021; 87 FR 72286, Nov. 23, 2022; 89 FR 69909, Aug. 28, 2024]

§ 412.2 Basis of payment.

(a) *Payment on a per discharge basis.* Under both the inpatient operating and inpatient capital-related prospective payment systems, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The prospective payment rate for each discharge (as defined in §412.4) is determined according to the methodology described in subpart D, E, or G of this part, as appropriate, for operating costs, and according to the methodology described in subpart M of this part for capital-related costs. An additional payment is made for both inpatient operating and inpatient capital-related costs, in accordance with subpart F of this part, for cases that are extraordinarily costly to treat.

(b) *Payment in full.* (1) The prospective payment amount paid for inpatient hospital services is the total Medicare payment for the inpatient operating costs (as described in paragraph (c) of this section) and the inpatient capital-related costs (as described in paragraph (d) of this section) incurred in furnishing services covered by the Medicare program.

(2) The full prospective payment amount, as determined under subpart D, E, or G and under subpart M of this part, is made for each stay during which there is at least one Medicare payable day of care. Payable days of care, for purposes of this paragraph include the following:

(i) Limitation of liability days payable under the payment procedures for custodial care and services that are not reasonable and necessary as specified in §411.400 of this chapter.

(ii) Guarantee of payment days, as authorized under §409.68 of this chapter, for inpatient hospital services furnished to an individual whom the hospital has reason to believe is entitled to Medicare benefits at the time of admission.

(3) If a patient is admitted to an acute care hospital and then the acute care hospital meets the criteria at §412.23(e) to be paid as a LTCH, during the course of the patient's hospitalization, Medicare considers all the days of the patient stay in the facility (days prior to and after the designation of LTCH status) to be a single episode of LTCH care. Medicare will not make payment under subpart H for any part of the hospitalization. Payment for the entire patient stay (days prior to and after the designation of LTCH status) will be made in accordance with the requirements specified in §412.521. The requirements of this paragraph (b)(3) apply only to a patient stay in which a patient is in an acute care hospital and that hospital is designated as a LTCH on or after October 1, 2004.

(c) *Inpatient operating costs.* The prospective payment system provides a payment amount for inpatient operating costs, including—

(1) Operating costs for routine services (as described in §413.53(b) of this chapter), such as the costs of room, board, and routine nursing services;

(2) Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;

(3) Special care unit operating costs (intensive care type unit services, as described in §413.53(b) of this chapter);

(4) Malpractice insurance costs related to services furnished to inpatients; and

(5) Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the 3 calendar days immediately preceding the date of the beneficiary's admission to the hospital that meet the condition specified in paragraph (c)(5)(i) of this section and at least one of the conditions specified in paragraphs (c)(5)(ii) through (c)(5)(iv).

(i) The services are furnished by the hospital or by an entity wholly owned or operated by the hospital. An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity.

(ii) For services furnished after January 1, 1991, the services are diagnostic (including clinical diagnostic laboratory tests).

(iii) For services furnished on or after October 1, 1991, through June 24, 2010, the services are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient and are not the following:

(A) Ambulance services.

(B) Maintenance renal dialysis.

(iv) Nondiagnostic services furnished on or after June 25, 2010, other than ambulance services and maintenance renal dialysis services, that are furnished on the date of the beneficiary's inpatient admission or on the first, second, or third calendar day immediately preceding the date of the beneficiary's inpatient admission and the hospital does not attest that such services are unrelated to the beneficiary's inpatient admission.

(d) *Inpatient capital-related costs.* For cost reporting periods beginning on or after October 1, 1991, the capital prospective payment system provides a payment amount for inpatient hospital capital-related costs as described in part 413, subpart G of this chapter.

(e) *Excluded costs.* The following inpatient hospital costs are excluded from the prospective payment amounts and are paid for on a reasonable cost basis:

(1) Capital-related costs for cost reporting periods beginning before October 1, 1991, and an allowance for return on equity, as described in §§ 413.130 and 413.157, respectively, of this chapter.

(2) Direct medical education costs for approved nursing and allied health education programs as described in § 413.85 of this chapter.

(3) Costs for direct medical and surgical services of physicians in teaching hospitals exercising the election in § 405.521 of this chapter.

(4) The acquisition costs of hearts, kidneys, livers, lungs, pancreas, and intestines (or multivisceral organs) incurred by approved transplant programs.

(5) The costs of qualified nonphysician anesthetists' services, as described in § 412.113(c).

(6) For cost reporting periods beginning on or after October 1, 2020, the costs of allogenic hematopoietic stem cell acquisition, as described in § 412.113(e), for the purpose of an allogeneic hematopoietic stem cell transplant.

(f) *Additional payments to hospitals.* In addition to payments based on the prospective payment system rates for inpatient operating and inpatient capital-related costs, hospitals receive payments for the following:

(1) Outlier cases, as described in subpart F of this part.

(2) The indirect costs of graduate medical education, as specified in subparts F and G of this part and in § 412.105 for inpatient operating costs and in § 412.322 for inpatient capital-related costs.

(3) Costs excluded from the prospective payment rates under paragraph (e) of this section, as provided in § 412.115.

(4) Bad debts of Medicare beneficiaries, as provided in § 412.115(a).

(5) ESRD beneficiary discharges if such discharges are ten percent or more of the hospital's total Medicare discharges, as provided in § 412.104.

(6) Serving a disproportionate share of low-income patients, as provided in § 412.106 for inpatient operating costs and § 412.320 for inpatient capital-related costs.

(7) The direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§ 413.75–413.83 of this chapter.

(8) For discharges on or after June 19, 1990, and before October 1, 1994, and for discharges on or after October 1, 1997, a payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia. 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 subchapter and the furnishing fee specified in § 410.63 of this subchapter.

(9) Special additional payment for certain new technology as specified in §§ 412.87 and 412.88 of subpart F.

(10) A payment adjustment for the additional resource costs of domestic National Institute for Occupational Safety and Health approved surgical N95 respirators as specified in § 412.113.

(11) A payment adjustment for small, independent hospitals for the additional resource costs of establishing and maintaining access to buffer stocks of essential medicines as specified in § 412.113.

(g) *Payment adjustment for certain replaced devices.* CMS makes a payment adjustment for certain replaced devices, as provided under § 412.89.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.2, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

§ 412.3 Admissions.

(a) For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if

formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and §§482.24(c), 482.12(c), and 485.638(a)(4)(iii) of this chapter for a critical access hospital. In addition, inpatient rehabilitation facilities also must adhere to the admission requirements specified in §412.622.

(b) The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient's hospital course, medical plan of care, and current condition. The practitioner may not delegate the decision (order) to another individual who is not authorized by the State to admit patients, or has not been granted admitting privileges applicable to that patient by the hospital's medical staff.

(c) The physician order must be furnished at or before the time of the inpatient admission.

(d)(1) Except as specified in paragraphs (d)(2) and (3) of this section, an inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights.

(i) The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.

(ii) If an unforeseen circumstance, such as a beneficiary's death or transfer, results in a shorter beneficiary stay than the physician's expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and payment for an inpatient hospital stay may be made under Medicare Part A.

(2) An inpatient admission for a surgical procedure specified by Medicare as inpatient only under §419.22(n) of this chapter is generally appropriate for payment under Medicare Part A regardless of the expected duration of care. Procedures no longer specified as inpatient only under §419.22(n) of this chapter are appropriate for payment under Medicare Part A in accordance with paragraph (d)(1) or (3) of this section. Claims for services and procedures removed from the inpatient only list under §419.22 of this chapter on or after January 1, 2020 are exempt from certain medical review activities.

(i) For those services and procedures removed on or after January 1, 2020, the exemption in this paragraph (d)(2) will last for 2 years from the date of such removal.

(ii) For those services and procedures removed on or after January 1, 2021, the exemption in this paragraph (d)(2) will last until the Secretary determines that the service or procedure is more commonly performed in the outpatient setting.

(3) Where the admitting physician expects a patient to require hospital care for only a limited period of time that does not cross 2 midnights, an inpatient admission may be appropriate for payment under Medicare Part A based on the clinical judgment of the admitting physician and medical record support for that determination. The physician's decision should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In these cases, the factors that lead to the decision to admit the patient as an inpatient must be supported by the medical record in order to be granted consideration.

[78 FR 50965, Aug. 19, 2013, as amended at 79 FR 67030, Nov. 10, 2014; 80 FR 70602, Nov. 13, 2015; 83 FR 41700, Aug. 17, 2018; 85 FR 86300, Dec. 29, 2020; 86 FR 63992, Nov. 16, 2021]

§412.4 Discharges and transfers.

(a) *Discharges.* Subject to the provisions of paragraphs (b) and (c) of this section, a hospital inpatient is considered discharged from a hospital paid under the prospective payment system when—

(1) The patient is formally released from the hospital; or

(2) The patient dies in the hospital.

(b) *Acute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of payment

under this part if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital that is—

(1) Paid under the prospective payment system described in subparts A through M of this part;

(2) Excluded from being paid under the prospective payment system described in subparts A through M of this part because of participation in an approved statewide cost control program as described in subpart C of part 403 of this chapter;

(3) An acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program; or

(4) A critical access hospital.

(c) *Postacute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in §412.60(c), to one of the qualifying diagnosis-related groups (DRGs) listed in paragraph (d) of this section and the discharge is made under any of the following circumstances:

(1) To a hospital or distinct part hospital unit excluded from the prospective payment system described in subparts A through M of this part under subpart B of this part.

(2) To a skilled nursing facility.

(3) To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

(4) For discharges occurring on or after October 1, 2018, to hospice care provided by a hospice program.

(d) *Qualifying DRGs.* (1) For a fiscal year prior to FY 2006, for purposes of paragraph (c) of this section, and subject to the provisions of paragraph (d)(2) of this section, the qualifying DRGs must meet the following criteria for both of the 2 most recent years for which data are available:

(i) The DRG must have a geometric mean length of stay of at least 3 days.

(ii) The DRG must have at least 14,000 cases identified as postacute care transfer cases.

(iii) The DRG must have at least 10 percent of the postacute care transfers occurring before the geometric mean length of stay for the DRG.

(iv) If the DRG is one of a paired DRG based on the presence or absence of a comorbidity or complication, one of the DRGs meets the criteria specified under paragraphs (d)(1)(i) through (d)(1)(iii) of this section.

(v) To initially qualify, the DRG must meet the criteria specified in paragraphs (d)(1)(i) through (d)(1)(iv) of this section and must have a decline in the geometric mean length of stay for the DRG during the most recent 5 years of at least 7 percent. Once a DRG initially qualifies, the DRG is subject to the criteria specified in paragraphs (d)(1)(i) through (d)(1)(iv) of this section for each subsequent fiscal year.

(2) For purposes of paragraph (c), a discharge is also considered to be a transfer if it meets the following conditions:

(i) The discharge is assigned to a DRG that contains only cases that were assigned to a DRG that qualified under this paragraph within the previous 2 years; and

(ii) The latter DRG was split or otherwise modified within the previous 2 fiscal years.

(3) For fiscal years beginning with FY 2006, for purposes of paragraph (c) of this section—

(i) The qualifying DRGs must meet the following criteria using data from the March 2005 update of the FY 2004 MedPAR file and Version 23.0 of the DRG Definitions Manual (FY 2006):

(A) The DRG has at least 2,050 total postacute care transfer cases;

(B) At least 5.5 percent of the cases in the DRG are discharged to postacute care prior to the geometric mean length of stay for the DRG;

(C) The DRG must have a geometric mean length of stay greater than 3 days;

(D) The DRG is paired with a DRG based on the presence or absence of a comorbidity or complication or major cardiovascular condition that, it meets the criteria specified in paragraphs (d)(3)(i)(A) and (d)(3)(ii)(B) of this section.

(ii) If a DRG did not exist in Version 23.0 of the DRG Definitions Manual or a DRG included in Version 23.0 of the DRG Definitions Manual is revised, the

DRG will be a qualifying DRG if it meets the following criteria based on the version of the DRG Definitions Manual in use when the new or revised DRG first becomes effective, using the most recent complete year of MedPAR data:

(A) The total number of discharges to postacute care in the DRG must equal or exceed the 55th percentile for all DRGs;

(B) The proportion of short-stay discharges to postacute care to total discharges in the DRG exceeds the 55th percentile for all DRGs;

(C) The DRG is paired with a DRG based on the presence or absence of a comorbidity or a complication or major cardiovascular condition that meets the criteria specified under paragraphs (d)(3)(ii)(A) and (d)(3)(ii)(B) of this section; and

(D) In the case of MS-DRGs that share the same base MS-DRG, if one MS-DRG meets the criteria specified under paragraph (d)(3)(ii)(B) of this section, every MS-DRG that shares the same base MS-DRG is a qualifying DRG.

(e) *Payment for discharges.* The hospital discharging an inpatient (under paragraph (a) of this section) is paid in full, in accordance with §412.2(b).

(f) *Payment for transfers*—(1) *General rule.* Except as provided in paragraph (f)(2) or (f)(3) of this section, a hospital that transfers an inpatient under the circumstances described in paragraph (b) or (c) of this section, is paid a graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid under subparts D and M of this part if the patient had been discharged to another setting. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under subparts D and M of this part) by the geometric mean length of stay for the specific DRG to which the case is assigned. Payment is graduated by paying twice the per diem amount for the first day of the stay, and the per diem amount for each subsequent day, up to the full DRG payment.

(2) *Special rule for DRGs 209, 210, and 211 for fiscal years prior to FY 2006.* For fiscal years prior to FY 2006, a hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section and the transfer is assigned to DRGs 209, 210, or 211 is paid as follows:

(i) 50 percent of the appropriate prospective payment rate (as determined under subparts D and M of this part) for the first day of the stay; and

(ii) 50 percent of the amount calculated under paragraph (f)(1) of this section for each day of the stay, up to the full DRG payment.

(3) *Transfer assigned to DRG for newborns that die or are transferred to another hospital.* If a transfer is classified into CMS DRG 385 (Neonates, Died or Transferred) prior to October 1, 2007, or into MS-DRG 789 (Neonates, Died or Transferred to Another Acute Care Facility) on or after October 1, 2007, the transferring hospital is paid in accordance with §412.2(b).

(4) *Outliers.* Effective with discharges occurring on or after October 1, 1984, a transferring hospital may qualify for an additional payment for extraordinarily high-cost cases that meet the criteria for cost outliers as described in subpart F of this part.

(5) *Special rule for DRGs meeting specific criteria.* For discharges occurring on or after October 1, 2005, and prior to October 1, 2007, a hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section is paid using the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section if the transfer case is assigned to one of the DRGs meeting the following criteria:

(i) The DRG meets the criteria specified in paragraph (d)(3)(i) or (d)(3)(ii) of this section.

(ii) The average charges of the 1-day discharge cases in the DRG must be at least 50 percent of the average charges for all cases in the DRG; and

(iii) The geometric mean length of stay for the DRG is greater than 4 days; and

(iv) If a DRG is paired with a DRG based on the presence or absence of a comorbidity or complication or a major cardiovascular complication that meets the criteria specified in paragraphs (f)(5)(i) through (f)(5)(iii) of this section, that DRG will also be paid

under the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section.

(6) *Special rule for DRGs meeting specific criteria.* For discharges occurring on or after October 1, 2007, a hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section is paid using the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section if the transfer case is assigned to one of the DRGs meeting the following criteria:

(i) The DRG meets the criteria specified in paragraph (d)(3)(i) or (d)(3)(ii) of this section;

(ii) The average charges of the 1-day discharge cases in the DRG must be at least 50 percent of the average charges for all cases in the DRG; and

(iii) The geometric mean length of stay for the DRG is greater than 4 days.

(iv) If a DRG is part of an MS-DRG group that meets the criteria specified in paragraphs (f)(6)(i) through (f)(6)(iii) of this section, that DRG will also be paid under the provisions of paragraphs (f)(2)(i) and (f)(2)(ii) of this section.

[63 FR 41003, July 31, 1998, as amended at 65 FR 47106, Aug. 1, 2000; 67 FR 50111, Aug. 1, 2002; 68 FR 45469, Aug. 1, 2003; 69 FR 49240, Aug. 11, 2004; 70 FR 47484, Aug. 12, 2005; 72 FR 47410, Aug. 22, 2007; 75 FR 50413, Aug. 16, 2010; 83 FR 41700, Aug. 17, 2018]

§ 412.6 Cost reporting periods subject to the prospective payment systems.

(a) *Initial cost reporting period for each prospective payment system.* (1) Each subject hospital is paid under the prospective payment system for operating costs for inpatient hospital services effective with the hospital's first cost reporting period beginning on or after October 1, 1983 and for inpatient capital-related costs effective with the hospital's first cost reporting period beginning on or after October 1, 1991.

(2) The hospital is paid the applicable prospective payment rate for inpatient operating costs and capital-related costs for each discharge occurring on or after the first day of its first cost reporting period subject to the applicable prospective payment system.

(3) If a discharged beneficiary was admitted to the hospital before the first day of the hospital's first cost reporting period subject to the prospective payment system for inpatient operating costs, the reasonable costs of services furnished before that day are paid under the cost reimbursement provisions of part 413 of this chapter. For such discharges, the amount otherwise payable under the applicable prospective payment rate is reduced by the amount paid on a reasonable cost basis for inpatient hospital services furnished to that beneficiary during the hospital stay. If the amount paid under reasonable cost exceeds the inpatient operating prospective payment amount, the reduction is limited to the inpatient operating prospective payment amount.

(b) *Changes in cost reporting periods.* CMS recognizes a change in a hospital's cost reporting period made after November 30, 1982 only if the change has been requested in writing by the hospital and approved by the intermediary in accordance with § 413.24(f)(3) of this chapter.

[57 FR 39819, Sept. 1, 1992]

§ 412.8 Publication of schedules for determining prospective payment rates.

(a) *Initial prospective payment rates—*(1) *For inpatient operating costs.* Initial prospective payment rates for inpatient operating costs (for the period October 1, 1983 through September 30, 1984) were determined in accordance with documents published in the FEDERAL REGISTER on September 1, 1983 (48 FR 39838), and January 3, 1984 (49 FR 324).

(2) *For inpatient capital-related costs.* Initial prospective payment rates for inpatient capital-related costs (for the period October 1, 1991 through September 30, 1992) were determined in accordance with the final rule published in the FEDERAL REGISTER on August 30, 1991 (56 FR 43196).

(b) *Annual publication of schedule for determining prospective payment rates.* (1) CMS proposes changes in the methods, amounts, and factors used to determine inpatient prospective payment rates in a FEDERAL REGISTER document published for public comment not later than the April 1 before the beginning of the Federal fiscal year in which the proposed changes would apply.

(2) Except as provided in paragraph (c) of this section, CMS publishes a FEDERAL REGISTER document setting forth final methods, amounts, and factors for determining inpatient prospective payment rates not later than the August 1 before the Federal fiscal year in which the rates would apply.

(c) *Publication schedule for FY 2007.* For FY 2007, not later than August 1, 2006, CMS publishes a FEDERAL REGISTER document setting forth a description of the methodology and data used in computing the inpatient prospective payment rates for that year.

[57 FR 39820, Sept. 1, 1992, as amended at 62 FR 46025, Aug. 29, 1997; 71 FR 48136, Aug. 18, 2006]

§ 412.10 Changes in the DRG classification system.

(a) *General rule.* CMS issues changes in the DRG classification system in a FEDERAL REGISTER notice at least annually. Except as specified in paragraphs (c) and (d) of this section, the DRG changes are effective prospectively with discharges occurring on or after the same date the payment rates are effective.

(b) *Basis for changes in the DRG classification system.* All changes in the DRG classification system are made using the principles established for the DRG system. This means that cases are classified so each DRG is—

(1) Clinically coherent; and

(2) Embraces an acceptable range of resource consumption.

(c) *Interim coverage changes*—(1) *Criteria.* CMS makes interim changes to the DRG classification system during the Federal fiscal year to incorporate items and services newly covered under Medicare.

(2) *Implementation and effective date.* CMS issues interim coverage changes through its administrative issuance system and makes the change effective as soon as is administratively feasible.

(3) *Publication for comment.* CMS publishes any change made under paragraph (c)(1) of this section in the next annual notice of changes to the DRG classification system published in accordance with paragraph (a) of this section.

(d) *Interim changes to correct omissions and inequities*—(1) *Criteria.* CMS makes interim changes to the DRG classification system to correct a serious omission or inequity in the system only if failure to make the changes would have—

(i) A potentially substantial adverse impact on the health and safety of beneficiaries; or

(ii) A significant and unwarranted fiscal impact on hospitals or the Medicare program.

(2) *Publication and effective date.* CMS publishes these changes in the FEDERAL REGISTER in a final notice with comment period with a prospective effective date. The change is also published for public information in the next annual notice of changes to the DRG classification system published in accordance with paragraph (a) of this section.

(e) *Review by ProPAC.* Changes published annually in accordance with paragraph (a) of this section are subject to review and comment by ProPAC upon publication. Interim changes to the DRG classification system that are made in accordance with paragraphs (c) and (d) of this section are subject to review by ProPAC before implementation.

[50 FR 35688, Sept. 3, 1985, as amended at 51 FR 31496, Sept. 3, 1986; 57 FR 39820, Sept. 1, 1992]

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

§ 412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraphs (b), (c), (d), and (e) of this section, all covered hospital inpatient services furnished to beneficiaries during the subject cost reporting periods are paid under the prospective payment system as specified in § 412.1(a)(1).

(b) Effective for cost reporting periods beginning on or after January 1, 2005, covered inpatient hospital services furnished to Medicare beneficiaries by an inpatient psychiatric facility that meets the conditions of § 412.404 are paid under the prospective payment

system described in subpart N of this part.

(c)(1) Effective for cost reporting periods beginning on or after January 1, 2002, covered inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meet the conditions of § 412.604 are paid under the prospective payment system described in subpart P of this part.

(2) CMS will not pay for services under subpart P of this part if the services are paid for by a health maintenance organization (HMO) or competitive medical plan (CMP) that elects not to have CMS make payments to an inpatient rehabilitation facility for services, which are inpatient hospital services, furnished to the HMO's or CMP's Medicare enrollees, as provided under part 417 of this chapter.

(d) Effective for cost reporting periods beginning on or after October 1, 2002, covered inpatient hospital services furnished to Medicare beneficiaries by a long-term care hospital that meets the conditions for payment of §§ 412.505 through 412.511 are paid under the prospective payment system described in subpart O of this part.

(e) Inpatient hospital services will not be paid under the prospective payment systems specified in § 412.1(a)(1) under any of the following circumstances:

(1) The services are furnished by a hospital (or hospital unit) explicitly excluded from the prospective payment systems under §§ 412.23, 412.25, 412.27, and 412.29.

(2) The services are emergency services furnished by a nonparticipating hospital in accordance with § 424.103 of this chapter.

(3) The services are paid for by an HMO or competitive medical plan (CMP) that elects not to have CMS make payments directly to a hospital for inpatient hospital services furnished to the HMO's or CMP's Medicare enrollees, as provided in §§ 417.240(d) and 417.586 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 53 FR 6648, Mar. 2, 1988; 57 FR 39820, Sept. 1, 1992; 59 FR 45400, Sept. 1, 1994; 66 FR 41386, Aug. 7, 2001; 67 FR 56048, Aug. 30, 2002; 68 FR 45698, Aug. 1, 2003; 69 FR 66976, Nov. 15, 2004]

§ 412.22 Excluded hospitals and hospital units: General rules.

(a) *Criteria.* Subject to the criteria set forth in paragraph (e) of this section, a hospital is excluded from the prospective payment systems specified in § 412.1(a)(1) of this part if it meets the criteria for one or more of the excluded classifications described in § 412.23. For purposes of this subpart, the term ''hospital'' includes a critical access hospital (CAH).

(b) *Cost reimbursement.* Except for those hospitals specified in paragraph (c) of this section, and § 412.20(b), (c), and (d), all excluded hospitals (and excluded hospital units, as described in § 412.23 through § 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this chapter, and are subject to the ceiling on the rate of hospital cost increases as specified in § 413.40 of this chapter.

(c) *Special payment provisions.* The following classifications of hospitals are paid under special provisions and therefore are not generally subject to the cost reimbursement or prospective payment rules of this chapter.

(1) Veterans Administration hospitals.

(2) Hospitals reimbursed under State cost control systems approved under part 403 of this chapter.

(3) Hospitals reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Public Law 92–603 (42 U.S.C. 1395b–1 (note)).

(4) Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

(d) *Changes in hospitals' status.* For purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of the hospital are made only at the start of a cost reporting period.

(e) *Hospitals-within-hospitals.* A hospital-within-a-hospital is a hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the

same campus as buildings used by another hospital. Prior to October 1, 2017, except as provided in paragraphs (e)(1)(vi) and (f) of this section, a hospital-within-a-hospital must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1). On or after October 1, 2017, except as provided in paragraphs (e)(1)(vi) and (f) of this section, a hospital-within-hospital that is excluded from the prospective payment systems specified in § 412.1(a)(1) that occupies space in a building also used by a hospital which is not excluded from the prospective payment systems specified in § 412.1(a)(1), or in one or more separate buildings located on the same campus as buildings used by a hospital not excluded from the prospective payment systems specified in § 412.1(a)(1) must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1).

(1) Except as specified in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997—

(i) *Separate governing body.* The hospital has a governing body that is separate from the governing body of the hospital occupying space in the same building or on the same campus. The hospital's governing body is not under the control of the hospital occupying space in the same building or on the same campus, or of any third entity that controls both hospitals.

(ii) *Separate chief medical officer.* The hospital has a single chief medical officer who reports directly to the governing body and who is responsible for all medical staff activities of the hospital. The chief medical officer of the hospital is not employed by or under contract with either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(iii) *Separate medical staff.* The hospital has a medical staff that is separate from the medical staff of the hospital occupying space in the same building or on the same campus. The hospital's medical staff is directly accountable to the governing body for the quality of medical care provided in the hospital, and adopts and enforces by-laws governing medical staff activities, including criteria and procedures for recommending to the governing body the privileges to be granted to individual practitioners.

(iv) *Chief executive officer.* The hospital has a single chief executive officer through whom all administration authority flows, and who exercises control and surveillance over all administrative activities of the hospital. The chief executive officer is not employed by, or under contract with, either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(v) *Performance of basic hospital functions.* Prior to October 1, 2017, the hospital meets one of the following criteria:

(A) The hospital performs the basic functions specified in §§ 482.21 through 482.27, 482.30, 482.42, 482.43, and 482.45 of this chapter through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or on the same campus, or a third entity that controls both hospitals. Food and dietetic services and housekeeping, maintenance, and other services necessary to maintain a clean and safe physical environment could be obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals.

(B) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of patients in § 412.23(d)(2) or the length-of-stay criterion in § 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for a period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the cost of the services that the hospital obtains under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals, is no more than 15 percent of the hospital's total inpatient operating costs, as defined in § 412.2(c). For purposes of this paragraph (e)(1)(v)(B), however, the costs of

preadmission services are those specified under § 413.40(c)(2) rather than those specified under § 412.2(c)(5).

(C) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of inpatients in § 412.23(d)(2) or the length-of-stay criterion in § 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for the period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the hospital has an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same building or on the same campus.

(vi) Effective October 1, 2008, if a State hospital that is occupying space in the same building or on the same campus as another State hospital cannot meet the criterion under paragraph (e)(1)(i) of this section solely because its governing body is under the control of the State hospital with which it shares a building or a campus, or is under the control of a third entity that also controls the State hospital with which it shares a building or a campus, the State hospital can nevertheless qualify for an exclusion if it meets the other applicable criteria in this section and—

(A) Both State hospitals occupy space in the same building or on the same campus and have been continuously owned and operated by the State since October 1, 1995;

(B) Is required by State law to be subject to the governing authority of the State hospital with which it shares space or the governing authority of a third entity that controls both hospitals; and

(C) Was excluded from the inpatient prospective payment system before October 1, 1995, and continues to be excluded from the inpatient prospective payment system through September 30, 2008.

(2) Effective for long-term care hospitals-within-hospitals for cost reporting periods beginning on or after October 1, 2004, the hospital must meet the governance and control requirements at paragraphs (e)(1)(i) through (e)(1)(iv) of this section.

(3) *Notification of co-located status.* A long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (e)(1) or (e)(2) of this section must notify its fiscal intermediary and CMS in writing of its co-location and identify by name, address, and Medicare provider number those hospital(s) with which it is co-located.

(f) *Application for certain hospitals.* Except as provided in paragraph (f)(3) of this section, if a hospital was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital, the criteria in paragraph (e) of this section do not apply to the hospital as long as the hospital—

(1) Continues to operate under the same terms and conditions, including the number of beds, unless the hospital is a children's hospital as defined at § 412.23(d), and square footage considered to be part of the hospital for purposes of Medicare participation and payment in effect on September 30, 1995; or

(2) In the case of a hospital that changes the terms and conditions under which it operates after September 30, 1995, but before October 1, 2003, continues to operate under the same terms and conditions, including the number of beds, unless the hospital is a children's hospital as defined at § 412.23(d), and square footage considered to be part of the hospital for purposes of Medicare participation and payment in effect on September 30, 2003.

(3) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (f)(1) or (f)(2) of this section, any hospital that was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as

buildings used by another hospital may increase or decrease the square footage or decrease the number of beds considered to be part of the hospital at any time without affecting the provisions of paragraph (f)(1) or (f)(2) of this section.

(i) If a hospital to which the provisions of paragraph (f)(1) of this section applies decreases its number of beds below the number of beds considered to be part of the hospital on September 30, 1995, it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the hospital does not exceed the number of beds at the hospital on September 30, 1995.

(ii) If a hospital to which the provisions of paragraph (f)(2) of this section applies decreases its number of beds below the number of beds considered to be part of the hospital on September 30, 2003, it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the hospital does not exceed the number of beds at the hospital on September 30, 2003.

(g) *Definition of control.* For purposes of this section, control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(h) *Satellite facilities.* (1) For purposes of paragraphs (h)(2) through (h)(5) of this section, a satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Except as provided in paragraphs (h)(3), (h)(4), (h)(5), (h)(7) and (h)(8) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

(i) In the case of a hospital (other than a children's hospital) that was excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the hospital's number of State-licensed and Medicare-certified beds, including those at the satellite facilities, does not exceed the hospital's number of State-licensed and Medicare-certified beds on the last day of the hospital's last cost reporting period beginning before October 1, 1997.

(ii) The satellite facility independently complies with—

(A) For psychiatric hospitals, the requirements under § 412.23(a);

(B) For rehabilitation hospitals, the requirements under § 412.23(b)(2);

(C) For the children's hospitals, the requirements under § 412.23(d)(2); or

(D) For long-term care hospitals, the requirements under §§ 412.23(e)(1) through (e)(3)(i).

(iii) The satellite facility meets all of the following requirements:

(A) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical officer of the hospital in which it is located.

(*1*) Except as provided in paragraph (h)(2)(iii)(A)(*2*) of this section, effective for cost reporting periods beginning on or after October 1, 2009, the governing body of the hospital of which the satellite facility is a part is not under the control of any third entity that controls both the hospital of which the satellite facility is a part and the hospital with which the satellite facility is co-located.

(*2*) If a hospital and its satellite facility were excluded from the inpatient prospective payment system under the provisions of this section for the most recent cost reporting period beginning prior to October 1, 2009, the hospital does not have to meet the requirements of paragraph (h)(2)(iii)(A)(*1*) of this section, with respect to that satellite facility, in order to retain its IPPS-excluded status.

(*3*) A hospital described in paragraph (h)(2)(iii)(A)(*2*) of this section that establishes an additional satellite facility in a cost reporting period beginning on or after October 1, 2009, must meet

the criteria in this section, including the provisions of paragraph (h)(2)(iii)(A)(*1*) of this section with respect to the additional satellite facility, in order to be excluded from the inpatient prospective payment system.

(B) It maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.

(C) It has beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located.

(D) It is serviced by the same fiscal intermediary as the hospital of which it is a part.

(E) It is treated as a separate cost center of the hospital of which it is a part.

(F) For cost reporting and apportionment purposes, it uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.

(G) It reports its costs on the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.

(*4*) On or after October 1, 2018, a satellite facility that is part of a hospital excluded from the prospective payment systems specified in §412.1(a)(1) that provides inpatient services in a building also used by another hospital that is excluded from the prospective payment systems specified in §412.1(a)(1), or in one or more entire buildings located on the same campus as buildings used by another hospital that is excluded from the prospective payment systems specified in §412.1(a)(1), is not required to meet the criteria specified in paragraphs (h)(2)(iii)(A)(*1*) through (*3*) of this section in order to be excluded from the inpatient prospective payment system. A satellite facility that is part of a hospital excluded from the prospective payment systems specified in §412.1(a)(1) which is located in a building also used by another hospital that is not excluded from the prospective payment systems specified in §412.1(a)(1), or in one or more entire buildings located on the same campus as buildings used by another hospital that is not excluded from the prospective payment systems specified in §412.1(a)(1), is required to meet the criteria specified in paragraphs (h)(2)(iii)(A)(*1*) through (*3*) of this section in order to be excluded from the prospective payment systems specified in §412.1(a)(1).

(3) Except as provided in paragraphs (h)(4) and (h)(5) of this section, the provisions of paragraph (h)(2) of this section do not apply to—

(i) Any hospital structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the hospital continues operating under the same terms and conditions, including the number of beds and square footage considered, for the purposes of Medicare participation and payment, to be part of the hospital, in effect on September 30, 1999; or

(ii) Any hospital excluded from the prospective payment systems under §412.23(e)(2)(ii).

(4) For cost reporting periods beginning before October 1, 2006, in applying the provisions of paragraph (h)(3) of this section, any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility if these changes are made necessary by relocation of a facility—

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(5) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (h)(3) of this section—

(i) Any hospital structured as a satellite facility on September 30, 1999, may increase or decrease the square footage or decrease the number of beds considered to be part of the satellite facility at any time without affecting the provisions of paragraph (h)(3) of this section; and

(ii) If the satellite facility decreases its number of beds below the number of

beds considered to be part of the satellite facility on September 30, 1999, it may subsequently increase the number of beds at any time as long as the resulting total number of beds considered to be part of the satellite facility does not exceed the number of beds at the satellite facility on September 30, 1999.

(6) *Notification of co-located status.* A satellite of a long-term care hospital that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital and that meets the criteria of paragraphs (h)(1) through (h)(5) of this section must notify its fiscal intermediary and CMS in writing of its co-location and identify by name, address, and Medicare provider number, those hospital(s) with which it is co-located.

(7) The provisions of paragraph (h)(2)(i) of this section do not apply to any long-term care hospital that is subject to the long-term care hospital prospective payment system under Subpart O of this subpart, effective for cost reporting periods occurring on or after October 1, 2002, and that elects to be paid based on 100 percent of the Federal prospective payment rate as specified in § 412.533(c), beginning with the first cost reporting period following that election, or when the LTCH is fully transitioned to 100 percent of the Federal prospective rate, or to a new long-term care hospital, as defined in § 412.23(e)(4).

(8) The provisions of paragraph (h)(2)(i) of this section do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of this part, effective for cost reporting periods beginning on or after October 1, 2003.

(i)(1) *Requirements for extended neoplastic disease care hospitals.* For cost reporting periods beginning on or after January 1, 2015, an extended neoplastic disease care hospital is a hospital that was first excluded from the prospective payment system under this section in 1986 which has an average inpatient length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days and demonstrates that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in fiscal year 1997 have a principal diagnosis that reflects a finding of neoplastic disease as defined in paragraph (f)(1)(iv) of this section.

(2) *Payment to extended neoplastic disease care hospitals.* Payment for inpatient operating costs for hospitals classified under paragraph (i)(1) of this section is made as set forth in § 412.526(c)(3). Payment for capital costs for hospitals classified under paragraph (i)(1) of this section is made as set forth in § 412.526(c)(4).

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.22, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

§ 412.23 Excluded hospitals: Classifications.

Hospitals that meet the requirements for the classifications set forth in this section are not reimbursed under the prospective payment systems specified in § 412.1(a)(1):

(a) *Psychiatric hospitals.* A psychiatric hospital must—

(1) Meet the following requirements to be excluded from the prospective payment system as specified in § 412.1(a)(1) and to be paid under the prospective payment system as specified in § 412.1(a)(2) and in subpart N of this part;

(2) Be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and

(3) Meet the conditions of participation for hospitals and special conditions of participation for psychiatric hospitals set forth in part 482 of this chapter.

(b) *Rehabilitation hospitals.* A rehabilitation hospital or unit must meet the requirements specified in § 412.29 of this subpart to be excluded from the prospective payment systems specified in § 412.1(a)(1) of this subpart and to be paid under the prospective payment system specified in § 412.1(a)(3) of this subpart and in subpart P of this part.

(c) [Reserved]

(d) *Children's hospitals.* A children's hospital must—

(1) Have a provider agreement under part 489 of this chapter to participate as a hospital; and

(2) Be engaged in furnishing services to inpatients who are predominantly individuals under the age of 18.

(e) *Long-term care hospitals.* A long-term care hospital must meet the requirements of paragraph (e)(1) and (e)(2) of this section and, when applicable, the additional requirement of § 412.22(e), to be excluded from the prospective payment system specified in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(4) and in Subpart O of this part.

(1) *Provider agreements.* The hospital must have a provider agreement under Part 489 of this chapter to participate as a hospital; and

(2) *Average length of stay.* (i) The hospital must have an average Medicare inpatient length of stay of greater than 25 days (which includes all covered and noncovered days of stay of Medicare patients) as calculated under paragraph (e)(3) of this section; or

(ii) For cost reporting periods beginning on or after August 5, 1997 and on or before December 31, 2014, a hospital that was first excluded from the prospective payment system under this section in 1986 meets the length-of-stay criterion if it has an average inpatient length of stay for all patients, including both Medicare and non-Medicare inpatients, of greater than 20 days and demonstrates that at least 80 percent of its annual Medicare inpatient discharges in the 12-month cost reporting period ending in fiscal year 1997 have a principal diagnosis that reflects a finding of neoplastic disease as defined in paragraph (f)(1)(iv) of this section.

(3) *Calculation of average length of stay.* (i) Subject to the provisions of paragraphs (e)(3)(ii) through (vii) of this section and paragraphs (e)(4)(iv) and (v) of this section as applicable, the average Medicare inpatient length of stay specified under paragraph (e)(2)(i) of this section is calculated by dividing the total number of covered and noncovered days of stay of Medicare inpatients (less leave or pass days) by the number of total Medicare discharges for the hospital's most recent complete cost reporting period. Subject to the provisions of paragraphs (e)(3)(ii) through (vii) of this section, the average inpatient length of stay specified under paragraph (e)(2)(ii) of this section is calculated by dividing the total number of days for all patients, including both Medicare and non-Medicare inpatients (less leave or pass days) by the number of total discharges for the hospital's most recent complete cost reporting period.

(ii) Effective for cost reporting periods beginning on or after July 1, 2004, in calculating the hospital's average length of stay, if the days of a stay of an inpatient involves days of care furnished during two or more separate consecutive cost reporting periods, that is, an admission during one cost reporting period and a discharge during a future consecutive cost reporting period, the total number of days of the stay are considered to have occurred in the cost reporting period during which the inpatient was discharged. However, if after application of this provision, a hospital fails to meet the average length of stay specified under paragraphs (e)(2)(i) and (ii) of this section, Medicare will determine the hospital's average inpatient length of stay for cost reporting periods beginning on or after July 1, 2004, but before July 1, 2005, by dividing the applicable total days for Medicare inpatients under paragraph (e)(2)(i) of this section or the total days for all inpatients under paragraph (e)(2)(ii) of this section, during the cost reporting period when they occur, by the number of discharges occurring during the same cost reporting period.

(iii) If a change in a hospital's average length of stay specified under paragraph (e)(2)(i) or (e)(2)(ii) of this section would result in the hospital not maintaining an average Medicare inpatient length of stay of greater than 25 days, the calculation is made by the same method for the period of at least 5 consecutive months of the immediately preceding 6-month period.

(iv) [Reserved]

(v) For periods beginning on or after October 1, 2011, a hospital that is excluded from the inpatient prospective payment system as a long-term care hospital that plans to undergo a change of ownership (as described in

§ 489.18 of this chapter) must notify its fiscal intermediary or MAC within 30 days of the effective date of such change of ownership, as specified in § 424.516(e) of this subchapter. The hospital will continue to be excluded from the inpatient prospective payment system as a long-term care hospital for the cost reporting period following the change of ownership only if, for the period of at least 5 months of the 6 months immediately preceding the change of ownership, the hospital meets the required average length of stay (calculated in accordance with paragraph (e)(3)(i) of this section).

(vi) For cost reporting periods beginning on or after October 1, 2015, the Medicare inpatient days and discharges that are paid at the site neutral payment rate specified at § 412.522(c)(1) or paid under a Medicare Advantage plan (Medicare Part C) will not be included in the calculation of the Medicare inpatient average length of stay specified under paragraph (e)(2)(i) of this section.

(vii) For cost reporting periods beginning on or after October 1, 2019, the Medicare inpatient days and discharges that are associated with patients discharged from a unit of the hospital will not be included in the calculation of the Medicare inpatient average length of stay specified under paragraph (e)(2)(i) of this section.

(4) For the purpose of calculating the average length of stay for hospitals seeking to become long-term care hospitals, with the exception of paragraphs (e)(3)(iii) and (v) of this section, the provisions of paragraph (e)(3) of this section apply.

(i) *Definition.* For the purpose of payment under the long-term care hospital prospective payment system under subpart O of this part, a new long-term care hospital is a provider of inpatient hospital services that meets the qualifying criteria in paragraphs (e)(1) and (e)(2) of this section; meets the applicable requirements of paragraphs (e)(4)(ii) through (v) of this section; and, under present or previous ownership (or both), its first cost reporting period as a LTCH begins on or after October 1, 2002.

(ii) *Satellite facilities and remote locations of hospitals seeking to become new long-term care hospitals.* Except as specified in paragraph (e)(4)(iii) of this section, a satellite facility (as defined in § 412.22(h)) or a remote location of a hospital (as defined in § 413.65(a)(2) of this chapter) that voluntarily reorganizes as a separate Medicare participating hospital, with or without a concurrent change in ownership, and that seeks to qualify as a new long-term care hospital for Medicare payment purposes must demonstrate through documentation that it meets the average length of stay requirement as specified under paragraphs (e)(2)(i) or (e)(2)(ii) of this section based on discharges that occur on or after the effective date of its participation under Medicare as a separate hospital.

(iii) *Provider-based facility or organization identified as a satellite facility and remote location of a hospital prior to July 1, 2003.* Satellite facilities and remote locations of hospitals that became subject to the provider-based status rules under § 413.65 as of July 1, 2003, that become separately participating hospitals, and that seek to qualify as long-term care hospitals for Medicare payment purposes may submit to the fiscal intermediary discharge data gathered during the period of at least 5 consecutive months of the immediate 6 months preceding the facility's separation from the main hospital for calculation of the average length of stay specified under paragraph (e)(2)(i) or paragraph (e)(2)(ii) of this section.

(iv) *Qualifying period for hospitals seeking to become long-term care hospitals.* A hospital may be classified as a long-term care hospital after a 6-month qualifying period, provided that the average length of stay during the period of at least 5 consecutive months of that 6-month qualifying period, calculated under paragraph (e)(2) of this section, is greater than 25 days. The 6-month qualifying period for a hospital is the 6 months immediately preceding the date of long-term care hospital classification.

(v) *Special rule for hospitals seeking to become long-term care hospitals that experience a change in ownership.* If a hospital seeks exclusion from the inpatient prospective payment system as a long-term care hospital and a change of ownership (as described in § 489.18 of

this chapter) occurs within the period of at least 5 consecutive months of the 6-month period preceding its petition for long-term care hospital status, the hospital may be excluded from the inpatient prospective payment system as a long-term care hospital for the next cost reporting period if, for the period of at least 5 consecutive months of the 6 months immediately preceding the start of the cost reporting period for which the hospital is seeking exclusion from the inpatient prospective payment system as a long-term care hospital (including time before the change of ownership), the hospital has met the required average length of stay, has continuously operated as a hospital, and has continuously participated as a hospital in Medicare.

(5) *Freestanding long-term care hospital.* For purposes of this paragraph, a freestanding long-term care hospital means a hospital that meets the requirements of paragraph (e)(1) and (2) of this section and all of the following:

(i) Does not occupy space in a building also used by another hospital.

(ii) Does not occupy space in one or more separate or entire buildings located on the same campus as buildings used by another hospital.

(iii) Is not part of a hospital that provides inpatient services in a building also used by another hospital.

(6) *Moratorium on the establishment of new long-term care hospitals and long-term care hospital satellite facilities*—(i) *General rule.* Except as specified in paragraphs (e)(6)(ii) and (e)(6)(iii) of this section for the period beginning December 29, 2007 and ending December 28, 2012, and the period beginning April 1, 2014 and ending September 30, 2017, a moratorium applies to the establishment and classification of a long-term care hospital as described in paragraphs (e) and (e)(1) through (e)(5) of this section or a long-term care hospital satellite facility as described in §412.22(h).

(ii) *Exception.* The moratorium specified in paragraph (e)(6)(i) of this section is not applicable to the establishment and classification of a long-term care hospital that meets the requirements of paragraphs (e) introductory text and (e)(1) through (e)(5) of this section, or a long-term care hospital satellite facility that meets the requirements of §412.22(h), if the long-term care hospital or long-term care satellite facility meets one or more of the following criteria on or before December 27, 2007, or prior to April 1, 2014, as applicable:

(A) Began its qualifying period for payment in accordance with paragraph (e) of this section.

(B)(*1*) Has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease or demolition for a long-term care hospital; and

(*2*)(*i*) Has expended prior to December 29, 2007, at least 10 percent (or, if less, $2.5 million) of the estimated cost of the project specified in paragraph (e)(6)(ii)(B)(*1*) of his section; or

(*ii*) Has expended, before April 1, 2014, at least 10 percent (or, if less, $2.5 million) of the estimated cost of the project specified in paragraph (e)(6)(ii)(B)(*1*) of this section.

(C) Had obtained an approved certificate of need from the State, when required by State law.

(7) *Moratorium on increasing the number of beds in existing long-term care hospitals and existing long-term care hospital satellite facilities.* (i) For purposes of this paragraph, an existing long-term care hospital or long-term care hospital satellite facility means a long-term care hospital that meets the requirements of paragraph(e) of this section or a long-term care hospital satellite facility that meets the requirements of §412.22(h) that received payment under the provisions of subpart O of this part prior to the dates noted in the following moratorium clauses.

(ii) December 29, 2007, through December 28, 2007—

(A) Except as specified in paragraph (e)(7)(ii)(B) and (C) of this section, the number of Medicare-certified beds in an existing long-term care hospital or an existing long-term care hospital satellite facility as defined in paragraph (e)(7)(i) of this section must not be increased beyond the number of Medicare-certified beds on December 29, 2007.

(B) Except as specified in paragraph (e)(7)(ii)(C) of this section, the moratorium specified in paragraph (e)(7)(ii)(A) of this section is not applicable to—

(*1*) An existing long-term care hospital or existing long-term care hospital satellite facility as defined in paragraph (e)(7)(i) of this section that meets both of the following requirements:

(*i*) Is located in a State where there is only one other long-term care hospital that meets the criteria specified in § 412.23(e) of this subpart.

(*ii*) Requests an increase in the number of Medicare-certified beds after the closure or decrease in the number of Medicare-certified beds of another long-term care hospital in the State; or

(*2*) An existing long-term care hospital or existing long-term care hospital satellite facility as defined in paragraph (e)(7)(i) of this section that obtained a certificate of need for an increase in beds and that meets both of the following requirements:

(*i*) Is in a State for which such certificate of need is required, and

(*ii*) Such certificate was issued on or after April 1, 2005, and before December 29, 2007.

(C) The exceptions specified in paragraph (e)(7)(ii)(B) of this section do not affect the limitation on increasing beds under § 412.22(f) and § 412.22(h)(3) of subpart.

(iii) April 1, 2014 through September 30, 2017—The number of Medicare-certified beds in an existing long-term care hospital or an existing long-term care hospital satellite facility must not be increased beyond the number of Medicare-certified beds prior to April 1, 2014, unless one of the exceptions specified in paragraph (e)(6)(ii) of this section is met.

(8) *Application of LTCH moratorium on the increase in beds at section 114(d)(1)(B) of Public Law 110–173 to LTCHs and LTCH satellite facilities established or classified as such under section 114(d)(2) of Public Law 110–173.* Effective for the period beginning October 1, 2011, and ending December 28, 2012, for long-term care hospitals and long-term care hospital satellite facilities established under paragraph (e)(6)(ii) of this section for the period beginning December 29, 2007, and ending September 30, 2011, the moratorium under paragraph (e)(7) of this section applies and the number of Medicare-certified beds must not be increased beyond the number of beds that were certified by Medicare at the long-term care hospital or the long-term care hospital satellite facility as of October 1, 2011.

(f) *Cancer hospitals*—(1) *General rule.* Except as provided in paragraph (f)(2) of this section, if a hospital meets the following criteria, it is classified as a cancer hospital and is excluded from the prospective payment systems beginning with its first cost reporting period beginning on or after October 1, 1989. A hospital classified after December 19, 1989, is excluded beginning with its first cost reporting period beginning after the date of its classification.

(i) It was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983.

(ii) It is classified on or before December 31, 1990, or, if on December 19, 1989, the hospital was located in a State operating a demonstration project under section 1814(b) of the Act, the classification is made on or before December 31, 1991.

(iii) It demonstrates that the entire facility is organized primarily for treatment of and research on cancer (that is, the facility is not a subunit of an acute general hospital or university-based medical center).

(iv) It shows that at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease. (The principal diagnosis for this purpose is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital. For the purposes of meeting this definition, only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect neoplastic disease.)

(2) *Alternative.* A hospital that applied for and was denied, on or before December 31, 1990, classification as a cancer hospital under the criteria set forth in paragraph (f)(1) of this section is classified as a cancer hospital and is excluded from the prospective payment systems beginning with its first cost reporting period beginning on or after

January 1, 1991, if it meets the criterion set forth in paragraph (f)(1)(i) of this section and the hospital is—

(i) Licensed for fewer than 50 acute care beds as of August 5, 1997;

(ii) Is located in a State that as of December 19, 1989, was not operating a demonstration project under section 1814(b) of the Act; and

(iii) Demonstrates that, for the 4-year period ending on December 31, 1996, at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease as defined in paragraph (f)(1)(iv) of this section.

(3) *PCHQR Program.* All hospitals classified as cancer hospitals under this paragraph must comply with the requirements of the PPS-Exempt Cancer Hospital Quality Reporting Program, as described in § 412.24.

(g) *Hospitals outside the 50 States, the District of Columbia, or Puerto Rico.* A hospital is excluded from the prospective payment systems if it is not located in one of the fifty States, the District of Columbia, or Puerto Rico.

(h) *Hospitals reimbursed under special arrangements.* A hospital must be excluded from prospective payment for inpatient hospital services if it is reimbursed under special arrangement as provided in § 412.22(c).

(i) *Changes in classification of hospitals.* For purposes of exclusions from the prospective payment system, the classification of a hospital is effective for the hospital's entire cost reporting period. Any changes in the classification of a hospital are made only at the start of a cost reporting period.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.23, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov.*

§ 412.24 Requirements under the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program.

(a) *Applicability.* The PCHQR Program applies to hospitals that are classified as cancer hospitals (PCHs) under the criteria described in § 412.23(f)(1) or (2).

(b) *Participation in the PCHQR Program.* In order to participate in the PCHQR Program, a PCH must do both of the following:

(1) Register with QualityNet (*http://qualitynet.cms.gov*) prior to reporting, including designating a QualityNet security official who completes all steps of the PCHQR Program registration process as described on the QualityNet website.

(2) Enroll in CDC's National Healthcare Safety Network (*https://www.cdc.gov/nhsn/enrollment/index.html*).

(c) *Submission of PCHQR Program data.* Except as provided in paragraph (e) of this section, PCHs that participate in the PCHQR Program must submit to CMS data on quality measures specified under section 1833(k)(3) of the Act in a form and manner, and at a time, specified by CMS. PCHs that participate in the PCHQR Program must also submit an annual online Data Accuracy and Completeness Acknowledgement via the Hospital Quality Reporting (HQR) system that attests to the accuracy and completeness of these data by the deadline specified by CMS on the QualityNet website (*http://qualitynet.cms.gov*).

(d) *Quality measure updates, retention, and removal*—(1) *Updating of measure specifications.* CMS uses rulemaking to make substantive updates to the specifications of measures used in the PCHQR Program. CMS announces technical measure specification updates through the QualityNet website (*http://qualitynet.cms.gov*) and listserv announcements.

(2) *Measure retention.* All quality measures specified under section 1866(k)(3) for the PCHQR Program measure set remain in the measure set unless CMS, through rulemaking, removes or replaces them.

(3) *Measure removal factors*—(i) *General rule.* CMS may remove or replace a quality measure based on one or more of the following factors:

(A) *Factor 1.* Measure performance among PCHs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made.

(B) *Factor 2.* A measure does not align with current clinical guidelines or practice.

(C) *Factor 3.* The availability of a more broadly applicable measure

(across settings or populations) or the availability of a measure that is more proximal in time to desired patient outcomes for the particular topic.

(D) *Factor 4.* Performance or improvement on a measure does not result in better patient outcomes.

(E) *Factor 5.* The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic.

(F) *Factor 6.* The collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

(G) *Factor 7.* It is not feasible to implement the measure specifications.

(H) *Factor 8.* The costs associated with a measure outweigh the benefit of its continued use in the program.

(ii) *Exception.* CMS may retain a quality measure that meets one or more of the measure removal factors described in paragraph (d)(3)(i) of this section if the continued collection of data on the quality measure would align with a stated CMS or HHS policy objective, including, but not limited to, an objective to increase the number of quality measures that a PCH can report electronically, or an objective to collect data on the measure in one or more other CMS quality reporting programs.

(iii) *Patient safety exception.* Upon a determination by CMS that the continued requirement for PCHs to submit data on a measure raises specific patient safety concerns, CMS may elect to immediately remove the measure from the PCHQR measure set. CMS will, upon removal of the measure—

(A) Provide notice to PCHs and the public at the time CMS removes the measure, along with a statement of the specific patient safety concerns that would be raised if PCHs continued to submit data on the measure; and

(B) Provide notice of the removal in the FEDERAL REGISTER.

(e) *Extraordinary circumstances exceptions (ECEs)*—(1) *General rule.* CMS may grant an ECE with respect to the reporting requirements under this section in the event of extraordinary circumstances beyond the control of the PCH. For purposes of this paragraph (e), an extraordinary circumstance is an event beyond the control of a PCH (for example, a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing) that affected the ability of the PCH to comply with one or more applicable reporting requirements with respect to a fiscal year.

(2) *Process for requesting an ECE.* (i) A PCH may request an ECE within 60 calendar days of the date that the extraordinary circumstance occurred by submitting the information specified by CMS at QualityNet or a successor website.

(ii) CMS notifies the PCH of its decision on the request, in writing, via email. In the event that CMS grants an ECE to the PCH, the written decision specifies whether the PCH is exempted from one or more reporting requirements or whether CMS has granted the PCH an extension of time to comply with one or more reporting requirements.

(3) *Authority to grant an ECE.* (i) CMS may grant an ECE to one or more PCHs that have not requested an ECE if CMS determines that—

(A) A systemic problem with a CMS data collection system directly impacted the ability of the PCH to comply with a quality data reporting requirement; or

(B) An extraordinary circumstance has affected an entire region or locale.

(ii) Any ECE granted under this paragraph (e)(3) specifies whether the affected PCHs are exempted from one or more reporting requirements or whether CMS has granted the PCHs an extension of time to comply with one or more reporting requirements.

(f) *Public reporting of PCHQR Program data.* CMS makes data submitted by PCHs under the PCHQR Program available to the public on CMS websites. Prior to making any such data submitted by a PCH available to the public, CMS gives the PCH an opportunity to review the data via the Hospital Quality Reporting (HQR) system and announces the timeline for review on the QualityNet website and applicable listservs.

[86 FR 45518, Aug. 13, 2021, as amended at 87 FR 49403, Aug. 10, 2022; 90 FR 37200, Aug. 4, 2025]

§ 412.25 Excluded hospital units: Common requirements.

(a) *Basis for exclusion.* In order to be excluded from the prospective payment systems as specified in § 412.1(a)(1) and be paid under the inpatient psychiatric facility prospective payment system as specified in § 412.1(a)(2) or the inpatient rehabilitation facility prospective payment system as specified in § 412.1(a)(3), a psychiatric or rehabilitation unit must meet the following requirements.

(1) Be part of an institution that—

(i) Has in effect an agreement under part 489 of this chapter to participate as a hospital;

(ii) Prior to October 1, 2019, is not excluded in its entirety from the prospective payment systems; and

(iii) Unless it is a unit in a critical access hospital, the hospital of which an IRF is a unit must have at least 10 staffed and maintained hospital beds that are paid under the applicable payment system under which the hospital is paid, or at least 1 staffed and maintained hospital bed for every 10 certified inpatient rehabilitation facility beds, whichever number is greater. Otherwise, the IRF will be classified as an IRF hospital, rather than an IRF unit. In the case of an inpatient psychiatric facility unit, the hospital must have enough beds that are paid under the applicable payment system under which the hospital is paid to permit the provision of adequate cost information, as required by § 413.24(c) of this chapter.

(2) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.

(3) Have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.

(4) Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit.

(5) Meet applicable State licensure laws.

(6) Have utilization review standards applicable for the type of care offered in the unit.

(7) Have beds physically separate from (that is, not commingled with) the hospital's other beds.

(8) Be serviced by the same fiscal intermediary as the hospital.

(9) Be treated as a separate cost center for cost finding and apportionment purposes.

(10) Use an accounting system that properly allocates costs.

(11) Maintain adequate statistical data to support the basis of allocation.

(12) Report its costs in the hospital's cost report covering the same fiscal period and using the same method of apportionment as the hospital.

(13) As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.

(b) *Changes in the size of excluded units.* Except in the special cases noted at the end of this paragraph, changes in the number of beds or square footage considered to be part of an excluded unit under this section are allowed one time during a cost reporting period if the hospital notifies its Medicare contractor and the CMS RO in writing of the planned change at least 30 days before the date of the change. The hospital must maintain the information needed to accurately determine costs that are attributable to the excluded unit. A change in bed size or a change in square footage may occur at any time during a cost reporting period and must remain in effect for the rest of that cost reporting period. Changes in bed size or square footage may be made at any time if these changes are made necessary by relocation of a unit to permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(c) The status of a hospital unit may be changed from not excluded to excluded or excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the CMS Regional Office in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine

costs that are or are not attributable to the hospital unit. A change in the status of a hospital unit from not excluded to excluded or excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

(d) *Number of excluded units.* Each hospital may have only one unit of each type (psychiatric or rehabilitation) excluded from the prospective payment systems specified in § 412.1(a)(1). A hospital excluded from the prospective payment systems as specified in § 412.1(a)(1) may not have an excluded unit (psychiatric or rehabilitation) that is excluded on the same basis as the hospital.

(e) *Satellite facilities.* (1) For purposes of paragraphs (e)(2) through (e)(5) of this section, a satellite facility is a part of a hospital unit that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Except as provided in paragraphs (e)(3) and (e)(6) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

(i) In the case of a unit excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the unit's number of State-licensed and Medicare-certified beds, including those at the satellite facility, does not exceed the unit's number of State-licensed and Medicare-certified beds on the last day of the unit's last cost reporting period beginning before October 1, 1997.

(ii) The satellite facility independently complies with—

(A) For a rehabilitation unit, the requirements under § 412.29 of this subpart; or

(B) For a psychiatric unit, the requirements under § 412.27(a).

(iii) The satellite facility meets all of the following requirements:

(A) Except as provided in paragraph (e)(2)(iv) of this section, it is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical officer of the hospital in which it is located.

(B) It maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.

(C) It has beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located.

(D) It is serviced by the same fiscal intermediary as the hospital unit of which it is a part.

(E) It is treated as a separate cost center of the hospital unit of which it is a part.

(F) For cost reporting and apportionment purposes, it uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.

(G) It reports its costs on the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.

(iv) Effective for cost reporting periods beginning on or after October 1, 2019, the requirements of paragraph (e)(2)(iii)(A) of this section do not apply to a satellite facility of a unit that is part of a hospital excluded from the prospective payment systems specified in § 412.1(a)(1) that does not furnish services in a building also used by another hospital that is not excluded from the prospective payment systems specified in § 412.1(a)(1), or in one or more entire buildings located on the same campus as buildings used by another hospital that is not excluded from the prospective payment systems specified in § 412.1(a)(1).

(3) Except as specified in paragraphs (e)(4) and (e)(5) of this section, the provisions of paragraph (e)(2) of this section do not apply to any unit structured as a satellite facility on September 30, 1999, and excluded from the

prospective payment systems on that date, to the extent the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit at the satellite facility on September 30, 1999.

(4) In applying the provisions of paragraph (e)(3) of this section, any unit structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility considered to be part of the satellite facility at any time, if these changes are made by the relocation of a facility—

(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility; or

(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.

(5) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (e)(3) of this section—

(i) Any unit structured as a satellite facility on September 30, 1999, may increase the square footage of the unit only at the beginning of a cost reporting period or decrease the square footage or number of beds considered to be part of the satellite facility subject to the provisions of paragraph (b)(2) of this section, without affecting the provisions of paragraph (e)(3) of this section; and

(ii) If the unit structured as a satellite facility decreases its number of beds below the number of beds considered to be part of the satellite facility on September 30, 1999, subject to the provisions of paragraph (b)(2) of this section, it may subsequently increase the number of beds at the beginning or a cost reporting period as long as the resulting total number of beds considered to be part of the satellite facility does not exceed the number of beds at the satellite facility on September 30, 1999.

(6) The provisions of paragraph (e)(2)(i) of this section do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of this part, effective for cost reporting periods beginning on or after October 1, 2003.

(f) *Changes in classification of hospital units.* For purposes of exclusions from the prospective payment system under this section, the classification of a hospital unit is effective for the unit's entire cost reporting period. Any changes in the classification of a hospital unit is made only at the start of a cost reporting period.

(g) *CAH units not meeting applicable requirements.* If a psychiatric or rehabilitation unit of a CAH does not meet the requirements of § 485.647 with respect to a cost reporting period, no payment may be made to the CAH for services furnished in that unit for that period. Payment to the CAH for services in the unit may resume only after the start of the first cost reporting period beginning after the unit has demonstrated to CMS that the unit meets the requirements of § 485.647.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.25, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

§ 412.27 Excluded psychiatric units: Additional requirements.

In order to be excluded from the prospective payment system as specified in § 412.1(a)(1), and paid under the prospective payment system as specified in § 412.1(a)(2), a psychiatric unit must meet the following requirements:

(a) Admit only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the International Classification of Diseases, Tenth Revision, Clinical Modification.

(b) Furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, and therapeutic activities.

(c) Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit, and that meet the following requirements:

(1) *Development of assessment/diagnostic data.* Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the inpatient is treated in the unit.

(i) The identification data must include the inpatient's legal status.

(ii) A provisional or admitting diagnosis must be made on every inpatient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(iii) The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved, or both.

(iv) The social service records, including reports of interviews with inpatients, family members, and others must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.

(v) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

(2) *Psychiatric evaluation.* Each inpatient must receive a psychiatric evaluation that must—

(i) Be completed within 60 hours of admission;

(ii) Include a medical history;

(iii) Contain a record of mental status;

(iv) Note the onset of illness and the circumstances leading to admission;

(v) Describe attitudes and behavior;

(vi) Estimate intellectual functioning, memory functioning, and orientation; and

(vii) Include an inventory of the inpatient's assets in descriptive, not interpretative fashion.

(3) *Treatment plan.* (i) Each inpatient must have an individual comprehensive treatment plan that must be based on an inventory of the inpatient's strengths and disabilities. The written plan must include a substantiated diagnosis; short-term and long-term goals; the specific treatment modalities utilized; the responsibilities of each member of the treatment team; and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out; and

(ii) The treatment received by the inpatient must be documented in such a way as to assure that all active therapeutic efforts are included.

(4) *Recording progress.* Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the inpatient, a nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the inpatient but must be recorded at least weekly for the first two months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the inpatient's progress in accordance with the original or revised treatment plan.

(5) *Discharge planning and discharge summary.* The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the inpatient's hospitalization in the unit and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge.

(d) Meet special staff requirements in that the unit must have adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written, individualized, comprehensive treatment plans, provide active treatment measures and engage in discharge planning, as follows:

(1) *Personnel.* The unit must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to—

(i) Evaluate inpatients;

(ii) Formulate written, individualized, comprehensive treatment plans;

(iii) Provide active treatment measures; and

(iv) Engage in discharge planning.

(2) *Director of inpatient psychiatric services: Medical staff.* Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of

medicine and osteopathy must be adequate to provide essential psychiatric services.

(i) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(ii) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.

(3) *Nursing services.* The unit must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each inpatient's active treatment program and to maintain progress notes on each inpatient.

(i) The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill. The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.

(ii) The staffing pattern must ensure the availability of a registered nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each inpatient's active treatment program.

(4) *Psychological services.* The unit must provide or have available psychological services to meet the needs of the inpatients. The services must be furnished in accordance with acceptable standards of practice, service objectives, and established policies and procedures.

(5) *Social services.* There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures. Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.

(6) *Therapeutic activities.* The unit must provide a therapeutic activities program.

(i) The program must be appropriate to the needs and interests of inpatients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

(ii) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each inpatient's active treatment program.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39820, Sept. 1, 1992; 59 FR 45397, 45400, Sept. 1, 1994; 69 FR 66976, Nov. 15, 2004; 71 FR 27086, May 9, 2006; 83 FR 38619, Aug. 6, 2018]

§ 412.29 Classification criteria for payment under the inpatient rehabilitation facility prospective payment system.

To be excluded from the prospective payment systems described in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(3), an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital (otherwise referred to as an IRF) must meet the following requirements:

(a) Have (or be part of a hospital that has) a provider agreement under part 489 of this chapter to participate as a hospital.

(b) Except in the case of a ''new'' IRF or ''new'' IRF beds, as defined in paragraph (c) of this section, an IRF must show that, during its most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the Medicare contractor), it served an inpatient population that meets the following criteria:

(1) For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the IRF served an inpatient population of whom at least 50

percent, and for cost reporting periods beginning on or after July 1, 2005, the IRF served an inpatient population of whom at least 60 percent required intensive rehabilitation services for treatment of one or more of the conditions specified at paragraph (b)(2) of this section. A patient with a comorbidity, as defined at § 412.602 of this part, may be included in the inpatient population that counts toward the required applicable percentage if—

(i) The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified in paragraph (b)(2) of this section;

(ii) The patient has a comorbidity that falls in one of the conditions specified in paragraph (b)(2) of this section; and

(iii) The comorbidity has caused significant decline in functional ability in the individual that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under subpart P of this part and that cannot be appropriately performed in another care setting covered under this title.

(2) List of conditions.

(i) Stroke.

(ii) Spinal cord injury.

(iii) Congenital deformity.

(iv) Amputation.

(v) Major multiple trauma.

(vi) Fracture of femur (hip fracture).

(vii) Brain injury.

(viii) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

(ix) Burns.

(x) Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

(xi) Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

(xii) Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

(xiii) Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one or more of the following specific criteria:

(A) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.

(B) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.

(C) The patient is age 85 or older at the time of admission to the IRF.

(c) In the case of new IRFs (as defined in paragraph (c)(1) of this section)

or new IRF beds (as defined in paragraph (c)(2)of this section), the IRF must provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b) of this section. This written certification will apply until the end of the IRF's first full 12-month cost reporting period or, in the case of new IRF beds, until the end of the cost reporting period during which the new beds are added to the IRF.

(1) *New IRFs.* An IRF hospital or IRF unit is considered new if it has not been paid under the IRF PPS in subpart P of this part for at least 5 calendar years. A new IRF will be considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost reporting period.

(2) *New IRF beds.* Any IRF beds that are added to an existing IRF must meet all applicable State Certificate of Need and State licensure laws. New IRF beds may be added one time at any point during a cost reporting period and will be considered new for the rest of that cost reporting period. A full 12-month cost reporting period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF beds to that IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the CMS RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds delicensed or decertified. New IRF beds are included in the compliance review calculations under paragraph (b) of this section from the time that they are added to the IRF.

(3) *Change of ownership or leasing.* An IRF hospital or IRF unit that undergoes a change of ownership or leasing, as defined in § 489.18 of this chapter, retains its excluded status and will continue to be paid under the prospective payment system specified in § 412.1(a)(3) before and after the change of ownership or leasing if the new owner(s) of the IRF accept assignment of the previous owners' Medicare provider agreement and the IRF continues to meet all of the requirements for payment under the IRF prospective payment system. If the new owner(s) do not accept assignment of the previous owners' Medicare provider agreement, the IRF is considered to be voluntarily terminated and the new owner(s) may re-apply to participate in the Medicare program. If the IRF does not continue to meet all of the requirements for payment under the IRF prospective payment system, then the IRF loses its excluded status and is paid according to the prospective payment systems described in § 412.1(a)(1).

(4) *Mergers.* If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s) of the merged hospital accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the prospective payment system specified in § 412.1(a)(3) before and after the merger, as long as the IRF hospital or IRF unit continues to meet all of the requirements for payment under the IRF prospective payment system. If the owner(s) of the merged hospital do not accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may reapply to the Medicare program to operate a new IRF.

(d) Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge, as defined in § 412.622 of this chapter, during the Public Health Emergency, as defined in § 400.200 of this chapter, have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program. This procedure must ensure that the preadmission screening for each Medicare Part A fee-for-Service patient is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.

(e) Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge, as defined in § 412.622, during the Public Health Emergency, as defined in § 400.200 of this chapter, have in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process except that during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID–19 pandemic such visits may be conducted using telehealth services (as defined in section 1834(m)(4)(F) of the Act). Beginning with the second week, as defined in § 412.622, of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law.

(f) Furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.

(g) Have a director of rehabilitation who—

(1) Provides services to the IRF hospital and its inpatients on a full-time basis or, in the case of a rehabilitation unit, at least 20 hours per week;

(2) Is a doctor of medicine or osteopathy;

(3) Is licensed under State law to practice medicine or surgery; and

(4) Has had, after completing a one-year hospital internship, at least 2 years of training or experience in the medical-management of inpatients requiring rehabilitation services.

(h) Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge, as defined in § 412.622 of this chapter, during the Public Health Emergency, as defined in § 400.200 of this chapter, have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.

(i) Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge, as defined in § 412.622 of this chapter, during the Public Health Emergency, as defined in § 400.200 of this chapter, use a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment and discharge plans, and that team conferences are held at least once per week to determine the appropriateness of treatment.

(j) *Retroactive adjustments.* If a new IRF (or new beds that are added to an existing IRF) are excluded from the prospective payment systems specified in § 412.1(a)(1) and paid under the prospective payment system specified in § 412.1(a)(3) for a cost reporting period under paragraph (c) of this section, but the inpatient population actually treated during that period does not meet the requirements of paragraph (b) of this section, we adjust payments to the IRF retroactively in accordance with the provisions in § 412.130.

[76 FR 47891, Aug. 5, 2011, as amended at 78 FR 47934, Aug. 6, 2013; 85 FR 19287, Apr. 6, 2020; 85 FR 27621, May 8, 2020; 85 FR 48462, Aug. 10, 2020]

§ 412.30 [Reserved]

Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

§ 412.40 General requirements.

(a) A hospital must meet the conditions of this subpart to receive payment under the prospective payment systems for inpatient hospital services furnished to Medicare beneficiaries.

(b) If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, CMS may, as appropriate—

(1) Withhold Medicare payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

(2) Terminate the hospital's provider agreement.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39821, Sept. 1, 1992]

§ 412.42 Limitations on charges to beneficiaries.

(a) *Prohibited charges.* A hospital may not charge a beneficiary for any services for which payment is made by Medicare, even if the hospital's costs of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment systems.

(b) *Permitted charges—Stay covered.* A hospital receiving payment under the prospective payment systems for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the following:

(1) The applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this chapter.

(2) Noncovered items and services, furnished at any time during a covered stay, unless they are excluded from coverage only on the basis of the following:

(i) The exclusion of custodial care under § 411.15(g) of this chapter (see paragraph (c) of this section for when charges may be made for custodial care).

(ii) The exclusion of medically unnecessary items and services under § 411.15(k) of this chapter (see paragraphs (c) and (d) of this section for when charges may be made for medically unnecessary items and services).

(iii) The exclusion under § 411.15(m) of this chapter of nonphysician services furnished to hospital inpatients by other than the hospital or a provider or supplier under arrangements made by the hospital.

(iv) The exclusion of items and services furnished when the patient is not entitled to Medicare Part A benefits under subpart A of part 406 of this chapter (see paragraph (e) of this section for when charges may be made for items and services furnished when the patient is not entitled to benefits).

(v) The exclusion of items and services furnished after Medicare Part A benefits are exhausted under § 409.61 of this chapter (see paragraph (e) of this section for when charges may be made for items and services furnished after benefits are exhausted).

(c) *Custodial care and medically unnecessary inpatient hospital care.* A hospital may charge a beneficiary for services excluded from coverage on the basis of § 411.15(g) of this chapter (custodial care) or § 411.15(k) of this chapter (medically unnecessary services) and furnished by the hospital after all of the following conditions have been met:

(1) The hospital (acting directly or through its utilization review committee) determines that the beneficiary no longer requires inpatient hospital care. (The phrase ''inpatient hospital care'' includes cases where a beneficiary needs a SNF level of care, but, under Medicare criteria, a SNF-level bed is not available. This also means that a hospital may find that a patient awaiting SNF placement no longer requires inpatient hospital care because either a SNF-level bed has become available or the patient no longer requires SNF-level care.)

(2) The attending physician agrees with the hospital's determination in writing (for example, by issuing a written discharge order). If the hospital believes that the beneficiary does not require inpatient hospital care but is unable to obtain the agreement of the

physician, it may request an immediate review of the case by the QIO as described in § 405.1208 of this chapter. Concurrence by the QIO in the hospital's determination will serve in lieu of the physician's agreement.

(3) The hospital (acting directly or through its utilization review committee) notifies the beneficiary (or his or her representative) of his or her discharge rights in writing consistent with § 405.1205 and notifies the beneficiary, in accordance with § 405.1206 of this chapter (if applicable) that in the hospital's opinion, and with the attending physician's concurrence or that of the QIO, the beneficiary no longer requires inpatient hospital care.

(4) If the beneficiary remains in the hospital after the appropriate notification, and the hospital, the physician who concurred in the hospital determination on which the notice was based, or QIO subsequently finds that the beneficiary requires an acute level of inpatient hospital care, the hospital may not charge the beneficiary for continued care until the hospital once again determines that the beneficiary no longer requires inpatient care, secures concurrence, and notifies the beneficiary, as required in paragraphs (c)(1), (c)(2), and (c)(3) of this section.

(d) *Medically unnecessary diagnostic and therapeutic services.* A hospital may charge a beneficiary for diagnostic procedures and studies, and therapeutic procedures and courses of treatment (for example, experimental procedures) that are excluded from coverage under § 411.15(k) of this chapter (medically unnecessary items and services), even though the beneficiary requires continued inpatient hospital care, if those services are furnished after the beneficiary (or the person acting on his or her behalf) has acknowledged in writing that the hospital (acting directly or through its utilization review committee and with the concurrence of the intermediary) has informed him or her as follows:

(1) In the hospital's opinion, which has been agreed to by the intermediary, the services to be furnished are not considered reasonable and necessary under Medicare.

(2) Customary charges will be made if he or she receives the services.

(3) If the beneficiary receives the services, a formal determination on the validity of the hospital's finding is made by the intermediary and, to the extent that the decision requires the exercise of medical judgment, the QIO.

(4) The determination is appealable by the hospital, the attending physician, or the beneficiary under the appeals procedure that applies to determinations affecting Medicare Part A payment.

(5) The charges for the services will be invalid and, to the extent collected, will be refunded by the hospital if the services are found to be covered by Medicare.

(e) *Services furnished on days when the individual is not entitled to Medicare Part A benefits or has exhausted the available benefits.* The hospital may charge the beneficiary its customary charges for noncovered items and services furnished on outlier days (as described in Subpart F of this part) for which payment is denied because the beneficiary is not entitled to Medicare Part A or his or her Medicare Part A benefits are exhausted. (1) If payment is considered for outlier days, the entire stay is reviewed and days up to the number of days in excess of the outlier threshold may be denied on the basis of nonentitlement to Part A or exhaustion of benefits. (2) In applying this rule, the latest days will be denied first.

(f) *Differential for private room or other luxury services.* The hospital may charge the beneficiary the customary charge differential for a private room or other luxury service that is more expensive than is medically required and is furnished for the personal comfort of the beneficiary at his or her request (or the request of the person acting on his or her behalf).

(g) *Review.* (1) The QIO or intermediary may review any cases in which the hospital advises the beneficiary (or the person acting on his or her behalf) of the noncoverage of the services in accordance with paragraph (c)(3) or (d) of this section.

(2) The hospital must identify such cases to the QIO or intermediary in accordance with CMS instructions.

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 35688, Sept. 3, 1985; 54 FR 41747, Oct. 11, 1989; 57 FR 39821, Sept. 1, 1992; 71 FR 48137, Aug. 18, 2006; 71 FR 68722, Nov. 27, 2006; 85 FR 72909, Nov. 16, 2020]

§ 412.44 Medical review requirements: Admissions and quality review.

Beginning on November 15, 1984, a hospital must have an agreement with a QIO to have the QIO review, on an ongoing basis, the following:

(a) The medical necessity, reasonableness and appropriateness of hospital admissions and discharges.

(b) The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of §§ 412.82 and 412.84 of this chapter.

(c) The validity of the hospital's diagnostic and procedural information.

(d) The completeness, adequacy, and quality of the services furnished in the hospital.

(e) Other medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries.

[50 FR 15326, Apr. 17, 1985, as amended at 50 FR 35689, Sept. 3, 1985; 50 FR 41886, Oct. 16, 1985]

§ 412.46 Medical review requirements.

(a) *Physician acknowledgement.* (1) *Basis.* Because payment under the prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's medical record, physicians must complete an acknowledgement statement to this effect.

(2) *Content of physician acknowledgement statement.* When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice:

> Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

(3) *Completion of acknowledgement.* The acknowledgement must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient. Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

(b) *Physician's order and certification regarding medical necessity.* No presumptive weight shall be assigned to the physician's order under § 412.3 or the physician's certification under Subpart B of Part 424 of the chapter in determining the medical necessity of inpatient hospital services under section 1862(a)(1) of the Act. A physician's order or certification will be evaluated in the context of the evidence in the medical record.

[78 FR 50965, Aug. 19, 2013]

§ 412.48 Denial of payment as a result of admissions and quality review.

(a) If CMS determines, on the basis of information supplied by a QIO that a hospital has misrepresented admissions, discharges, or billing information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits under Part A, unnecessary multiple admissions of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, CMS may as appropriate—

(1) Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided with respect to such an unnecessary admission or subsequent readmission of an individual; or

(2) Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(b) When payment with respect to admission of an individual patient is denied by a QIO under paragraph (a)(1) of

this section, and liability is not waived in accordance with §§ 411.400 through 411.402 of this chapter, notice and appeals are provided under procedures established by CMS to implement the provisions of section 1155 of the Act, Right to Hearing and Judicial Review.

(c) A determination under paragraph (a) of this section, if it is related to a pattern of inappropriate admissions and billing practices that has the effect of circumventing the prospective payment systems, is referred to the Department's Office of Inspector General, for handling in accordance with § 1001.301 of this title.

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 35688, 35689, Sept. 3, 1985; 51 FR 34787, Sept. 30, 1986; 57 FR 39821, Sept. 1, 1992; 71 FR 48137, Aug. 18, 2006]

§ 412.50 Furnishing of inpatient hospital services directly or under arrangements.

(a) The applicable payments made under the prospective payment systems, as described in subparts H and M of this part, are payment in full for all inpatient hospital services, as defined in § 409.10 of this chapter. Inpatient hospital services do not include the following types of services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69 of this chapter.

(b) CMS does not pay any provider or supplier other than the hospital for services furnished to a beneficiary who is an inpatient, except for the services described in paragraphs (a)(1) through (a)(6) of this section.

(c) The hospital must furnish all necessary covered services to the beneficiary either directly or under arrangements (as defined in § 409.3 of this chapter).

[50 FR 12741, Mar. 29, 1985, as amended at 53 FR 38527, Sept. 30, 1988; 57 FR 39821, Sept. 1, 1992; 60 FR 63188, Dec. 8, 1995; 65 FR 18537, Apr. 7, 2000]

§ 412.52 Reporting and recordkeeping requirements.

All hospitals participating in the prospective payment systems must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 57 FR 39821, Sept. 1, 1992]

Subpart D—Basic Methodology for Determining Prospective Payment Federal Rates for Inpatient Operating Costs

§ 412.60 DRG classification and weighting factors.

(a) *Diagnosis-related groups.* CMS establishs a classification of inpatient hospital discharges by Diagnosis-Related Groups (DRGs).

(b) *DRG weighting factors.* CMS assigns, for each DRG, an appropriate weighting factor that reflects the estimated relative cost of hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups, subject to a maximum ten percent reduction to the weighting factor for a DRG as compared to the weighting factor for the same DRG for the prior fiscal year.

(c) *Assignment of discharges to DRGs.* CMS establishs a methodology for classifying specific hospital discharges within DRGs which ensures that each hospital discharge is appropriately assigned to a single DRG based on essential data abstracted from the inpatient bill for that discharge.

(1) The classification of a particular discharge is based, as appropriate, on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status.

(2) Each discharge is assigned to only one DRG (related, except as provided in paragraph (c)(3) of this section, to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

(3) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill is returned to the hospital for validation and reverification. CMS's DRG classification system provides a DRG, and an appropriate weighting factor, for the group of cases for which the unrelated diagnosis and procedure are confirmed.

(d) *Review of DRG assignment.* (1) A hospital has 60 days after the date of the notice of the initial assignment of a discharge to a DRG to request a review of that assignment. The hospital may submit additional information as a part of its request.

(2) The intermediary reviews the hospital's request and any additional information and decides whether a change in the DRG assignment is appropriate. If the intermediary decides that a higher-weighted DRG should be assigned, the case will be reviewed by the appropriate QIO as specified in § 466.71(c)(2) of this chapter.

(3) Following the 60-day period described in paragraph (d)(1) of this section, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

(e) *Revision of DRG classification and weighting factors.* Beginning with discharges in fiscal year 1988, CMS adjusts the classifications and weighting factors established under paragraphs (a) and (b) of this section at least annually to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources.

[50 FR 12741, Mar. 29, 1985, as amended at 52 FR 33057, Sept. 1, 1987; 57 FR 39821, Sept. 1, 1992; 59 FR 45397, Sept. 1, 1994; 87 FR 49403, Aug. 10, 2022]

§ 412.62 Federal rates for inpatient operating costs for fiscal year 1984.

(a) *General rule.* CMS determines national adjusted DRG prospective payment rates for operating costs, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system under subpart B of this part, and determines regional adjusted DRG prospective payment rates for inpatient operating costs for such discharges in each region, for which payment may be made under Medicare Part A. Such rates are determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as described in paragraphs (b) through (k) of this section.

(b) *Determining allowable individual hospital inpatient operating costs.* CMS determines the Medicare allowable operating costs per discharge of inpatient hospital services for each hospital in the data base for the most recent cost reporting period for which data are available.

(c) *Updating for fiscal year 1984.* CMS updates each amount determined under paragraph (b) of this section for fiscal year 1984 by—

(1) Updating for fiscal year 1983 by the estimated average rate of change of hospital costs industry-wide between the cost reporting period used under paragraph (b) of this section and fiscal year 1983; and

(2) Projecting for fiscal year 1984 by the applicable percentage increase in the hospital market basket for fiscal year 1984.

(d) *Standardizing amounts.* CMS standardizes the amount updated under paragraph (c) of this section for each hospital by—

(1) Adjusting for area variations in case mix among hospitals;

(2) Excluding an estimate of indirect medical education costs;

(3) Adjusting for area variations in hospital wage levels; and

(4) Adjusting for the effects of a higher cost of living for hospitals located in Alaska and Hawaii.

(e) *Computing urban and rural averages.* CMS computes an average of the standardized amounts determined under paragraph (d) of this section for urban and rural hospitals in the United States and for urban and rural hospitals in each region.

(f) *Geographic classifications.* (1) For purposes of paragraph (e) of this section, the following definitions apply:

(i) The term *region* means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes.

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21, 42 U.S.C. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(iii) The term *rural area* means any area outside an urban area.

(iv) The phrase *hospital reclassified as rural* means a hospital located in a county that was part of an MSA or NECMA, as defined by the Executive Office of Management and Budget, but is not part of an MSA or NECMA as a result of an Executive Office of Management and Budget redesignation occurring after April 20, 1983.

(2) For hospitals within an MSA or NECMA that crosses census division boundaries, the following provisions apply:

(i) The MSA or NECMA is deemed to belong to the census division in which most of the hospitals within the MSA or NECMA are located.

(ii) If a hospital would receive a lower Federal rate because most of the hospitals are located in a census division with a lower Federal rate than the rate applicable to the census division in which the hospital is located, the payment rate will not be reduced for the hospital's cost reporting period beginning before October 1, 1984.

(iii) If an equal number of hospitals within the MSA or NECMA are located in each census division, such hospitals are deemed to be in the census division with the higher Federal rate.

(g) *Adjusting the average standardized amounts.* CMS adjusts each of the average standardized amounts determined under paragraphs (c), (d), and (e) of this section by factors representing CMS's estimates of the following:

(1) The amount of payment that would have been made under Medicare Part B for nonphysician services to hospital inpatients during the first cost reporting period subject to prospective payment were it not for the fact that such services must be furnished either directly by hospitals or under arrangements in order for any Medicare payment to be made after September 30, 1983 (the effective date of § 405.310(m) of this chapter).

(2) The amount of FICA taxes that would be incurred during the first cost reporting period subject to the prospective payment system, by hospitals that had not incurred such taxes for any or all of their employees during the base period described in paragraph (c) of this section.

(h) *Reducing for value of outlier payments.* CMS reduces each of the adjusted average standardized amounts determined under paragraphs (c) through (g) of this section by a proportion equal to the proportion (estimated by CMS) of the total amount of payments based on DRG prospective payment rates that are additional payments for outlier cases under subpart F of this part.

(i) *Maintaining budget neutrality.* (1) CMS adjusts each of the reduced standardized amounts determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) is not greater or less than 25 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1984 under the Social Security Act as in effect on April 19, 1983.

(2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.

(j) *Computing Federal rates for inpatient operating costs for urban and rural hospitals in the United States and in each region.* For each discharge classified within a DRG, CMS establishes a national prospective payment rate for inpatient operating costs and a regional prospective payment rate for inpatient operating costs for each region, as follows:

(1) For hospitals located in an urban area in the United States or in that region respectively, the rate equals the product of—

(i) The adjusted average standardized amount (computed under paragraphs (c) through (i) of this section) for hospitals located in an urban area in the United States or in that region; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(2) For hospitals located in a rural area in the United States or in that region respectively, the rate equals the product of—

(i) The adjusted average standardized amount (computed under paragraphs (c) through (i) of this section) for hospitals located in a rural area in the United States or that region; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(k) *Adjusting for different area wage levels.* CMS adjusts the proportion (as estimated by CMS from time to time) of Federal rates computed under paragraph (j) of this section that are attributable to wages and labor-related costs, for area differences in hospital wage levels by a factor (established by CMS) reflecting the relative hospital wage level in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (f) of this section) of the hospital compared to the national average hospital wage level.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 53 FR 38527, Sept. 30, 1988; 57 FR 39821, Sept. 1, 1992; 58 FR 46337, Sept. 1, 1993]

§ 412.63 Federal rates for inpatient operating costs for Federal fiscal years 1984 through 2004.

(a) *General rule.* (1) CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal years 1985 through 2004 involving inpatient hospital service of a hospital in the United States, subject to the PPS, and determines a regional adjusted PPS rate for operating costs for such discharges in each region for which payment may be made under Medicare Part A.

(2) Each such rate is determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as described under paragraphs (b) through (u) of this section.

(b) *Geographic classifications.* Effective for fiscal years 1985 through 2004, the following rules apply.

(1) For purposes of this section, the definitions set forth in § 412.62(f) apply, except that, effective January 1, 2000, a hospital reclassified as rural may mean a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103.

(2) For hospitals within an MSA or NECMA that crosses census division boundaries, the following provisions apply:

(i) The MSA or NECMA is deemed to belong to the census division in which most of the hospitals within the MSA or NECMA are located.

(ii) A hospital that met the conditions specified in § 412.62(f)(2)(ii) and therefore did not receive a lower Federal rate that would have applied for cost reporting periods beginning before October 1, 1984, receives the lower Federal rate applicable to all hospitals in the MSA or NECMA in which it is located effective with the hospital's cost reporting period that begins on or after October 1, 1984.

(iii) The higher Federal rate is payable to all hospitals in the MSA or NECMA if an equal number of hospitals within the MSA or NECMA are located in each census division.

(3) For discharges occurring on or after October 1, 1988, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs or NECMAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs or NECMAs. These EOMB standards are set forth in the notice of final standards for classification of MSAs published in the FEDERAL REGISTER on January 3, 1980 (45 FR 956), and available from CMS, East High Rise Building, room 132, 6325 Security Boulevard, Baltimore, Maryland 21207.

(4) For purposes of this section, any change in an MSA or NECMA designation is recognized on the October 1 following the effective date of the change.

(5) For discharges occurring on or after October 1, 1988, for hospitals that consist of two or more separately located inpatient hospital facilities the national adjusted prospective payment rate is based on the geographic location of the hospital facility at which the discharge occurs.

(c) *Updating previous standardized amounts.* (1) For discharges occurring in fiscal year 1985 through fiscal year 2003, CMS computes average standardized amounts for hospitals in urban areas and rural areas within the United States, and in urban areas and rural areas within each region. For discharges occurring in fiscal year 2004, CMS computes an average standardized amount for hospitals located in all areas.

(2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under § 412.62(g)—

(i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;

(ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;

(iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and

(iv) Adjusted for budget neutrality under paragraph (h) of this section.

(3) For fiscal year 1986 and thereafter. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective adjusted average standardized amounts computed for the previous fiscal year—

(i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;

(ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and

(iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by CMS) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by CMS) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

(4) For fiscal years 1987 through 1990 CMS standardizes the average standardized amounts by excluding an estimate of the payments for hospitals that serve a disproportionate share of low-income patients.

(5) For fiscal years 1987 through 2004, CMS standardizes the average standardized amounts by excluding an estimate of indirect medical education payments.

(6) For fiscal years 1988 through 2003, CMS computes average standardized amounts for hospitals located in large urban areas, other urban areas, and rural areas. The term *large urban area* means an MSA with a population of more than 1,000,000 or an NECMA, with a population of more than 970,000 based on the most recent available population data published by the Census Bureau. For fiscal year 2004, CMS computes an average standardized amount for hospitals located in all areas.

(d) *Applicable percentage change for fiscal year 1986.* (1) The applicable percentage change for fiscal year 1986 is—

(i) For discharges occurring on or after October 1, 1985 and before May 1. 1986, zero percent; and

(ii) For discharges occurring on or after May 1, 1986, one-half of one percent.

(2) For purposes of determining the standardized amounts for discharges occurring on or after October 1, 1986, the applicable percentage increase for fiscal year 1986 is deemed to have been one-half of one percent.

(e) *Applicable percentage change for fiscal year 1987.* The applicable percentage change for fiscal year 1987 is 1.15 percent.

(f) *Applicable percentage change for fiscal year 1988.* (1) The applicable percentage change for fiscal year 1988 is—

(i) For discharges occurring on or after October 1, 1987 and before November 21, 1987, zero percent;

(ii) For discharges occurring on or after November 21, 1987 and before April 1, 1988, 2.7 percent; and

(iii) For discharges occurring on or after April 1, 1988 and before October 1, 1988—

(A) 3.0 percent for hospitals located in rural areas;

(B) 1.5 percent for hospitals located in large urban areas; and

(C) 1.0 percent for hospitals located in other urban areas.

(2) For purposes of determining the standardized amounts for discharges occurring on or after October 1, 1988 (for Federal fiscal year 1989), the applicable percentage change for fiscal year 1988 is deemed to have been—

(i) 3.0 percent for hospitals located in rural areas;

(ii) 1.5 percent for hospitals located in large urban areas; and

(iii) 1.0 percent for hospitals located in other urban areas.

(g) *Applicable percentage change for fiscal year 1989.* The applicable percentage change for fiscal year 1989 is the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter)—

(1) Minus 1.5 percentage points for hospitals located in rural areas;

(2) Minus 2.0 percentage points for hospitals in large urban areas; and

(3) Minus 2.5 percentage points for hospitals in other urban areas.

(h) *Applicable percentage change for fiscal year 1990.* (1) The applicable percentage change for fiscal year 1990 is—

(i) For discharges occurring on or after October 1, 1989 and before January 1, 1990, 5.5 percent; and

(ii) For discharges occurring on or after January 1, 1990 and before October 1, 1990—

(A) 9.72 percent for hospitals located in rural areas;

(B) 5.62 percent for hospitals located in large urban areas; and

(C) 4.97 percent for hospitals located in other urban areas.

(2) For purposes of determining the standardized amounts for discharges occurring on or after October 1, 1990, the applicable percentage change for fiscal year 1990 is deemed to have been the percentage change provided for in paragraph (h)(1)(ii) of this section.

(i) *Applicable percentage change for fiscal year 1991.* (1) The applicable percentage change for fiscal year 1991 is—

(i) For discharges occurring on or after October 1, 1990 and before October 21, 1990, 5.2 percent;

(ii) For discharges occurring on or after October 21, 1990 and before January 1, 1991, 0.0 percent; and

(iii) For discharges occurring on or after January 1, 1991 and before October 1, 1991—

(A) 4.5 percent for hospitals located in rural areas; and

(B) 3.2 percent for hospitals located in large urban areas and other urban areas.

(2) For purposes of determining the standardized amounts for discharges occurring on or after October 1, 1991, the applicable percentage change for fiscal year 1991 is deemed to have been the percentage change provided for in paragraph (i)(1)(iii) of this section.

(j) *Applicable percentage change for fiscal year 1992.* The applicable percentage change for fiscal year 1992 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a)(3) of this chapter)—

(1) Minus 0.6 percentage points for hospitals located in rural areas.

(2) Minus 1.6 percentage points for hospitals located in large urban areas and other urban areas.

(k) *Applicable percentage change for fiscal year 1993.* The applicable percentage change for fiscal year 1993 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a)(3) of this chapter)—

(1) Minus 0.55 percentage points for hospitals located in rural areas.

(2) Minus 1.55 percentage points for hospitals located in large urban areas and other urban areas.

(l) *Applicable percentage change for fiscal year 1994.* The applicable percentage change for fiscal year 1994 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter)—

(1) Minus 1.0 percentage point for hospitals located in rural areas.

(2) Minus 2.5 percentage points for hospitals located in large urban areas and other urban areas.

(m) *Applicable percentage change for fiscal year 1995.* The applicable percentage change for fiscal year 1995 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter)—

(1) Plus, for hospitals located in rural areas, the percentage increase necessary so that the average standardized amounts computed under paragraph (c) through (i) of this section are equal to the average standardized amounts for hospitals located in an urban area other than a large urban area.

(2) Minus 2.5 percentage points for hospitals located in large urban areas and other urban areas.

(n) *Applicable percentage change for fiscal year 1996.* The applicable percentage change for fiscal year 1996 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter) minus 2.0 percentage points for all areas.

(o) *Applicable percentage change for fiscal year 1997.* The applicable percentage change for fiscal year 1997 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter) minus 0.5 percentage point for all areas.

(p) *Applicable percentage change for fiscal year 1998.* The applicable percentage change for fiscal year 1998 is 0 percent for hospitals in all areas.

(q) *Applicable percentage change for fiscal year 1999.* The applicable percentage change for fiscal year 1999 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) minus 1.9 percentage points for hospitals in all areas.

(r) *Applicable percentage change for fiscal year 2000.* The applicable percentage change for fiscal year 2000 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this chapter) minus 1.8 percentage points for hospitals in all areas.

(s) *Applicable percentage change for fiscal year 2001.* The applicable percentage change for discharges occurring in fiscal year 2001 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas as follows:

(1) For discharges occurring on October 1, 2000 or before April 1, 2001 the percentage increase in the market basket index for prospective payment hospitals (as defined in § 41340(a) of this subchapter) for sole community hospitals and the increase in the market basket index minus 1.1 percentage points for other hospitals in all areas; and

(2) For discharges occurring on April 1, 2001 or before October 1, 2001 the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for sole community hospitals and the increase in the market basket index plus 1.1 percentage points for other hospitals in all areas.

(t) *Applicable percentage change for fiscal years 2002 and 2003.* The applicable percentage change for fiscal years 2002 and 2003 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) minus 0.55 percentage points for hospitals in all areas.

(u) *Applicable percentage change for fiscal year 2004.* The applicable percentage change for fiscal year 2004 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas.

(v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is not greater or less than 50 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1985 under the law as in effect on April 19, 1983.

(2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.

(w) *Computing Federal rates for inpatient operating costs for hospitals located in large urban and other areas.* For each discharge classified within a DRG, CMS establishes for the fiscal year a national prospective payment rate and a regional prospective payment rate for inpatient operating costs, for each region, as follows:

(1) For hospitals located in a large urban area in the United States or that region respectively, the rate equals the product of—

(i) The adjusted average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in a large urban area in the United States or in that region; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(2) For hospitals located in an other area in the United States or that region respectively, the rate equals the product of—

(i) The adjusted average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in an other area in the United States or that region; and

(ii) The weighting factor (determined under § 412.60(b)) for that DRG.

(x) *Adjusting for different area wage levels.* (1) CMS adjusts the proportion (as estimated by CMS from time to time) of Federal rates for inpatient operating costs computed under paragraph (j) of this section that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs. The wage index is updated annually.

(2)(i) CMS makes a midyear correction to the wage index for an area only if a hospital can show that—

(A) The intermediary or CMS made an error in tabulating its data; and

(B) The hospital could not have known about the error, or did not have the opportunity to correct the error, before the beginning of the Federal fiscal year.

(ii) A midyear correction to the wage index is effective prospectively from the date the change is made to the wage index.

(3) If a judicial decision reverses a CMS denial of a hospital's wage data

revision request, CMS pays the hospital by applying a revised wage index that reflects the revised wage data as if CMS's decision had been favorable rather than unfavorable.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.63, see the List of CFR Sections Affected, which appears in the finding Aids section of the printed volume and at *www.govinfo.gov*.

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term *region* means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area or a Metropolitan division (in the case where a Metropolitan Statistical Area is divided into Metropolitan Divisions), as defined by the Executive Office of Management and Budget; or

(B) For discharges occurring on or after October 1, 1983, and before October 1, 2007, the following New England counties are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21, 42 U.S.C. 1395ww (note); Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3)(i) For discharges occurring on or after October 1, 2004, a hospital that is located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. Qualifying counties are determined based upon OMB standards, using the most recent OMB standards for delineating statistical areas adopted by CMS.

(ii) For discharges occurring on or after October 1, 2007, hospitals in the following New England counties, if not already located in an urban area, are deemed to be located in urban areas under section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21, 42 U.S.C. 1395ww (note): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.

(5) For hospitals that consist of two or more separately located inpatient hospital facilities, the national adjusted prospective payment rate is based on the geographic location of the hospital facility at which the discharge occurred.

(c) *Computing the standardized amount.* CMS computes an average standardized amount that is applicable to all hospitals located in all areas, updated by the applicable percentage increase specified in paragraph (d) of this section. CMS standardizes the average

standardized amount by excluding an estimate of indirect medical education payments.

(d) *Applicable percentage change for fiscal year 2005 and for subsequent fiscal years.* (1) The applicable percentage change for updating the standardized amount for all hospitals in all areas is—

(i) For fiscal year 2005 through fiscal year 2009, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraph (d)(2) of this section.

(ii) For fiscal year 2010, for discharges—

(A) On or after October 1, 2009 and before April 1, 2010, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraph (d)(2) of this section; and

(B) On or after April 1, 2010 and before October 1, 2010, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraph (d)(2) of this section, less 0.25 percentage point.

(iii) For fiscal year 2011, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this subchapter) for prospective payment hospitals, subject to the provisions of paragraph (d)(2) of this section, less 0.25 percentage point.

(iv) For fiscal years 2012 and 2013, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraph (d)(2) of this section, less a multifactor productivity adjustment (as determined by CMS) and less 0.1 percentage point.

(v) For fiscal year 2014, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraph (d)(2) of this section, less a multifactor productivity adjustment (as determined by CMS) and less 0.3 percentage point.

(vi) For fiscal years 2015 and 2016, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraphs (d)(2) and (3) of this section, less a multifactor productivity adjustment (as determined by CMS) and less 0.2 percentage point.

(vii) For fiscal years 2017, 2018, and 2019, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraphs (d)(2) and (3) of this section, less a multifactor productivity adjustment (as determined by CMS) and less 0.75 percentage point.

(viii) For fiscal year 2020 and subsequent fiscal years, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals, subject to the provisions of paragraphs (d)(2) and (3) of this section, less a multifactor productivity adjustment (as determined by CMS).

(2)(i) In the case of a ''subsection (d) hospital,'' as defined under section 1886(d)(1)(B) of the Act, that does not submit quality data on a quarterly basis to CMS, in the form and manner specified by CMS, the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals is reduced—

(A) For fiscal years 2005 and 2006, by 0.4 percentage points; and

(B) For fiscal year 2007 through 2014, by 2 percentage points.

(C) For fiscal year 2015 and subsequent fiscal years, by one-fourth.

(ii) Any reduction pursuant to this paragraph (d)(2) will apply only to the fiscal year involved and will not be taken into account in computing the applicable percentage change for a subsequent fiscal year.

(3)(i) Beginning fiscal year 2015, in the case of a ''subsection (d) hospital,'' as defined under section 1886(d)(1)(B) of the Act, that is not a meaningful electronic health record (EHR) user as defined in part 495 of this chapter for the applicable EHR reporting period and does not receive an exception, three-fourths of the percentage increase in

the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals is reduced—

(A) For fiscal year 2015, by 33⅓ percent;

(B) For fiscal year 2016, by 66⅔ percent; and

(C) For fiscal year 2017 and subsequent fiscal years, by 100 percent.

(ii) Beginning fiscal year 2022, in the case of a ''subsection (d) Puerto Rico hospital,'' as defined under section 1886(d)(9)(A) of the Act, that is not a meaningful EHR user as defined in part 495 of this chapter for the applicable EHR reporting period and does not receive an exception, three-fourths of the percentage increase in the market basket index (as defined in § 413.40(a)(3) of this chapter) for prospective payment hospitals is reduced—

(A) For fiscal year 2022, by 33⅓ percent;

(B) For fiscal year 2023, by 66⅔ percent; and

(C) For fiscal year 2024 and subsequent fiscal years, by 100 percent.

(4) *Exception*—(i) *General rules.* The Secretary may, on a case-by-case basis, exempt an eligible hospital that is not a qualifying eligible hospital from the application of the reduction under paragraph (d)(3) of this section if the Secretary determines that compliance with the requirement for being a meaningful EHR user would result in a significant hardship for the eligible hospital.

(ii) To be considered for an exception, a hospital must submit an application, in the manner specified by CMS, demonstrating that it meets one or more than one of the criteria specified in this paragraph (d)(4) of this section. These types of exceptions are subject to annual renewal, but in no case may a hospital be granted this type of exception for more than 5 years. (See § 495.4 for definitions of payment adjustment year, EHR reporting period, and meaningful EHR user.)

(A) During any 90-day period from the beginning of the fiscal year that is 2 years before the payment adjustment year to July 1 of the year before the payment adjustment year, or a later date specified by CMS, the hospital was located in an area without sufficient Internet access to comply with the meaningful use objectives requiring internet connectivity, and faced insurmountable barriers to obtaining such internet connectivity. Applications requesting this exception must be submitted by July 1 of the year before the applicable payment adjustment year, or a later date specified by CMS.

(B)(*1*) During the fiscal year that is 2 fiscal years before the payment adjustment year, the hospital that has previously demonstrated meaningful use faces extreme and uncontrollable circumstances that prevent it from becoming a meaningful EHR user. Applications requesting this exception must be submitted by July 1 of the year before the applicable payment adjustment year, or a later date specified by CMS.

(*2*) During the fiscal year preceding the payment adjustment year, the hospital that has not previously demonstrated meaningful use faces extreme and uncontrollable circumstances that prevent it from becoming a meaningful EHR user. Applications requesting this exception must be submitted by July 1 of the year before the applicable payment adjustment year, or a later date specified by CMS.

(C) The hospital is new in the payment adjustment year, and has not previously operated (under previous or present ownership). This exception expires beginning with the first Federal fiscal year that begins on or after the hospital has had at least one 12-month (or longer) cost reporting period after they accept their first Medicare covered patient. For purposes of this exception, the following hospitals are not considered new hospitals:

(*1*) A hospital that builds new or replacement facilities at the same or another location even if coincidental with a change of ownership, a change in management, or a lease arrangement.

(*2*) A hospital that closes and subsequently reopens.

(*3*) A hospital that changes its status from a CAH to a hospital that is subject to the Medicare hospital inpatient prospective payment systems.

(iii) *Exception for decertified EHR technology.* Beginning with the fiscal year

2019 payment adjustment year, the Secretary shall exempt an eligible hospital that is not a qualifying eligible hospital from the application of the reduction under paragraph (d)(3) of this section if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by the eligible hospital has been decertified under ONC's Health IT Certification Program. To be considered for an exception, an eligible hospital must submit an application, in the manner specified by CMS, demonstrating that the certified EHR technology was decertified during the 12-month period preceding the applicable EHR reporting period for the payment adjustment year, or during the applicable EHR reporting period for the payment adjustment year, and that the eligible hospital made a good faith effort to obtain another certified EHR technology for that EHR reporting period. (See §495.4 of this chapter for definitions of payment adjustment year, EHR reporting period, and meaningful EHR user.) Applications requesting this exception must be submitted by July 1 of the year before the applicable payment adjustment year, or a later date specified by CMS. This exception is subject to annual renewal, but in no case may an eligible hospital be granted an exception under paragraph (d)(4) of this section for more than 5 years.

(5) A State in which hospitals are paid for services under section 1814(b)(3) of the Act must—

(i) Adjust the payments to each eligible hospital in the State that is not a meaningful EHR user in a manner that is designed to result in an aggregate reduction in payments to hospitals in the State that is equivalent to the aggregate reduction that would have occurred if payments had been reduced to each eligible hospital in the State in a manner comparable to the reduction under paragraph (d)(3) of this section; and

(ii) Provide to the Secretary, by January 1, 2013, a report on the method that it proposes to employ in order to make the requisite payment adjustment described in paragraph (d)(5)(i) of this section.

(e) *Maintaining budget neutrality.* (1) CMS makes an adjustment to the standardized amount to ensure that—

(i) Changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to hospitals are not affected; and

(ii) Except as provided in paragraphs (e)(4) and (h)(4)(vii) of this section, the annual updates and adjustments to the wage index under paragraph (h) of this section are made in a manner that ensures that aggregate payments are not affected; and

(2) CMS also makes an adjustment to the rates to ensure that aggregate payments after implementation of reclassifications under subpart L of this part are equal to the aggregate prospective payments that would have been made in the absence of these provisions.

(3) To the extent CMS determines that changes to the DRG classification and recalibrations of the DRG relative weights for a previous year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in coding or classification of discharges that do not reflect real changes in case mix, CMS may adjust the standardized amount for subsequent fiscal years so as to eliminate the effect of such coding and classification changes.

(4) CMS makes an adjustment to the wage index to ensure that aggregate payments after implementation of the rural floor under section 4410 of the Balanced Budget Act of 1997 (Pub. L. 105–33) and, for discharges on or after October 1, 2004, and before October 1, 2018, the imputed floor under paragraph (h)(4) of this section are equal to the aggregate prospective payments that would have been made in the absence of such provisions as follows:

(i) Beginning October 1, 2008, such adjustment is transitioned from a nationwide to a statewide adjustment as follows:

(A) From October 1, 2008 through September 30, 2009, the wage index is a blend of 20 percent of a wage index with a statewide adjustment and 80 percent of a wage index with a nationwide adjustment.

(B) From October 1, 2009 through September 30, 2010, the wage index is a blend of 50 percent of a wage index with a statewide adjustment and 50 percent of a wage index with a nationwide adjustment.

(ii) Beginning October 1, 2010, such adjustment is a full nationwide adjustment.

(5) CMS makes an adjustment to the standardized amount to ensure that the reasonable cost based payments for allogeneic hematopoietic stem cell acquisition costs are made in a manner so that aggregate payments to hospitals are not affected.

(f) *Adjustment for outlier payments.* CMS reduces the adjusted average standardized amount determined under paragraph (c) through (e) of this section by a proportion equal to the proportion (estimated by CMS) to the total amount of payments based on DRG prospective payment rates that are additional payments for outlier cases under subpart F of this part.

(g) *Computing Federal rates for inpatient operating costs for hospitals located in all areas.* For each discharge classified within a DRG, CMS establishes for the fiscal year a national prospective payment rate for inpatient operating costs based on the standardized amount for the fiscal year and the weighting factor determined under § 412.60(b) for that DRG.

(h) *Adjusting for different area wage levels.* CMS adjusts the proportion of the Federal rate for inpatient operating costs that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs. The adjustment described in this paragraph (h) also takes into account the earnings and paid hours of employment by occupational category.

(1) The wage index is updated annually.

(2) CMS determines the proportion of the Federal rate that is attributable to wages and labor-related costs from time to time, employing a methodology that is described in the annual regulation updating the system of payment for inpatient hospital operating costs.

(3) For discharges occurring on or after October 1, 2004, CMS employs 62 percent as the proportion of the rate that is adjusted for the relative level of hospital wages and wage-related costs, unless employing that percentage would result in lower payments for the hospital than employing the proportion determined under the methodology described in paragraph (h)(2) of this section.

(4) For discharges on or after October 1, 2004 and before October 1, 2018, and for discharges on or after October 1, 2021, CMS establishes a minimum wage index for each all-urban State, as defined in paragraph (h)(5) of this section. This minimum wage index value is computed using the following methodology:

(i) CMS computes the ratio of the lowest-to-highest wage index for each all-urban State;

(ii) CMS computes the average of the ratios of the lowest-to-highest wage indexes of all the all-urban States;

(iii) For each all-urban State, CMS determines the higher of the State's own lowest-to-highest rate (as determined under paragraph (h)(4)(i) of this section) or the average lowest-to-highest rate (as determined under paragraph (h)(4)(ii) of this section);

(iv) For each State, CMS multiplies the rate determined under paragraph (h)(4)(iii) of this section by the highest wage index value in the State;

(v) The product determined under paragraph (h)(4)(iv) of this section is the minimum wage index value for the State, except as provided under paragraph (h)(4)(vi) of this section;

(vi) For discharges on or after October 1, 2012 and before October 1, 2018, and for discharges on or after October 1, 2021, the minimum wage index value for the State is the higher of the value determined under paragraph (h)(4)(iv) of this section or the value computed using the following alternative methodology:

(A) CMS estimates a percentage representing the average percentage increase in wage index for hospitals receiving the rural floor due to such floor.

(B) For each all-urban State, CMS makes a onetime determination of the lowest hospital wage index in the State (including all adjustments to the hospital's wage index, except for the rural floor, the rural floor budget neutrality, and the outmigration adjustment) and increases this wage index by the percentage determined under paragraph (h)(4)(vi)(A) of this section, the result of which establishes the alternative minimum wage index value for the State.

(vii) For discharges on or after October 1, 2021, the minimum wage index computed under this paragraph must not be applied in a budget neutral manner.

(5)(i) For purposes of paragraph (h)(4) of this section, for discharges on or after October 1, 2004 and before October 1, 2018, an all-urban State is a State with no rural areas, as defined in this section, or a State in which there are no hospitals classified as rural. For purposes of this definition, a State with rural areas and with hospitals reclassified as rural under § 412.103 is not an all-urban State.

(ii) For purposes of paragraph (h)(4) of this section, for discharges on or after October 1, 2021, an all-urban State is a State with no rural areas, as defined in this section, or a State in which there are no hospitals classified as rural under section 1886 of the Act. For purposes of this definition, a hospital is classified as rural under section 1886 of the Act if it is assigned the State's rural area wage index value.

(6) If a new rural hospital that is subject to the hospital inpatient prospective payment system opens in a State that has an imputed rural floor and has rural areas, CMS uses the imputed floor as the hospital's wage index until the hospital's first cost report as an inpatient prospective payment system provider is contemporaneous with the cost reporting period being used to develop a given fiscal year's wage index.

(7) Beginning with fiscal year 2023, if CMS determines that a hospital's wage index value for a fiscal year would decrease by more than 5 percent as compared to the hospital's wage index value for the prior fiscal year, CMS limits the decrease to 5 percent for the fiscal year.

(i) *Adjusting the wage index to account for commuting patterns of hospital workers*—(1) *General criteria.* For discharges occurring on or after October 1, 2004, CMS adjusts the hospital wage index for hospitals located in qualifying counties to recognize the commuting patterns of hospital employees. A qualifying county is a county that meets all of the following criteria:

(i) Hospital employees in the county commute to work in an MSA (or MSAs) with a wage index (or wage indices) higher than the wage index of the MSA or rural statewide area in which the county is located.

(ii) At least 10 percent of the county's hospital employees commute to an MSA (or MSAs) with a higher wage index (or wage indices).

(iii) The 3-year average hourly wage of the hospital(s) in the county equals or exceeds the 3-year average hourly wage of all hospitals in the MSA or rural statewide area in which the county is located.

(2) *Amount of adjustment.* A hospital located in a county that meets the criteria under paragraphs (i)(1)(i) through (i)(1)(iii) of this section will receive an increase in its wage index that is equal to a weighted average of the difference between the postreclassified wage index of the MSA (or MSAs) with the higher wage index (or wage indices) and the postreclassified wage index of the MSA or rural statewide area in which the qualifying county is located, weighted by the overall percentage of the hospital employees residing in the qualifying county who are employed in any MSA with a higher wage index.

(3) *Process for determining the adjustment.* (i) CMS will use the most accurate data available, as determined by CMS, to determine the out-migration percentage for each county.

(ii) CMS will include, in its annual proposed and final notices of updates to the hospital inpatient prospective payment system, a listing of qualifying counties and the hospitals that are eligible to receive the adjustment to their wage indexes for commuting hospital

employees, and the wage index increase applicable to each qualifying county.

(iii) Any wage index adjustment made under this paragraph (i) is effective for a period of 3 fiscal years, except that hospitals in a qualifying county may elect to waive the application of the wage index adjustment. A hospital may waive the application of the wage index adjustment by notifying CMS in writing within 45 days of the date of public display of the annual notice of proposed rulemaking for the hospital inpatient prospective payment system at the Office of the Federal Register.

(iv) A hospital in a qualifying county that receives a wage index adjustment under this paragraph (i) is not eligible for reclassification under subpart L of this part or section 1886(d)(8) of the Act.

(j) *Wage index assignment for rural referral centers for FY 2005.* (1) CMS makes an exception to the wage index assignment of a rural referral center for FY 2005 if the rural referral center meets the following conditions:

(i) The rural referral center was reclassified for FY 2004 by the MGCRB to another MSA, but, upon applying to the MGCRB for FY 2005, was found to be ineligible for reclassification because its average hourly wage was less than 84 percent (but greater than 82 percent) of the average hourly wage of the hospitals geographically located in the MSA to which the rural referral center applied for reclassification for FY 2005.

(ii) The hospital may not qualify for any geographic reclassification under subpart L of this part, effective for discharges occurring on or after October 1, 2004.

(2) CMS will assign a rural referral center that meets the conditions of paragraph (j)(1) of this section the wage index value of the MSA to which it was reclassified by the MGCRB in FY 2004. The wage index assignment is applicable for discharges occurring during the 3-year period beginning October 1, 2004 and ending September 30, 2007.

(k) *Midyear corrections to the wage index.* (1) CMS makes a midyear correction to the wage index for an area only if a hospital can show that—

(i) The intermediary or CMS made an error in tabulating its data; and

(ii) The hospital could not have known about the error, or did not have the opportunity to correct the error, before the beginning of the Federal fiscal year.

(2)(i) Except as provided in paragraph (k)(2)(ii) of this section, a midyear correction to the wage index is effective prospectively from the date the change is made to the wage index.

(ii) Effective October 1, 2005, a change to the wage index may be made retroactively to the beginning of the Federal fiscal year, if, for the fiscal year in question, CMS determines all of the following—

(A) The fiscal intermediary or CMS made an error in tabulating data used for the wage index calculation;

(B) The hospital knew about the error in its wage data and requested the fiscal intermediary and CMS to correct the error both within the established schedule for requesting corrections to the wage data (which is at least before the beginning of the fiscal year for the applicable update to the hospital inpatient prospective payment system) and using the established process; and

(C) CMS agreed before October 1 that the fiscal intermediary or CMS made an error in tabulating the hospital's wage data and the wage index should be corrected.

(l) *Judicial decision.* If a judicial decision reverses a CMS denial of a hospital's wage data revision request, CMS pays the hospital by applying a revised wage index that reflects the revised wage data as if CMS's decision had been favorable rather than unfavorable.

(m) *Adjusting the wage index to account for the Frontier State floor*—(1) *General criteria.* For discharges occurring on or after October 1, 2010, CMS adjusts the hospital wage index for hospitals located in qualifying States to recognize the wage index floor established for frontier States. A qualifying frontier State meets both of the following criteria:

(i) At least 50 percent of counties located within the State have a reported population density less than 6 persons per square mile.

(ii) The State does not receive a nonlabor-related share adjustment determined by the Secretary to take into account the unique circumstances of hospitals located in Alaska and Hawaii.

(2) *Amount of wage index adjustment.* A hospital located in a qualifying State will receive a wage index value not less than 1.00.

(3) *Process for determining and posting wage index adjustments.* (i) CMS uses the most recent Population Estimate data published by the U.S. Census Bureau to determine county definitions and population density. This analysis will be periodically revised, such as for updates to the decennial census data.

(ii) CMS will include a listing of qualifying frontier States and denote the hospitals receiving a wage index increase attributable to this provision in its annual updates to the hospital inpatient prospective payment system published in the FEDERAL REGISTER.

[69 FR 49242, Aug. 11, 2004]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.64, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

Subpart E—Determination of Transition Period Payment Rates for the Prospective Payment System for Inpatient Operating Costs

§ 412.70 General description.

For discharges occurring on or after April 1, 1988, and before October 1, 1996, payments to a hospital are based on the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the region in which the hospital is located.

[57 FR 39822, Sept. 1, 1992, as amended at 58 FR 46338, Sept. 1, 1993]

§ 412.71 Determination of base-year inpatient operating costs.

(a) *Base-year costs.* (1) For each hospital, the intermediary will estimate the hospital's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1982 and before September 30, 1983.

(2) If the hospital's last cost reporting period ending before September 30, 1983 is for less than 12 months, the base period will be the hospital's most recent 12-month or longer cost reporting period ending before such short reporting period, with an appropriate adjustment for inflation. (The rules applicable to new hospitals are set forth in § 412.74.)

(b) *Modifications to base-year costs.* Prior to determining the hospital-specific rate, the intermediary will adjust the hospital's estimated base-year inpatient operating costs, as necessary, to include malpractice insurance costs in accordance with § 413.53(a)(1)(i) of this chapter, and exclude the following:

(1) Medical education costs as described in § 413.85 of this chapter.

(2) Capital-related costs as described in § 413.130 of this chapter.

(3) Kidney acquisition costs incurred by hospitals with approved kidney transplant programs as described in § 412.100. Kidney acquisition costs in the base year are determined by multiplying the hospital's average kidney acquisition cost per kidney times the number of kidney transplants covered by Medicare Part A during the base period.

(4) Higher costs that were incurred for purposes of increasing base-year costs.

(5) One-time nonrecurring higher costs or revenue offsets that have the effect of distorting base-year costs as an appropriate basis for computing the hospital-specific rate.

(6) Higher costs that result from changes in hospital accounting principles initiated in the base year.

(7) The costs of qualified nonphysician anesthetists' services, as described in § 412.113(c).

(c) *Hospital's request for adjustment of base-year inpatient operating costs.* (1) Before the date it becomes subject to the prospective payment system for inpatient operating costs, a hospital may request the intermediary to further adjust its estimated base-period costs to take into account the following:

(i) Services paid for under Medicare Part B during the hospital's base year that will be paid for under prospective

payments. The base-year costs may be increased to include estimated payments for certain services previously billed as physicians' services before the effective date of § 415.102(a) of this chapter, and estimated payments for nonphysicians' services that were not furnished either directly or under arrangements before October 1, 1983 (the effective date of § 405.310(m) of this chapter), but may not include the costs of anesthetists' services for which a physician employer continues to bill under § 405.553(b)(4) of this chapter.

(ii) The payment of FICA taxes during cost reporting periods subject to the prospective payment system, if the hospital had not paid such taxes for all its employees during its base period and will be required to participate effective January 1, 1984.

(2) If a hospital requests that its base-period costs be adjusted under paragraph (c)(1) of this section, it must timely provide the intermediary with sufficient documentation to justify the adjustment, and adequate data to compute the adjusted costs. The intermediary decides whether to use part or all of the data on the basis of audit, survey and other information available.

(d) *Intermediary's determination.* The intermediary uses the best data available at the time in estimating each hospital's base-year costs and the modifications to those costs authorized by paragraphs (b) and (c) of this section. The intermediary's estimate of base-year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided in § 412.72.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 52 FR 33057, Sept. 1, 1987; 57 FR 33897, July 31, 1992; 57 FR 39822, Sept. 1, 1992; 59 FR 45398, Sept. 1, 1994; 60 FR 63188, Dec. 8, 1995; 86 FR 73510, Dec. 27, 2021]

§ 412.72 Modification of base-year costs.

(a) *Bases for modification of base-year costs.* Base-year costs as determined under § 412.71(d) may be modified under the following circumstances:

(1) *Inadvertent omissions.* (i) A hospital that becomes subject to the prospective payment system beginning on or after October 1, 1983 and before November 16, 1983 has until November 15, 1983 to request its intermediary to reestimate its base-period costs to take into account inadvertent omissions in its previous submissions to the intermediary related to changes made by the prospective payment legislation for purposes of estimating the base-period costs.

(ii) The intermediary may also initiate changes to the estimation—

(A) For any reason before the date the hospital becomes subject to prospective payment; and

(B) Before November 16, 1983, for corrections to take into account inadvertent omissions in the hospital's previous submissions related to changes made by the prospective payment legislation for purposes of estimating the base-period costs.

(iii) Such omissions pertain to adjustments to exclude capital-related costs and the direct medical education costs of approved educational activities and to adjustments specified in § 412.71(c).

(iv) The intermediary must notify the provider of any change to the hospital-specific amount as a result of the provider's request within 30 days of receipt of the additional data.

(v) Any change to base-period costs made under this paragraph (a)(1) will be made effective retroactively, beginning with the first day of the affected hospital's fiscal year.

(2) *Correction of mathematical errors of calculations.* (i) The hospital must report mathematical errors of calculations to the intermediary within 90 days of the intermediary's notification to the hospital of the hospital's payments rates.

(ii) The intermediary may also identify such errors and initiate their correction during this period.

(iii) The intermediary will either make an appropriate adjustment or notify the hospital that no adjustment is warranted within 30 days of receipt of the hospital's report of an error.

(iv) Corrections of errors of calculation will be effective with the first day of the hospital's first cost reporting period subject to the prospective payment system.

(3) *Recognition of additional costs.* (i) The intermediary may adjust base-period costs to take into account additional costs recognized as allowable costs for the hospital's base year as the result of any of the following:

(A) A reopening and revision of the hospital's base-year notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(B) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(C) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(D) An administrative or judicial review decision under § 405.1831, § 405.1871, or § 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-year notice of amount of program reimbursement.

(ii) The intermediary will recalculate the hospital's base-year costs, incorporating the additional costs recognized as allowable for the hospital's base year. Adjustments to base-year costs to take into account these additional costs—

(A) Will be effective with the first day of the hospital's first cost reporting period beginning on or after the date of the revision, order or finding, or review decision; and

(B) Will not be used to recalculate the hospital-specific portion as determined for fiscal years beginning before the date of the revision, order or finding, or review decision.

(4) *Successful appeal.* The intermediary may modify base-year costs to take into account a successful appeal relating to modifications to base-year costs that were made under § 412.71(b). If a hospital successfully contests a modification to base-year costs—

(i) The intermediary will recalculate the hospital's base-year costs to reflect the modification determined appropriate as a result of the appeal; and

(ii) Such adjustments will be effective retroactively to the time of the intermediary's initial estimation of base-year costs.

(5) *Unlawfully claimed costs.* The intermediary may modify base-year costs to exclude costs that were unlawfully claimed as determined as a result of criminal conviction, imposition of a civil judgment under the False Claims Act (31 U.S.C. 3729–3731), or a proceeding for exclusion from the Medicare program. In addition to adjusting base-year costs, CMS will recover both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates. The amount to be recovered will be computed on the basis of the final resolution of the amount of the inappropriate base-year costs.

(b) *Right to administrative and judicial review.* (1) An intermediary's estimation of a hospital's base-year costs, and modifications, made for purposes of determining the hospital-specific rate, are subject to administrative and judicial review. Review will be available to a hospital upon receipt of its notice of amount of program reimbursement following the close of its cost reporting period, but only with respect to whether the intermediary followed the provisions of §§ 412.71 and 412.72. (Sections 405.1803 and 405.1807 of this chapter set forth the rules for intermediary determinations and notice of amount of program reimbursement and the effect of those determinations.)

(2) In any administrative or judicial review of whether the intermediary used the best data available at the time, as required by § 412.71(d), an intermediary's estimation will be revised on the basis of this review only if the estimation was unreasonable and clearly erroneous in light of the data available at the time the estimation was made.

(3) Specifically excluded from administrative or judicial review are any issues based on data, information, or

arguments not presented to the intermediary at the time of the estimation.

§ 412.73 Determination of the hospital-specific rate based on a Federal fiscal year 1982 base period.

(a) *Costs on a per discharge basis.* The intermediary will determine the hospital's estimated adjusted base-year operating cost per discharge by dividing the total adjusted operating costs by the number of discharges in the base period.

(b) *Case-mix adjustment.* The intermediary will divide the adjusted base-year costs by the hospital's 1981 case-mix index. If the hospital's case-mix index is statistically unreliable (as determined by CMS), the hospital's base-year costs will be divided by the lower of the following:

(1) The hospital's estimated case-mix index.

(2) The average case-mix index for the appropriate classifications of all hospitals subject to cost limits established under § 413.30 of this chapter for cost reporting periods beginning on or after October 1, 1982 and before October 1, 1983.

(c) *Updating base-year costs*—(1) *For Federal fiscal year 1984.* The case-mix adjusted base-year cost per discharge will be updated by the applicable updating factor, that is, the rate-of-increase percentage determined under § 413.40(c)(3) of this chapter, as adjusted for budget neutrality.

(2) *For Federal fiscal year 1985.* The amount determined under paragraph (c)(1) of this section will be updated by the applicable updating factor, as adjusted for budget neutrality.

(3) *For Federal fiscal year 1986.* (i) The amount determined under paragraph (c)(2) of this section is updated by—

(A) Zero percent for the first seven months of the hospital's cost reporting period; and

(B) One-half of one percent for the remaining five months of the hospital's cost reporting period.

(ii) For purposes of determining the updated base-year costs for cost reporting periods beginning in Federal fiscal year 1987 (that is, on or after October 1, 1986 and before October 1, 1987), the update factor for the previous cost reporting period is deemed to have been one-half of one percent.

(4) *For Federal fiscal year 1987.* The amount determined under paragraph (c)(3)(ii) of this section is updated by 1.15 percent.

(5) *For Federal fiscal year 1988.* (i) For purposes of determining the prospective payment rates for sole community hospitals under § 412.92(d) for cost reporting periods beginning in Federal fiscal year 1988 (that is, on or after October 1, 1987 and before October 1, 1988), the base-year cost per discharge is updated as follows:

(A) For the first 51 days of the hospital's cost reporting period, by zero percent.

(B) For the next 132 days of the hospital's cost reporting period, by 2.7 percent.

(C) For the remainder of the hospital's cost reporting period, by—

(*1*) 3.0 percent for hospitals located in rural areas;

(*2*) 1.5 percent for hospitals located in large urban areas; and

(*3*) 1.0 percent for hospitals located in other urban areas.

(ii) For purposes of determining the updated base-year costs for cost reporting periods beginning in Federal fiscal year 1989 (that is, beginning on or after October 1, 1988 and before October 1, 1989), the update factor for the cost reporting period beginning during federal Fiscal year 1988 is deemed to have been—

(A) 3.0 percent for hospitals located in rural areas;

(B) 1.5 percent for hospitals located in large urban areas; and

(C) 1.0 percent for hospitals located in other urban areas.

(6) *For Federal fiscal year 1989.* For cost reporting periods beginning in Federal fiscal year 1989, the update factor is determined using the methodology set forth in § 412.63(g).

(7) *For Federal fiscal year 1990.* (i) Except as described in paragraph (c)(7)(ii) of this section, for cost reporting periods beginning in Federal fiscal year 1990, the base-period cost per discharge is updated as follows:

(A) For cost reporting periods beginning on or after October 1, 1989 and before January 1, 1990, by 5.5 percent for discharges occurring before January 1,

1990 and by the factors set forth in paragraph (c)(7)(i)(B) of this section for discharges occurring on or after January 1, 1990.

(B) For cost reporting periods beginning on or after January 1, 1990 and before October 1, 1990, by—

(*1*) 9.72 percent for hospitals located in rural areas;

(*2*) 5.62 percent for hospitals located in large urban areas; and

(*3*) 4.97 percent for hospitals located in other urban areas.

(ii) For discharges occurring on or after October 21, 1990 and before January 1, 1991, the base-period cost per discharge, updated as set forth in paragraph (c)(7)(i) of this section, is reduced by 5.5 percent.

(iii) For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 1991 (that is, beginning on or after October 1, 1990 and before October 1, 1991), the update factor for the cost reporting period beginning during Federal fiscal year 1990 is deemed to have been the percentage change provided for in paragraph (c)(7)(i)(B) of this section.

(8) *For Federal fiscal year 1991.* (i) Except as described in paragraph (c)(8)(ii) of this section, for cost reporting periods beginning in Federal fiscal year 1991, the base-period cost per discharge is updated by 5.2 percent.

(ii) For discharges occurring on or after October 21, 1990 and before January 1, 1991, the base-period cost per discharge is updated by 0.0 percent.

(iii) For purposes of determining the updated base period costs for cost reporting periods beginning in Federal fiscal year 1992, the update factor for the cost reporting period beginning during Federal fiscal year 1991 is deemed to have been the percentage change provided for in paragraph (c)(8)(i) of this section.

(9) *For Federal fiscal years 1992 and 1993.* For Federal fiscal years 1992 and 1993, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in §413.40(a) of this chapter).

(10) *For Federal fiscal year 1994.* For Federal fiscal year 1994, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in §413.40(a) of the chapter) minus 2.3 percentage points. For purposes of determining the hospital-specific rate for Federal fiscal year 1994 and subsequent years, this update factor is adjusted to take into account the portion of the 12-month cost reporting period beginning during Federal fiscal year 1993 that occurs in Federal fiscal year 1994.

(11) *For Federal fiscal year 1995.* For Federal fiscal year 1995, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in §413.40(a) of this chapter) minus 2.2 percentage points.

(12) *For Federal fiscal years 1996 through 2000.* For Federal fiscal years 1996 through 2000, the update factor is the applicable percentage change for other prospective payment hospitals in each respective year as set forth in §§412.63(n) through (r).

(13) *For Federal fiscal year 2001.* For Federal fiscal year 2001, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in §413.40(a) of this chapter).

(14) *For Federal fiscal year 2002.* For Federal fiscal year 2002, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in §413.40(a) of this chapter) minus 1.1 percentage points.

(15) *For Federal fiscal year 2003 through Federal fiscal year 2009.* For Federal fiscal year 2003 through Federal fiscal year 2009, the update factor is the percentage increase in the market basket index for prospective payment hospitals (as defined in §413.40(a) of this chapter).

(16) *For Federal fiscal year 2010 and subsequent years.* For Federal fiscal year 2010 and subsequent years, the update factor is the percentage increase specified in §412.64(d).

(d) *Budget neutrality*—(1) *Federal fiscal year 1984.* For cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984, CMS adjusts the target rate percentage used under paragraph (c)(1) of this section. This adjustment is based on a factor actuarially estimated to ensure that the estimated

amount of aggregate Medicare payments based on the hospital-specific portion of the transition payment rates is neither greater nor less than 75 percent of the amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1984 under the law in effect before April 20, 1983.

(2) *Federal fiscal year 1985.* For cost reporting periods beginning on or after October 1, 1984 and before October 1, 1985, CMS adjusts the target rate percentage used under paragraph (c)(2) of this section. This adjustment is based on a factor actuarially estimated to ensure that the estimated amount of aggregate Medicare payment based on the hospital-specific portion of the transition payment rates is neither greater nor less than 50 percent of the amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1985 under the Social Security Act as in effect on April 19, 1983.

(e) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(f) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 16787, May 6, 1986; 51 FR 34793, Sept. 30, 1986; 51 FR 42234, Nov. 24, 1986; 52 FR 33057, Sept. 1, 1987; 53 FR 38528, Sept. 30, 1988; 55 FR 15173, Apr. 20, 1990; 56 FR 573, Jan. 7, 1991; 57 FR 39822, Sept. 1, 1992; 58 FR 46338, Sept. 1, 1993; 59 FR 1658, Jan. 12, 1994; 59 FR 32383, June 23, 1994; 65 FR 47106, Aug. 1, 2000; 70 FR 47485, Aug. 12, 2005; 75 FR 50413, Aug. 16, 2010]

§ 412.75 Determination of the hospital-specific rate for inpatient operating costs based on a Federal fiscal year 1987 base period.

(a) *Base-period costs*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, for each hospital, the intermediary determines the hospital's Medicare part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1987 and before September 30, 1988.

(2) *Exceptions.* (i) If the hospital's last cost reporting period ending before September 30, 1988 is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short period report.

(ii) If the hospital does not have a cost reporting period ending on or after September 30, 1987 and before September 30, 1988 and does have a cost reporting period beginning on or after October 1, 1986 and before October 1, 1987, that cost reporting period is the base period unless the cost reporting period is for less than 12 months. In that case, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short cost reporting period.

(b) *Costs on a per discharge basis.* The intermediary determines the hospital's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as defined in § 412.4(b) is considered to be a discharge.

(c) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the hospital's case-mix index for the base period.

(d) *Updating base-period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 1988, the update factor is determined using the methodology set forth in §§ 412.73(c)(15) and 412.73(c)(16).

(e) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(f) *Notice of hospital-specific rate.* The intermediary furnishes the hospital a notice of its hospital-specific rate,

which contains a statment of the hospital's Medicare part A allowable inpatient operating costs, number of Medicare discharges, and case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 1987 base period.

(g) *Right to administrative and judicial review.* An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to a hospital upon receipt of the notice of the hospital-specific rate. This notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of part 405 of this chapter, governing provider reimbursement determinations and appeals.

(h) *Modification of hospital-specific rate.* (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the hospital's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the hospital's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under §§ 405.1831, 405.1871, or 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (h)(1) and (2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

(i) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.

[55 FR 15173, Apr. 20, 1990, as amended at 55 FR 36069, Sept. 4, 1990; 55 FR 39775, Sept. 2, 1990; 56 FR 573, Jan. 7, 1991; 55 FR 46887, Nov. 7, 1990; 57 FR 39822, Sept. 1, 1992; 58 FR 46338, Sept. 1, 1993; 65 FR 47106, Aug. 1, 2000; 70 FR 47485, Aug. 12, 2005; 75 FR 50414, Aug. 16, 2010]

§ 412.76 Recovery of excess transition period payment amounts resulting from unlawful claims.

If a hospital's base-year costs, as estimated for purposes of determining the hospital-specific portion, are determined, by criminal conviction or imposition of a civil money penalty or assessment, to include costs that were unlawfully claimed, the hospital's base-period costs are adjusted to remove the effect of the excess costs, and CMS recovers both the excess costs reimbursed for the base period and the additional amounts paid due to the inappropriate increase of the hospital-specific portion of the hospital's transition payment rates.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39822, Sept. 1, 1992. Redesignated at 65 FR 47106, Aug. 1, 2000, and further redesignated at 73 FR 48754, Aug. 19, 2008]

§ 412.77 Determination of the hospital-specific rate for inpatient operating costs for sole community hospitals based on a Federal fiscal year 1996 base period.

(a) *Applicability.* (1) This section applies to a hospital that has been designated as a sole community hospital, as described in § 412.92. If the 1996 hospital-specific rate exceeds the rate that would otherwise apply, that is, either the Federal rate under § 412.64 (or under § 412.63 for periods prior to FY 2005) or the hospital-specific rates for either FY 1982 under § 412.73 or FY 1987 under § 412.75, this 1996 rate will be used in the payment formula set forth in § 412.92(d)(1).

(2) This section applies only to cost reporting periods beginning on or after October 1, 2000.

(3) The formula for determining the hospital-specific costs for hospitals described under paragraph (a)(1) of this section is set forth in paragraph (f) of this section.

(b) *Based costs for hospitals subject to fiscal year 1996 rebasing*—(1) *General rule.* Except as provided in paragraph (b)(2) of this section, for each hospital eligible under paragraph (a) of this section, the intermediary determines the hospital's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1996 and before September 30, 1997, and computes the hospital-specific rate for purposes of determining prospective payment rates for inpatient operating costs as determined under § 412.92(d).

(2) *Exceptions.* (i) If the hospital's last cost reporting period ending before September 30, 1997 is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short period report.

(ii) If the hospital does not have a cost reporting period ending on or after September 30, 1996 and before September 30, 1997, and does have a cost reporting period beginning on or after October 1, 1995 and before October 1, 1996, that cost reporting period is the base period unless the cost reporting period is for less than 12 months. If that cost reporting period is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short cost reporting period. If a hospital has no cost reporting period beginning in fiscal year 1996, the hospital will not have a hospital-specific rate based on fiscal year 1996.

(c) *Costs on a per discharge basis.* The intermediary determines the hospital's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as defined in § 412.4(b) is considered to be a discharge.

(d) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the hospital's case-mix index for the base period.

(e) *Updating base-period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 1996, the update factor is determined using the methodology set forth in § 412.73(c)(12) through (c)(16).

(f) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(g) *Notice of hospital-specific rates.* The intermediary furnishes a hospital eligible for rebasing a notice of the hospital-specific rate as computed in accordance with this section. The notice will contain a statement of the hospital's Medicare Part A allowable inpatient operating costs, the number of Medicare discharges, and the case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 1996 base period.

(h) *Right to administrative and judicial review.* An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to a hospital upon receipt of the notice of the hospital-specific rate. This notice is treated as a final intermediary

determination of the amount of program reimbursement for purposes of subpart R of part 405 of this chapter.

(i) *Modification of hospital-specific rate.* (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the hospital's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for the recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the hospital's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under § 405.1831, § 405.1871, or § 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (i)(1) and (i)(2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

(j) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.

[65 FR 47106, Aug. 1, 2000, as amended at 66 FR 32192, June 13, 2001; 70 FR 47485, Aug. 12, 2005; 75 FR 50414, Aug. 16, 2010]

§ 412.78 Determination of the hospital-specific rate for inpatient operating costs for sole community hospitals based on a Federal fiscal year 2006 base period.

(a) *Applicability.* (1) This section applies to a hospital that has been designated as a sole community hospital, as described in § 412.92. If the 2006 hospital-specific rate exceeds the rate that would otherwise apply, that is, either the Federal rate under § 412.64 or the hospital-specific rates for either FY 1982 under § 412.73, FY 1987 under § 412.75 or FY 1996 under § 412.77, this 2006 rate will be used in the payment formula set forth in § 412.92(d)(1).

(2) This section applies only to cost reporting periods beginning on or after January 1, 2009.

(3) The formula for determining the hospital-specific costs for hospitals described under paragraph (a)(1) of this section is set forth in paragraph (f) of this section.

(b) *Based costs for hospitals subject to fiscal year 2006 rebasing*—(1) *General rule.* Except as provided in paragraph (b)(2) of this section, for each hospital eligible under paragraph (a) of this section, the intermediary determines the hospital's Medicare Part A allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 2006, and before September 30, 2007, and computes the hospital-specific rate for purposes of determining prospective payment rates for inpatient operating costs as determined under § 412.92(d).

(2) *Exceptions.* (i) If the hospital's last cost reporting period ending before September 30, 2007 is for less than 12

months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short period report.

(ii) If the hospital does not have a cost reporting period ending on or after September 30, 2006 and before September 30, 2007, and does have a cost reporting period beginning on or after October 1, 2005 and before October 1, 2006, that cost reporting period is the base period unless the cost reporting period is for less than 12 months. If that cost reporting period is for less than 12 months, the base period is the hospital's most recent 12-month or longer cost reporting period ending before the short cost reporting period. If a hospital has no cost reporting period beginning in fiscal year 2006, the hospital will not have a hospital-specific rate based on fiscal year 2006.

(c) *Costs on a per discharge basis.* The intermediary determines the hospital's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as defined in §412.4(b) is considered to be a discharge.

(d) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the hospital's case-mix index for the base period.

(e) *Updating base-period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 2006, the update factor is determined using the methodology set forth in§§412.73(c)(15) and 412.73(c)(16).

(f) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(g) *Notice of hospital-specific rates.* The intermediary furnishes a hospital eligible for rebasing a notice of the hospital-specific rate as computed in accordance with this section. The notice will contain a statement of the hospital's Medicare Part A allowable inpatient operating costs, the number of Medicare discharges, and the case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 2006 base period.

(h) *Right to administrative and judicial review.* An intermediary's determination under this section of the hospital-specific rate for a hospital is subject to administrative and judicial review in accordance with §412.77(h).

(i) *Modification of hospital-specific rate.* The intermediary recalculates the hospital-specific rate determined under this section in the manner set forth in §412.77(i).

(j) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate determined under this section in the manner set forth in §412.77(j).

[73 FR 48754, Aug. 19, 2008, as amended at 75 FR 50414, Aug. 16, 2010]

§ 412.79 Determination of the hospital-specific rate for inpatient operating costs for Medicare-dependent, small rural hospitals based on a Federal fiscal year 2002 base period.

(a) *Base-period costs*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, for each MDH, the intermediary determines the MDH's Medicare Part A allowable inpatient operating costs, as described in §412.2(c), for the 12-month or longer cost reporting period beginning on or after October 1, 2001, and before October 1, 2002.

(2) *Exceptions.* (i) If the MDH's last cost reporting period beginning before October 1, 2002, is for less than 12 months, the base period is the MDH's most recent 12-month or longer cost reporting period beginning before that short cost reporting period.

(ii) If the MDH does not have a cost reporting period beginning on or after October 1, 2001, and before October 1, 2002, and does have a cost reporting period beginning on or after October 1, 2000, and before October 1, 2001, that cost reporting period is the base period unless the cost reporting is for less than 12 months. In that case, the base period is the MDH's most recent 12-month or longer cost reporting period beginning before that short cost reporting period.

(b) *Costs on a per discharge basis.* The intermediary determines the MDH's average base-period operating cost per discharge by dividing the total operating costs by the number of discharges in the base period. For purposes of this section, a transfer as described in § 412.4(b) is considered to be a discharge.

(c) *Case-mix adjustment.* The intermediary divides the average base-period cost per discharge by the MDH's case-mix index for the base period.

(d) *Updating base period costs.* For purposes of determining the updated base-period costs for cost reporting periods beginning in Federal fiscal year 2002, the update factor is determined using the methodology set forth in § 412.73(c)(14) through (c)(16).

(e) *DRG adjustment.* The applicable hospital-specific cost per discharge is multiplied by the appropriate DRG weighting factor to determine the hospital-specific base payment amount (target amount) for a particular covered discharge.

(f) *Notice of hospital-specific rate.* The intermediary furnishes the MDH a notice of its hospital-specific rate which contains a statement of the hospital's Medicare Part A allowable inpatient operating costs, number of Medicare discharges, and case-mix index adjustment factor used to determine the hospital's cost per discharge for the Federal fiscal year 2002 base period.

(g) *Right to administrative and judicial review.* An intermediary's determination of the hospital-specific rate for a hospital is subject to administrative and judicial review. Review is available to an MDH upon receipt of the notice of the hospital-specific rate. The notice is treated as a final intermediary determination of the amount of program reimbursement for purposes of subpart R of part 405 of this chapter, governing provider reimbursement determinations and appeals.

(h) *Modification of hospital-specific rate.* (1) The intermediary recalculates the hospital-specific rate to reflect the following:

(i) Any modifications that are determined as a result of administrative or judicial review of the hospital-specific rate determinations; or

(ii) Any additional costs that are recognized as allowable costs for the MDH's base period as a result of administrative or judicial review of the base-period notice of amount of program reimbursement.

(2) With respect to either the hospital-specific rate determination or the amount of program reimbursement determination, the actions taken on administrative or judicial review that provide a basis for recalculations of the hospital-specific rate include the following:

(i) A reopening and revision of the MDH's base-period notice of amount of program reimbursement under §§ 405.1885 through 405.1889 of this chapter.

(ii) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority under § 405.1821 or § 405.1853 of this chapter that resolved a matter at issue in the MDH's base-period notice of amount of program reimbursement.

(iii) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of CMS under § 405.1875 of this chapter that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(iv) An administrative or judicial review decision under § 405.1831, § 405.1871, or § 405.1877 of this chapter that is final and no longer subject to review under applicable law or regulations by a higher reviewing authority, and that resolved a matter at issue in the hospital's base-period notice of amount of program reimbursement.

(v) A final, nonappealable court judgment relating to the base-period costs.

(3) The adjustments to the hospital-specific rate made under paragraphs (h)(1) and (2) of this section are effective retroactively to the time of the intermediary's initial determination of the rate.

(i) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate

payments to section 1886(d) hospitals are not affected.

[71 FR 48137, Aug. 18, 2006, as amended at 75 FR 50414, Aug. 16, 2010]

Subpart F—Payments for Outlier Cases, Special Treatment Payment for New Technology, and Payment Adjustment for Certain Replaced Devices

PAYMENT FOR OUTLIER CASES

§ 412.80 Outlier cases: General provisions.

(a) *Basic rule*—(1) *Discharges occurring on or after October 1, 1994 and before October 1, 1997.* For discharges occurring on or after October 1, 1994, and before October 1, 1997, except as provided in paragraph (b) of this section concerning transferring hospitals, CMS provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if either of the following conditions is met:

(i) The beneficiary's length-of-stay (including days at the SNF level of care if a SNF bed is not available in the area) exceeds the mean length-of-stay for the applicable DRG by the lesser of the following:

(A) A fixed number of days, as specified by CMS; or

(B) A fixed number of standard deviations, as specified by CMS.

(ii) The beneficiary's length-of-stay does not exceed criteria established under paragraph (a)(1)(i) of this section, but the hospital's charges for covered services furnished to the beneficiary, adjusted to operating costs and capital costs by applying cost-to-charge ratios as described in § 412.84(h), exceed the DRG payment for the case plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

(2) *Discharges occurring on or after October 1, 1997 and before October 1, 2001.* For discharges occurring on or after October 1, 1997 and before October 1, 2001, except as provided in paragraph (b) of this section concerning transfers, CMS provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges for covered services, adjusted to operating costs and capital costs by applying cost-to-charge ratios, as described in § 412.84(h), exceed the DRG payment for the case, payments for indirect costs of graduate medical education (§ 412.105), and payments for serving disproportionate share of low-income patients (§ 412.106), plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

(3) *Discharges occurring on or after October 1, 2001.* For discharges occurring on or after October 1, 2001, except as provided in paragraph (b) of this section concerning transfers, CMS provides for additional payment, beyond standard DRG payments and beyond additional payments for new medical services or technology specified in §§ 412.87 and 412.88, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges for covered services, adjusted to operating costs and capital costs by applying cost-to-charge ratios as described in § 412.84(h), exceed the DRG payment for the case (plus payments for indirect costs of graduate medical education (§ 412.105), payments for serving a disproportionate share of low-income patients (§ 412.106), and additional payments for new medical services or technologies) plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

(b) *Outlier cases in transferring hospitals.* CMS provides cost outlier payments to a transferring hospital for cases paid in accordance with § 412.4(f), if the hospital's charges for covered services furnished to the beneficiary, adjusted to costs by applying cost-to-charge ratios as described in § 412.84(h), exceed the DRG payment for the case plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS, divided by the geometric mean length of stay for the DRG, and multiplied by an applicable factor determined as follows:

(1) For transfer cases paid in accordance with § 412.4(f)(1), the applicable factor is equal to the length of stay plus 1 day.

(2) For transfer cases paid in accordance with § 412.4(f)(2), the applicable factor is equal to 0.5 plus the product of the length of stay plus 1 day multiplied by 0.5.

(c) *Publication and revision of outlier criteria.* CMS will issue threshold criteria for determining outlier payment in the annual notice of the prospective payment rates published in accordance with § 412.8(b).

[62 FR 46028, Aug. 29, 1997, as amended at 63 FR 41003, July 31, 1998; 66 FR 46924, Sept. 7, 2001; 67 FR 50111, Aug. 1, 2002]

§ 412.82 Payment for extended length-of-stay cases (day outliers).

(a) For discharges occurring before October 1, 1997, if the hospital stay reflected by a discharge includes covered days of care beyond the applicable threshold criterion, the intermediary will make an additional payment, on a per diem basis, to the discharging hospital for those days. A special request or submission by the hospital is not necessary to initiate this payment. However, a hospital may request payment for day outliers before the medical review required in paragraph (b) of this section.

(b) The QIO must review and approve to the extent required by CMS—

(1) The medical necessity and appropriateness of the admission and outlier services in the context of the entire stay;

(2) The validity of the diagnostic and procedural coding; and

(3) The granting of grace days.

(c) Except as provided in § 412.83, the per diem payment made under paragraph (a) of this section is derived by taking a percentage of the average per diem payment for the applicable DRG, as calculated by dividing the Federal prospective payment rate for inpatient operating costs and inpatient capital-related costs determined under subpart D of this part, by the arithmetic mean length of stay for that DRG. CMS issues the applicable percentage of the average per diem payment in the annual publication of the prospective payment rates in accordance with § 412.8(b).

(d) Any days in a covered stay identified as noncovered reduce the number of days reimbursed at the day outlier rate but not to exceed the number of days that occur after the day outlier threshold.

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 15326, Apr. 17, 1985; 50 FR 35689, Sept. 3, 1985; 53 FR 38529, Sept. 30, 1988; 57 FR 39822, Sept. 1, 1992; 59 FR 45398, Sept. 1, 1994; 62 FR 46028, Aug. 29, 1997; 85 FR 59020, Sept. 18, 2020]

§ 412.84 Payment for extraordinarily high-cost cases (cost outliers).

(a) A hospital may request its intermediary to make an additional payment for inpatient hospital services that meet the criteria established in accordance with § 412.80(a).

(b) The hospital must request additional payment—

(1) With initial submission of the bill; or

(2) Within 60 days of receipt of the intermediary's initial determination.

(c) Except as specified in paragraph (e) of this section, an additional payment for a cost outlier case is made prior to medical review.

(d) As described in paragraph (f) of this section, the QIO reviews a sample of cost outlier cases after payment. The charges for any services identified as noncovered through this review are denied and any outlier payment made for these services are recovered, as appropriate, after a determination as to the provider's liability has been made.

(e) If the QIO finds a pattern of inappropriate utilization by a hospital, all cost outlier cases from that hospital are subject to medical review, and this review may be conducted prior to payment until the QIO determines that appropriate corrective actions have been taken.

(f) The QIO reviews the cost outlier cases, using the medical records and itemized charges, to verify the following:

(1) The admission was medically necessary and appropriate.

(2) Services were medically necessary and delivered in the most appropriate setting.

(3) Services were ordered by the physician, actually furnished, and not duplicatively billed.

(4) The diagnostic and procedural codings are correct.

(g) The intermediary bases the operating and capital costs of the discharge

on the billed charges for covered inpatient services adjusted by the cost to charge ratios applicable to operating and capital costs, respectively, as described in paragraph (h) of this section.

(h) For discharges occurring before October 1, 2003, the operating and capital cost-to-charge ratios used to adjust covered charges are computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for the same time period as that covered by the cost report. For discharges occurring before August 8, 2003, statewide cost-to-charge ratios are used in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. CMS sets forth the reasonable parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published in the FEDERAL REGISTER in accordance with § 412.8(b).

(i)(1) For discharges occurring on or after August 8, 2003, CMS may specify an alternative to the ratios otherwise applicable under paragraphs (h) or (i)(2) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. Such a request must be approved by the CMS Regional Office.

(2) For discharges occurring on or after October 1, 2003, the operating and capital cost-to-charge ratios applied at the time a claim is processed are based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period.

(3) For discharges occurring on or after August 8, 2003, the fiscal intermediary may use a statewide average cost-to-charge ratio if it is unable to determine an accurate operating or capital cost-to-charge ratio for a hospital in one of the following circumstances:

(i) New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(ii) Hospitals whose operating or capital cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with § 412.8(b).

(iii) Other hospitals for whom the fiscal intermediary obtains accurate data with which to calculate either an operating or capital cost-to-charge ratio (or both) are not available.

(4) For discharges occurring on or after August 8, 2003, any reconciliation of outlier payments will be based on operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(j) If any of the services are determined to be noncovered, the charges for these services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.

(k) Except as provided in paragraph (l) of this section, the additional amount is derived by first taking 80 percent of the difference between the hospital's adjusted operating cost for the discharge (as determined under paragraph (g) of this section) and the operating threshold criteria established under § 412.80(a)(1)(ii); 80 percent is also taken of the difference between the hospital's adjusted capital cost for the discharge (as determined under paragraph (g) of this section) and the capital threshold criteria established under § 412.80(a)(1)(ii). The resulting capital amount is then multiplied by the applicable Federal portion of the payment as determined in § 412.340(a) or § 412.344(a).

(l) For discharges occurring on or after April 1, 1988, the additional payment amount for the DRGs related to burn cases, which are identified in the most recent annual notice of prospective payment rates published in accordance with § 412.8(b), is computed under the provisions of paragraph (k) of this section except that the payment is made using 90 percent of the difference

between the hospital's adjusted cost for the discharge and the threshold criteria.

(m) Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under paragraph (i)(4) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment will be based upon a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 35689, Sept. 3, 1985; 51 FR 31496, Sept. 3, 1986; 53 FR 38529, Sept. 30, 1988; 54 FR 36494, Sept. 1, 1989; 55 FR 15174, Apr. 20, 1990; 56 FR 43448, Aug. 30, 1991; 57 FR 39823, Sept. 1, 1992; 59 FR 45398, Sept. 1, 1994; 62 FR 46028, Aug. 29, 1997; 68 FR 34515, June 9, 2003; 71 FR 48138, Aug. 18, 2006]

PAYMENT ADJUSTMENT FOR CERTAIN CLINICAL TRIAL CASES AND EXPANDED ACCESS USE IMMUNOTHERAPY

§ 412.85 Payment adjustment for certain immunotherapy cases.

(a) *General rule.* For discharges occurring on or after October 1, 2020, the amount of payment for a discharge described in paragraph (b) of this section is adjusted as described in paragraph (c) of this section.

(b) *Discharges subject to payment adjustment.* Payment is adjusted in accordance with paragraph (c) of this section for discharges assigned to MS–DRG 018 involving expanded access use of immunotherapy or that are part of an applicable clinical trial as determined by CMS based on the reporting of a diagnosis code indicating the encounter is part of a clinical research program on the claim for the discharge or, for discharges occurring on or after October 1, 2025, other cases where the immunotherapy product is not purchased in the usual manner, such as provided at no cost.

(c) *Adjustment.* The DRG weighting factor determined under § 412.60(b) is adjusted by a factor that reflects the average cost for cases assigned to MS–DRG 018 that involve expanded access use of immunotherapy, are part of an applicable clinical trial, or where the immunotherapy product is not purchased in the usual manner, such as provided at no cost, to the average cost for all other cases assigned to MS–DRG 018.

[85 FR 59020, Sept. 18, 2020, as amended at 90 FR 37200, Aug. 4, 2025]

§ 412.83 Payment for extraordinarily high-cost day outliers.

For discharges occurring before October 1, 1997, if a discharge that qualifies for an additional payment under the provisions of § 412.82 has charges adjusted to costs that exceed the cost outlier threshold criteria for an extraordinarily high-cost case as set forth in § 412.80(a)(1)(ii), the additional payment made for the discharge is the greater of—

(a) The applicable per diem payment computed under § 412.82 (c) or (d); or

(b) The payment that would be made under § 412.84 (i) or (j) if the case had not met the day outlier criteria threshold set forth in § 412.80(a)(1)(i).

[53 FR 38529, Sept. 30, 1988, as amended at 62 FR 46028, Aug. 29, 1997. Redesignated at 85 FR 59020, Sept. 18, 2020]

412.86 [Reserved]

ADDITIONAL SPECIAL PAYMENT FOR CERTAIN NEW TECHNOLOGY

§ 412.87 Additional payment for new medical services and technologies: General provisions.

(a) *Basis.* Sections 412.87 and 412.88 implement sections 1886(d)(5)(K) and 1886(d)(5)(L) of the Act, which authorize the Secretary to establish a mechanism to recognize the costs of new medical services and technologies under the hospital inpatient prospective payment system.

(b) *Eligibility criteria.* For discharges occurring on or after October 1, 2001, CMS provides for additional payments (as specified in § 412.88) beyond the standard DRG payments and outlier payments to a hospital for discharges involving covered inpatient hospital services that are new medical services and technologies, if the following conditions are met:

(1) A new medical service or technology represents an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.

(i) The totality of the circumstances is considered when making a determination that a new medical service or technology represents an advance that substantially improves, relative to services or technologies previously available, the diagnosis or treatment of Medicare beneficiaries.

(ii) A determination that a new medical service or technology represents an advance that substantially improves, relative to services or technologies previously available, the diagnosis or treatment of Medicare beneficiaries means one of the following:

(A) The new medical service or technology offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments.

(B) The new medical service or technology offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable, or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods and there must also be evidence that use of the new medical service or technology to make a diagnosis affects the management of the patient.

(C) The use of the new medical service or technology significantly improves clinical outcomes relative to services or technologies previously available as demonstrated by one or more of the outcomes described in paragraphs (b)(1)(ii)(C(*1*) through (*7*) of this section.

(*1*) A reduction in at least one clinically significant adverse event, including a reduction in mortality or a clinically significant complication.

(*2*) A decreased rate of at least one subsequent diagnostic or therapeutic intervention.

(*3*) A decreased number of future hospitalizations or physician visits.

(*4*) A more rapid beneficial resolution of the disease process treatment including, but not limited to, a reduced length of stay or recovery time

(*5*) An improvement in one or more activities of daily living

(*6*) An improved quality of life

(*7*) A demonstrated greater medication adherence or compliance.

(D) The totality of the information otherwise demonstrates that the new medical service or technology substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.

(iii) Evidence from published or unpublished information sources from within the United States or elsewhere may be sufficient to establish that a new medical service or technology represents an advance that substantially improves, relative to services or technologies previously available, the diagnosis or treatment of Medicare beneficiaries. Information source may include the following:

(A) Clinical trials;

(B) Peer reviewed journal articles;

(C) Study results;

(D) Meta-analyses;

(E) Consensus statements;

(F) White papers;

(G) Patient surveys;

(H) Case studies;

(I) Reports;

(J) Systematic literature reviews;

(K) Letters from major healthcare associations;

(L) Editorials and letters to the editor; and,

(M) Public comments.

(N) Other appropriate information sources may be considered.

(iv) The medical condition diagnosed or treated by the new medical service or technology may have a low prevalence among Medicare beneficiaries.

(v) The new medical service or technology may represent an advance that substantially improves, relative to services or technologies previously available, the diagnosis or treatment of a subpopulation of patients with the medical condition diagnosed or treated by the new medical service or technology.

(2) A medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the inpatient hospital code (as defined in section 1886(d)(5)(K)(iii) of the Social

Security Act) assigned to the new service or technology (depending on when a new code is assigned and data on the new service or technology become available for DRG recalibration). After CMS has recalibrated the DRGs, based on available data, to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered ''new'' under the criterion of this section.

(3) The DRG prospective payment rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate, based on application of a threshold amount to estimated charges incurred with respect to such discharges. To determine whether the payment would be adequate, CMS will determine whether the charges of the cases involving a new medical service or technology will exceed a threshold amount that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation beyond the geometric mean standardized charge for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs if the new medical service or technology occurs in many different DRGs). Standardized charges reflect the actual charges of a case adjusted by the prospective payment system payment factors applicable to an individual hospital, such as the wage index, the indirect medical education adjustment factor, and the disproportionate share adjustment factor.

(c) *Eligibility criteria for alternative pathway for certain transformative new devices.* For discharges occurring on or after October 1, 2020, CMS provides for additional payments (as specified in § 412.88) beyond the standard DRG payments and outlier payments to a hospital for discharges involving covered inpatient hospital services that are new medical devices, if the following conditions are met:

(1) A new medical device is part of the Food and Drug Administration's (FDA) Breakthrough Devices Program and has received marketing authorization for the indication covered by the Breakthrough Device designation.

(2) A medical device that meets the condition in paragraph (c)(1) of this section will be considered new for not less than 2 years and not more than 3 years after the point at which data begin to become available reflecting the inpatient hospital code (as defined in section 1886(d)(5)(K)(iii) of the Social Security Act) assigned to the new technology (depending on when a new code is assigned and data on the new technology become available for DRG recalibration). After CMS has recalibrated the DRGs, based on available data, to reflect the costs of an otherwise new medical technology, the medical technology will no longer be considered ''new'' under the criterion of this section.

(3) The new medical device meets the conditions described in paragraph (b)(3) of this section.

(d) *Eligibility criteria for alternative pathway for certain antimicrobial products.* (1)(i) A new medical product is designated by FDA as a Qualified Infectious Disease Product and has received marketing authorization for the indication covered by the Qualified Infectious Disease Product designation; or

(ii) For discharges occurring on or after October 1, 2021, a new medical product is approved under FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD) and used for the indication approved under the LPAD pathway.

(2) A medical product that meets the condition in paragraph (d)(1) of this section will be considered new for not less than 2 years and not more than 3 years after the point at which data begin to become available reflecting the inpatient hospital code (as defined in section 1886(d)(5)(K)(iii) of the Social Security Act) assigned to the new technology (depending on when a new code is assigned and data on the new technology become available for DRG recalibration). After CMS has recalibrated the DRGs, based on available data, to reflect the costs of an otherwise new medical technology, the medical technology will no longer be considered ''new'' under the criterion of this section.

(3) The new medical product meets the conditions described in paragraph (b)(3) of this section.

(e) *FDA status requirement.* CMS only considers, for add-on payments for a particular fiscal year, an application for which one of the following conditions are met at the time of new technology add-on payment application submission:

(1) The new medical service or technology is FDA market authorized for the indication that is the subject of the new technology add-on payment application.

(2) The new medical service or technology is the subject of a complete and active FDA marketing authorization request and documentation of FDA acceptance or filing of the request is provided to CMS.

(f) *Announcement of determinations and deadline for consideration of new medical service or technology applications, and conditional approval for certain antimicrobial products.* (1) CMS will consider whether a new medical service or technology meets the eligibility criteria specified in paragraph (b), (c), or (d) of this section and announce the results in the FEDERAL REGISTER as part of its annual updates and changes to the IPPS. CMS will only consider any particular new medical service or technology for add-on payments under paragraph (b), (c), or (d) of this section.

(2) Except as provided for in paragraph (f)(3) of this section, CMS only considers, for add-on payments for a particular fiscal year, an application for which the new medical service or technology has received FDA marketing authorization by May 1 prior to the particular fiscal year.

(3) A technology for which an application is submitted under an alternative pathway for certain antimicrobial products under paragraph (d) of this section that does not receive FDA marketing authorization by July 1 prior to the particular fiscal year for which the applicant applied for new technology add-on payments may be conditionally approved for the new technology add-on payment for that fiscal year, effective for discharges beginning in the first quarter after FDA marketing authorization is granted, provided that FDA marketing authorization is granted before July 1 of the fiscal year for which the applicant applied for new technology add-on payments.

[66 FR 46924, Sept. 7, 2001, as amended at 68 FR 45469, Aug. 1, 2003; 69 FR 49243, Aug. 11, 2004; 73 FR 48755, Aug. 19, 2008; 74 FR 43997, Aug. 27, 2009; 82 FR 38511, Aug. 14, 2017; 84 FR 42611, Aug. 16, 2019; 85 FR 59020, Sept. 18, 2020; 88 FR 59331, Aug. 28, 2023]

§ 412.88 Additional payment for new medical service or technology.

(a) For discharges involving new medical services or technologies that meet the criteria specified in § 412.87, Medicare payment will be:

(1) One of the following:

(i) The full DRG payment (including adjustments for indirect medical education and disproportionate share but excluding outlier payments);

(ii) The payment determined under § 412.4(f) for transfer cases;

(iii) The payment determined under § 412.92(d) for sole community hospitals; or

(iv) The payment determined under § 412.108(c) for Medicare-dependent hospitals; plus

(2)(i) *For discharges occurring before October 1, 2019.* If the costs of the discharge (determined by applying the operating cost-to-charge ratios as described in § 412.84(h)) exceed the full DRG payment, an additional amount equal to the lesser of—

(A) 50 percent of the costs of the new medical service or technology; or

(B) 50 percent of the amount by which the costs of the case exceed the standard DRG payment.

(ii) *For discharges occurring on or after October 1, 2019.* (A) Except as provided under paragraph (a)(2)(ii)(B) of this section, if the costs of the discharge (determined by applying the operating cost-to-charge ratios as described in § 412.84(h)) exceed the full DRG payment, an additional amount equal to the lesser of—

(*1*) 65 percent of the costs of the new medical service or technology; or

(*2*) 65 percent of the amount by which the costs of the case exceed the standard DRG payment.

(B) For a medical product designated by FDA as a Qualified Infectious Disease Product or, for discharges occurring on or after October 1, 2020, for a product approved under FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs, if the costs of the discharge (determined by applying the operating cost-to-charge ratios as described in § 412.84(h)) exceed the full DRG payment, an additional amount equal to the lesser of—

(*1*) 75 percent of the costs of the new medical service or technology; or

(*2*) 75 percent of the amount by which the costs of the case exceed the standard DRG payment.

(C) For a medical product that is a gene therapy that is indicated and used specifically for the treatment of sickle cell disease and approved for new technology add-on payments in the FY 2025 IPPS/LTCH PPS final rule, for discharges occurring on or after October 1, 2024, if the costs of the discharge (determined by applying the operating cost-to-charge ratios as described in § 412.84(h)) exceed the full DRG payment, an additional amount equal to the lesser of—

(*1*) 75 percent of the costs of the new medical service or technology; or

(*2*) 75 percent of the amount by which the costs of the case exceed the standard DRG payment.

(b)(1) *For discharges occurring before October 1, 2019.* Unless a discharge case qualifies for outlier payment under § 412.84, Medicare will not pay any additional amount beyond the DRG payment plus 50 percent of the estimated costs of the new medical service or technology.

(2) *For discharges occurring on or after October 1, 2019.* Unless a discharge case qualifies for outlier payment under § 412.84, Medicare will not pay any additional amount beyond the DRG payment plus—

(i) 65 percent of the estimated costs of the new medical service or technology;

(ii) For a medical product designated by FDA as a Qualified Infectious Disease Product, 75 percent of the estimated costs of the new medical service or technology; or

(iii) For discharges occurring on or after October 1, 2020, for a product approved under FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs, 75 percent of the estimated costs of the new medical service or technology.

(iv) For discharges occurring on or after October 1, 2024, for a medical product that is a gene therapy that is indicated and used specifically for the treatment of sickle cell disease and approved for new technology add-on payments in the FY 2025 IPPS/LTCH PPS final rule, 75 percent of the estimated costs of the new medical service or technology.

[66 FR 46924, Sept. 7, 2001, as amended at 67 FR 50111, Aug. 1, 2002; 69 FR 49244, Aug. 11, 2004; 72 FR 47411, Aug. 22, 2007; 84 FR 42612, Aug. 16, 2019; 85 FR 59021, Sept. 18, 2020; 89 FR 69910, Aug. 28, 2024]

PAYMENT ADJUSTMENT FOR CERTAIN REPLACED DEVICES

§ 412.89 Payment adjustment for certain replaced devices.

(a) *General rule.* For discharges occurring on or after October 1, 2007, the amount of payment for a discharge described in paragraph (b) of this section is reduced when—

(1) A device is replaced without cost to the hospital;

(2) The provider received full credit for the cost of a device; or

(3) The provider receives a credit equal to 50 percent or more of the cost of the device.

(b) *Discharges subject to payment adjustment.* (1) Payment is reduced in accordance with paragraph (a) of this section only if the implantation of the device determines the DRG assignment.

(2) CMS lists the DRGs that qualify under paragraph (b)(1) of this section in the annual final rule for the hospital inpatient prospective payment system.

(c) *Amount of reduction.* (1) For a device provided to the hospital without cost, the cost of the device is subtracted from the DRG payment.

[72 FR 47411, Aug. 22, 2007]

Subpart G—Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Operating Costs

§ 412.90 General rules.

(a) *Sole community hospitals.* CMS may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hosptials, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries. If a hospital meets the criteria for such an exception under § 412.92(a), its prospective payment rates for inpatient operating costs are determined under § 412.92(d).

(b) *Referral center.* CMS may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital acts as a referral center for patients transferred from other hospitals. Criteria for identifying such referral centers are set forth in § 412.96.

(c) [Reserved]

(d) *Kidney acquisition costs incurred by hospitals with approved kidney transplant programs.* CMS pays for kidney acquisition costs incurred by kidney transplant programs on a reasonable cost basis. The criteria for this special payment provision are set forth in § 412.100.

(e) *Hospitals located in areas that are reclassified from urban to rural.* (1) CMS adjusts the rural Federal payment amounts for inpatient operating costs for hospitals located in geographic areas that are reclassified from urban to rural as defined in subpart D of this part. This adjustment is set forth in § 412.102.

(2) CMS establishes a procedure by which certain individual hospitals located in urban areas may apply for reclassification as rural. The criteria for reclassification are set forth in § 412.103.

(f) *Hospitals that have a high percentage of ESRD beneficiary discharges.* CMS makes an additional payment to a hospital if ten percent or more of its total Medicare discharges in a cost reporting period beginning on or after October 1, 1984 are ESRD beneficiary discharges. In determining ESRD discharges, discharges in DRG Nos. 302, 316, and 317 are excluded. The criteria for this additional payment are set forth in § 412.104.

(g) *Hosptials that incur indirect costs for graduate medical education programs.* CMS makes an additional payment for inpatient operating costs to a hospital for indirect medical education costs attributable to an approved graduate medical education program. The criteria for this additional payment are set forth in § 412.105.

(h) *Hospitals that serve a disproportionate share of low-income patients.* For discharges occurring on or after May 1, 1986, CMS makes an additional payment for inpatient operating costs to hospitals that serve a disproportionate share of low-income patients. The criteria for this additional payment are set forth in § 412.106.

(i) *Hospitals that receive an additional update for FYs 1998 and 1999.* For FYs 1998 and 1999, CMS makes an upward adjustment to the standardized amounts for certain hospitals that do not receive indirect medical education or disproportionate share payments and are not Medicare- dependent, small rural hospitals. The criteria for identifying these hospitals are set forth in § 412.107.

(j) *Medicare-dependent, small rural hospitals.* For cost reporting periods beginning on or after April 1, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997 and before October 1, 2025, CMS adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part if a hospital is classified as a Medicare-dependent, small rural hospital.

(k) *Essential access community hospitals (EACHs).* If a hospital was designated as an EACH by CMS as described in § 412.109(a) and is located in a rural area as defined in § 412.109(b), CMS determines the prospective payment rate for that hospital, as it does

for sole community hospitals, under § 412.92(d).

[57 FR 39823, Sept. 1, 1992, as amended at 58 FR 30669, May 26, 1993; 62 FR 46028, Aug. 29, 1997; 64 FR 67051, Nov. 30, 1999; 65 FR 47047, Aug. 1, 2000; 70 FR 47485, Aug. 12, 2005; 71 FR 48138, Aug. 18, 2006; 82 FR 38511, Aug. 14, 2017; 83 FR 41701, Aug. 17, 2018; 86 FR 73511, Dec. 27, 2021; 88 FR 59331, Aug. 28, 2023; 89 FR 69910, Aug. 28, 2024; 90 FR 37200, Aug. 4, 2025]

§ 412.92 Special treatment: Sole community hospitals.

(a) *Criteria for classification as a sole community hospital.* CMS classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in § 412.64) and meets one of the following conditions:

(1) The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:

(i) No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area;

(ii) The hospital has fewer than 50 beds and the MAC certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital; or

(iii) Because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(2) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

(4) 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 (a)(1)(i) and (ii) of this section are met. For the mileage and rural location criteria in paragraph (a) of this section and the mileage, accessibility, and travel time criteria specified in paragraphs (a)(1) through (3) of this section, the hospital must demonstrate that the main campus and its remote location(s) each independently satisfy those requirements.

(b) *Classification procedures*—(1) *Request for classification as sole community hospital.* (i) The hospital must make its request to its MAC.

(ii) If a hospital is seeking sole community hospital classification under paragraph (a)(1)(i) or (a)(1)(ii) of this section, the hospital must include the following information with its request:

(A) The hospital must provide patient origin data (for example, the number of patients from each zip code from which the hospital draws inpatients) for all inpatient discharges to document the boundaries of its service area.

(B) The hospital must provide patient origin data from all other hospitals located within a 35 mile radius of it or, if larger, within its service area, to document that no more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care.

(iii)(A) If the hospital is unable to obtain the information required under paragraph (b)(1)(ii)(A) of this section concerning the residences of Medicare beneficiaries who were inpatients in other hospitals located within a 35 mile radius of the hospital or, if larger, within the hospital's service area, the hospital may request that CMS provide this information.

(B) If a hospital obtains the information as requested under paragraph (b)(1)(iii)(A) of this section, that information is used by both the MAC and CMS in making the determination of the residences of Medicare beneficiaries under paragraphs (b)(1)(iii) and (b)(1)(iv) of this section, regardless of any other information concerning the residences of Medicare beneficiaries submitted by the hospital.

(iv) The MAC reviews the request and send the request, with its recommendation, to CMS.

(v) CMS reviews the request and the MAC's recommendation and forwards its approval or disapproval to the MAC.

(2) *Effective dates of classification.*(i) For applications received on or before September 30, 2018, sole community hospital status is effective 30 days after the date of CMS' written notification of approval, except as provided in paragraph (b)(2)(v) of this section. For applications received on or after October 1, 2018, sole community hospital status is effective as of the date the MAC receives the complete application, except as provided in paragraphs (b)(2)(v) and (vi) of this section.

(ii) When a court order or a determination by the Provider Reimbursement Review Board (PRRB) reverses a CMS denial of sole community hospital status and no further appeal is made, the sole community hospital status is effective as follows:

(A) If the hospital's application was submitted prior to October 1, 1983, its status as a sole community hospital is effective at the start of the cost reporting period for which it sought exemption from the cost limits.

(B) If the hospital's application for sole community hospital status was received on or after October 1, 1983 and on or before September 30, 2018, the effective date is 30 days after the date of CMS' original written notification of denial.

(C) If the hospital's application for sole community hospital status was received on or after October 1, 2018, the effective date is as provided in paragraph (b)(2)(i) of this section.

(iii) When a hospital is granted retroactive approval of sole community hospital status by a court order or a PRRB decision and the hospital wishes its sole community hospital status terminated before the date of the court order or PRRB determination, it must submit written notice to the CMS regional office within 90 days of the court order or PRRB decision. A written request received after the 90-day period is effective no later than 30 days after the request is submitted.

(iv) For applications received on or before September 30, 2018, a hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after 30 days after the date of CMS' approval of the classification. For applications received on or after October 1, 2018, a hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after the effective date as provided in paragraph (b)(2)(i) of this section.

(v) If a hospital that is classified as an MDH under § 412.108 applies for classification as a sole community hospital because its status under the MDH program expires with the expiration of the MDH program, and that hospital's sole community hospital status is approved, the effective date of approval of sole community hospital status is the day following the expiration date of the MDH program if the hospital—

(A) Applies for classification as a sole community hospital prior to 30 days before the expiration of the MDH program; and

(B) Requests that sole community hospital status be effective with the expiration of the MDH program.

(vi) For applications received on or after October 1, 2023, where eligibility for sole community hospital classification is dependent on the hospital's merger with another hospital, sole community hospital status is effective as of the effective date of the approved merger if, and only if, the date that the Medicare administrative contractor (MAC) receives the complete application is within 90 days of CMS' written notification to the hospital of the approval of the merger.

(3) *Duration of classification.* (i) An approved classification as a sole community hospital remains in effect without

need for reapproval unless there is a change in the circumstances under which the classification was approved. An approved sole community hospital must notify the MAC if any change that is specified in paragraph (b)(3)(ii) of this section occurs. If CMS determines that a sole community hospital failed to comply with this requirement, CMS will cancel the hospital's classification as a sole community hospital effective with the date that the hospital no longer met the criteria for such classification, consistent with the provisions of § 405.1885 of this chapter.

(ii) A sole community hospital must report the following to the MAC within 30 days of the event:

(A) The opening of a new hospital in its service area.

(B) The opening of a new road between itself and a like provider within 35 miles.

(C) An increase in the number of beds to more than 50 if the hospital qualifies as a sole community hospital under paragraph (a)(1)(ii) of this section.

(D) Its geographic classification changes.

(E) Any changes to the driving conditions that result in a decrease in the amount of travel time between itself and a like provider if the hospital qualifies as a sole community hospital under paragraph (a)(3) of this section.

(iii) A sole community hospital must report to the MAC if it becomes aware of any change that would affect its classification as a sole community hospital beyond the events listed in paragraph (b)(3)(ii) of this section within 30 days of the event. If CMS determines that a sole community hospital has failed to comply with this requirement, CMS will cancel the hospital's classification as a sole community hospital effective with the date the hospital became aware of the event that resulted in the sole community hospital no longer meeting the criteria for such classification, consistent with the provisions of § 405.1885 of this chapter.

(iv) A sole community hospital must report to the MAC any factor or information that could have affected its initial classification as a sole community hospital.

(A) If CMS determines that a sole community hospital has failed to comply with the requirement of paragraph ((b)(3)(iv) of this section, CMS may cancel the hospital's classification as a sole community hospital effective with the date the hospital failed to meet the criteria for such classification, consistent with the provisions of § 405.1885 of this chapter.

(B) Effective on or after October 1, 2012, if a hospital reports to CMS any factor or information that could have affected its initial determination and CMS determines that the hospital should not have qualified for sole community hospital status, CMS will cancel the sole community hospital status effective 30 days from the date of the determination.

(4) *Cancellation of classification.* (i) A hospital may at any time request cancellation of its classification as a sole community hospital, and be paid at rates determined under subparts D and E of this part, as appropriate.

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

(iii) If a hospital requests that its sole community hospital classification be cancelled, it may not be reclassified as a sole community hospital unless it meets the following conditions:

(A) At least one full year has passed since the effective date of its cancellation.

(B) The hospital meets the qualifying criteria set forth in paragraph (a) of this section in effect at the time it reapplies.

(5) *Automatic classification as a sole community hospital.* A hospital that has been granted an exemption from the hospital cost limits before October 1, 1983, or whose request for the exemption was received by the appropriate intermediary before October 1, 1983, and was subsequently approved, is automatically classified as a sole community hospital unless that classification has been cancelled under paragraph (b)(3) of this section, or there is a change in the circumstances under which the classification was approved.

(c) *Terminology.* As used in this section—

(1) The term *miles* means the shortest distance in miles measured over improved roads. An improved road for

this purpose is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the hospital.

(2) The term *like hospital* means a hospital furnishing short-term, acute care. Effective with cost reporting periods beginning on or after October 1, 2002, for purposes of a hospital seeking sole community hospital designation, CMS will not consider the nearby hospital to be a like hospital if the total inpatient days attributable to units of the nearby hospital that provides a level of care characteristic of the level of care payable under the acute care hospital inpatient prospective payment system are less than or equal to 8 percent of the similarly calculated total inpatient days of the hospital seeking sole community hospital designation.

(3) The term *service area* means the area from which a hospital draws at least 75 percent of its inpatients during the most recent 12-month cost reporting period ending before it applies for classification as a sole community hospital. If the most recent cost reporting period ending before the hospital applies for classification as a sole community hospital is for less than 12 months, the hospital's most recent 12-month or longer cost reporting period before the short period is used.

(d) *Determining prospective payment rates for inpatient operating costs for sole community hospitals*—(1) *General rule.* For cost reporting periods beginning on or after April 1, 1990, a sole community hospital is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period:

(i) The Federal payment rate applicable to the hospitals as determined under subpart D of this part.

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

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

(iv) For cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate as determined under § 412.77 (calculated under the transition schedule set forth in paragraph (d)(2) of this section).

(v) For cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate as determined under § 412.78.

(2) *Transition of FY 1996 hospital-specific rate.* The MAC calculates the hospital-specific rate determined on the basis of the fiscal year 1996 base period rate as follows:

(i) For Federal fiscal year 2001, the hospital-specific rate is the sum of 75 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 25 percent of the hospital-specific rate as determined under § 412.77.

(ii) For Federal fiscal year 2002, the hospital-specific rate is the sum of 50 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 50 percent of the hospital-specific rate as determined under § 412.77.

(iii) For Federal fiscal year 2003, the hospital-specific rate is the sum of 25 percent of the greater of the amounts specified in paragraph (d)(1)(i), (d)(1)(ii), or (d)(1)(iii) of this section, plus 75 percent of the hospital-specific rate as determined under § 412.77.

(iv) For Federal fiscal year 2004 and any subsequent fiscal years, the hospital-specific rate is 100 percent of the hospital-specific rate specified in paragraph (d)(1)(iv) of this section.

(3) *Adjustment to payments.* A sole community hospital may receive an adjustment to its payments to take into account a significant decrease in the number of discharges, as described in paragraph (e) of this section.

(e) *Additional payments to sole community hospitals experiencing a significant volume decrease.* (1) For cost reporting periods beginning on or after October 1, 1983, the MAC provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (e)(2) of this section a more than five percent decrease in its total discharges of inpatients 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 sole community hospital must submit its request no later than 180 days after the date on the MAC's Notice of Amount of Program Reimbursement—

(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) Effective for cost reporting periods beginning before October 1, 2017, the MAC determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on 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). Effective for cost reporting periods beginning on or after October 1, 2017, the MAC determines a 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.govinfo.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 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 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 2026 and subsequent 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 2025, 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 2026 and subsequent 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 2025, 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; 89 FR 69911, Aug. 28, 2024; 90 FR 37201, Aug. 4, 2025]

§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 basis of an additional amount that equals two-thirds of the difference between the urban standardized amount and disproportionate share payments applicable to the hospital before its geographic redesignation and the rural standardized amount and disproportionate share payments otherwise applicable to the Federal fiscal year for which the adjustment is made.

(2) Effective on or after October 1, 2014, the hospital's rural disproportionate share payments as described in §412.106 are adjusted on the basis of an additional amount that equals two-thirds of the difference between the disproportionate share payments as an urban hospital applicable to the hospital before its geographic redesignation to a rural area as a result of implementation of the most recent OMB standards for delineating statistical areas adopted by CMS and the rural disproportionate share payment otherwise applicable to the Federal fiscal year for which the adjustment is made.

(b) *Second year adjustment.* (1) Effective on or after October 1, 1983 and before October 1, 2014, if a hospital's status continues to be rural as a result of geographic redesignation, its rural average standardized amount and disproportionate share payments are adjusted on the basis of an additional amount that equals one-third of the difference between the urban standardized amount and disproportionate share payments applicable to the hospital before its redesignation and the rural standardized amounts and disproportionate share payments otherwise applicable to the Federal fiscal year for which the adjustment is made.

(2) Effective on or after October 1, 2014, if a hospital's status continues to be rural as a result of geographic redesignation, its disproportionate share payments are adjusted on the basis of an additional amount that equals one-

third of the difference between the disproportionate share payments applicable to the hospital before its geographic redesignation to a rural area as a result of implementation of the most recent OMB standards for delineating statistical areas adopted by CMS and the rural disproportionate share payments otherwise applicable to the Federal fiscal year for which the adjustment is made.

[79 FR 50353, Aug. 22, 2014]

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

(1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, using the Rural-Urban Commuting Area codes and additional criteria, as determined by the Federal Office of Rural Health Policy (FORHP) of the Health Resources and Services Administration (HRSA), which is available at the web link provided in the most recent FEDERAL REGISTER notice issued by HRSA defining rural areas.

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.

(4) For any period after September 30, 2004 and before October 1, 2006, a CAH in a county that, in FY 2004, was not part of a MSA as defined by the Office of Management and Budget, but as of FY 2005 was included as part of an MSA as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003, may be reclassified as being located in a rural area for purposes of meeting the rural location requirement in § 485.610(b) of this chapter if it meets any of the requirements in paragraphs (a)(1), (a)(2), or (a)(3) of this section.

(5) For any period after September 30, 2009, and before October 1, 2011, a CAH in a county that, in FY 2009, was not part of an MSA as defined by the Office of Management and Budget, but, as of FY 2010, was included as part of an MSA as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on November 20, 2008, may be reclassified as being located in a rural area for purposes of meeting the rural location requirement in § 485.610(b) of this chapter if it meets any of the requirements under paragraph (a)(1), (a)(2), or (a)(3) of this section.

(6) For any period on or after October 1, 2014, a CAH in a county that was not in an urban area as defined by the Office of Management and Budget (OMB), but was included in an urban area as a result of the most recent OMB standards for delineating statistical areas adopted by CMS and the most recent Census Bureau data, may be reclassified as being located in a rural area for purposes of meeting the rural location requirement at § 485.610(b) of this chapter for a period of 2 years, beginning with the date of the implementation of the new labor market area delineations, if it meets any of the requirements under paragraph (a)(1), (a)(2), or (a)(3) of this section.

(7) 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, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

(8) 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, approved rural reclassification status applies to the main campus and any remote location located in an urban area (as defined in §412.64(b) and including a main campus or any remote location deemed urban under section 1886(d)(8)(B) of the Act).

(b) *Application requirements*—(1) *Written application.* A hospital seeking reclassification under this section must submit a complete application in writing to CMS in accordance with paragraphs (b)(2) and (b)(3) of this section.

(2) *Contents of application.* An application is complete if it contains an explanation of how the hospital meets the condition that constitutes the basis of the request for reclassification set forth in paragraph (a) of this section, including data and documentation necessary to support the request.

(3) *Submission of application.* An application may be submitted to the CMS Regional Office by the requesting hospital by mail or by facsimile or other electronic means.

(4) *Notification by CMS.* Within 5 business days after receiving the hospital's application, the CMS Regional Office will send the hospital a letter acknowledging receipt, with a copy to the CMS Central Office.

(5) *Filing date.* The filing date of the application is the date CMS receives the application.

(6) *Lock-in date for the wage index calculation and budget neutrality.* In order for a hospital to be treated as rural in the wage index and budget neutrality calculations under §412.64(e)(1)(ii), (e)(2) and (4), and (h) for the payment rates for the next Federal fiscal year, the hospital's application must be approved by the CMS Regional Office in accordance with the requirements of this section no later than 60 days after the public display date at the Office of the Federal Register of the inpatient prospective payment system proposed rule for the next Federal fiscal year.

(c) *CMS review.* The CMS Regional Office will review the application and notify the hospital of its approval or disapproval of the request within 60 days of the filing date.

(d) *Effective dates of reclassification.* (1) Except as specified in paragraphs (d)(2) and (3) of this section, CMS will consider a hospital that satisfies any of the criteria set forth in paragraph (a) of this section as being located in the rural area of the State in which the hospital is located as of that filing date.

(2) If a hospital's complete application is received in CMS by September 1, 2000, and satisfies any of the criteria set forth in paragraph (a) of this section, CMS will consider the filing date to be January 1, 2000.

(3) CMS will consider a hospital that satisfies the criteria set forth in paragraph (a)(3) of this section and which qualifies for sole community hospital status in accordance with the requirements of §412.92(b)(2)(vi) as being located in the rural area of the State in which the hospital is located as of the effective date set forth in §412.92(b)(2)(vi).

(e) *Withdrawal of application.* A hospital may withdraw an application at any time prior to the date of CMS's decision as set forth in paragraph (c) of this section.

(f) *Duration of classification.* An approved reclassification under this section remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved.

(g) *Cancellation of classification*—(1) *Hospitals other than rural referral centers.* Except as provided in paragraph (g)(2) of this section—

(i) A hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office not less than 120 days prior to the end of its current cost reporting period.

(ii) The hospital's cancellation of the classification is effective beginning with the next full cost reporting period.

(iii) The provisions of paragraphs (g)(1)(i) and (ii) of this section are effective for all written requests submitted by hospitals before October 1, 2019 to cancel rural reclassifications.

(2) *Hospitals classified as rural referral centers.* For a hospital that was classified as a rural referral center under

§ 412.96 based on rural reclassification under this section—

(i) A hospital may cancel its rural reclassification by submitting a written request to the CMS Regional Office not less than 120 days prior to the end of a Federal fiscal year and after being paid as rural for at least one 12-month cost reporting period.

(ii) The hospital's cancellation of the classification is not effective until it has been paid as rural for at least one 12-month cost reporting period, and not until the beginning of the Federal fiscal year following such 12-month cost reporting period.

(iii) The provisions of paragraphs (g)(2)(i) and (ii) of this section are effective for all written requests submitted by hospitals on or after October 1, 2007 and before October 1, 2019, to cancel rural reclassifications.

(3) *Cancellation of rural reclassification on or after October 1, 2019, and before October 1, 2021.* For all written requests submitted by hospitals on or after October, 1, 2019, and before 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 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.

(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 period. This count of available bed days excludes bed days associated with—

(1) Beds in a unit or ward that is not occupied to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system at any time during the 3 preceding months (the beds in the unit or ward are to be excluded from the determination of available bed days during the current month);

(2) Beds in a unit or ward that is otherwise occupied (to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system) that could not be made available for inpatient occupancy within 24 hours for 30 consecutive days;

(3) Beds in excluded distinct part hospital units;

(4) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or inpatient hospice services.

(5) Beds or bassinets in the healthy newborn nursery; and

(6) Custodial care beds.

(c) *Measurement for teaching activity.* The factor representing the effect of teaching activity on inpatient operating costs equals .405 for discharges occurring on or after May 1, 1986.

(d) *Determination of education adjustment factor.* Each hospital's education adjustment factor is calculated as follows:

(1) *Step one.* A factor representing the sum of 1.00 plus the hospital's ratio of full-time equivalent residents to beds, as determined under paragraph (a)(1) of this section, excluding beds temporarily added during the time frame that the Public Health Emergency as defined in § 400.200 of this chapter is in effect, is raised to an exponential power equal to the factor set forth in paragraph (c) of this section.

(2) *Step two.* The factor derived from step one is reduced by 1.00.

(3) *Step three.* The factor derived from completing steps one and two is multiplied by ''c'', and where ''c'' is equal to the following:

(i) For discharges occurring on or after October 1, 1988, and before October 1, 1997, 1.89.

(ii) For discharges occurring during fiscal year 1998, 1.72.

(iii) For discharges occurring during fiscal year 1999, 1.6.

(iv) For discharges occurring during fiscal year 2000, 1.47.

(A) Each hospital receives an amount that is equal in the aggregate to the difference between the amount of payments made to the hospital if ''c'' equaled 1.6, rather than 1.47.

(B) The payment of this amount will not affect any other payments, determinations, or budget neutrality adjustments.

(v) For fiscal year 2001—

(A) For discharges occurring on or after October 1, 2000 and before April 1, 2001, 1.54.

(B) For discharges occurring on or after April 1, 2001 and before October 1, 2001, the adjustment factor is determined as if ''c'' equaled 1.66, rather than 1.54. This payment increase will not apply to discharges occurring after fiscal year 2001 and will not be taken into account in calculating the payment amounts applicable for discharges occurring after fiscal year 2001.

(vi) For discharges occurring during fiscal year 2002, 1.6.

(vii) For discharges occurring on or after October 1, 2002 and before April 1, 2004, 1.35.

(viii) For discharges occurring on or after April 1, 2004 and before October 1, 2004, 1.47.

(ix) For discharges occurring during fiscal year 2005, 1.42.

(x) For discharges occurring during fiscal year 2006, 1.37.

(xi) For discharges occurring during fiscal year 2007, 1.32.

(xii) For discharges occurring during fiscal year 2008 and thereafter, 1.35.

(4) For discharges occurring on or after July 1, 2005, with respect to FTE residents added as a result of increases in the FTE resident cap under paragraph (f)(1)(iv)(C) of this section, the factor derived from completing steps one and two is multiplied by 'c', where 'c' is equal to 0.66.

(e)(1) *Determination of payment amount.* Each hospital's indirect medical education payment under the prospective payment system for inpatient operating costs is determined by multiplying the total DRG revenue for inpatient operating costs, as determined under paragraph (a)(2) of this section, by the applicable education adjustment factor derived in paragraph (d) of this section.

(2) For discharges occurring on or after July 1, 2005, a hospital that counts additional residents as a result of an increase in its FTE resident cap under paragraph (f)(1)(iv)(C) of this section will receive indirect medical education payments based on the sum of the following two indirect medical education adjustment factors:

(i) An adjustment factor that is calculated using the schedule of formula multipliers in paragraph (d)(3) of this section and the hospital's FTE resident count, not including residents attributable to an increase in its FTE cap under paragraph (f)(1)(iv)(C) under this section; and

(ii) An adjustment factor that is calculated using the applicable formula multiplier under paragraph (d)(4) of this section, and the additional number of FTE residents that are attributable to the increase in the hospital's FTE resident cap under paragraph (f)(1)(iv)(C) in this section.

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.* (1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:

(i) The resident must be enrolled in an approved teaching program. An approved teaching program is one that meets one of the following requirements:

(A) Is approved by one of the national organizations listed in §415.152 of this chapter.

(B) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(*1*) The Directory of Graduate Medical Education Programs published by the American Medical Association.

(*2*) The Annual Report and Reference Handbook published by the American Board of Medical Specialties.

(C) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(D) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

(ii) In order to be counted, the resident must be assigned to one of the following areas:

(A) The portion of the hospital subject to the hospital inpatient prospective payment system.

(B) The outpatient department of a hospital that meets provider-based status as defined at §413.65(a)(2) of this subchapter.

(C) The portions of a hospital located in Puerto Rico that are subject to the hospital inpatient prospective payment system, including off-campus outpatient departments that meet provider-based status as defined at §413.65(a)(2) of this subchapter.

(D) The portions of a hospital that are reimbursed under a reimbursement system authorized under section 1814(b)(3) of the Act.

(E) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonprovider setting in patient care activities, as defined in §413.75(b) of this subchapter, under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth in §413.78(c), (d), (e), (f), or (g) of this subchapter, as applicable, are met.

(iii)(A) Full-time equivalent status is based on the total time necessary to fill a residency slot. No individual may be counted as more than one full-time equivalent. If a resident is assigned to more than one hospital, the resident counts as a partial full-time equivalent based on the proportion of time worked in any areas of the hospital listed in paragraph (f)(1)(ii) of this section to the total time worked by the resident. A hospital cannot claim the time spent by residents training at another hospital, unless the exception provided at §413.78(i) of this chapter applies. A part-time resident or one working in an area of the hospital other than those listed under paragraph (f)(1)(ii) of this section (such as a freestanding family practice center or an excluded hospital unit) would be counted as a partial full-time equivalent based on the proportion of time assigned to an area of the hospital listed in paragraph (f)(1)(ii) of this section, compared to the total time necessary to fill a full-time residency slot.

(B) The time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable.

(C) Effective for cost reporting periods beginning on or after January 1, 1983, except for research activities described in paragraph (f)(1)(iii)(B) of this section, the time a resident is training in an approved medical residency program in a hospital setting, as described in paragraphs (f)(1)(ii)(A) through (f)(1)(ii)(D) of this section, must be spent in either patient care activities, as defined in §413.75(b) of this subchapter, or in nonpatient care activities, such as didactic conferences and seminars, to be counted. This provision may not be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which, as of March 23, 2010, there is a jurisdictionally proper appeal pending on direct GME or IME payments.

(D) Effective for cost reporting periods beginning on or after January 1, 1983, the time spent by a resident in an approved medical residency program on vacation, sick leave, or other approved leave that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program is countable. This provision may not be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which, as of March 23, 2010, there is a jurisdictionally proper appeal pending on direct GME or IME payments.

(iv)(A) Effective for discharges occurring on or after October 1, 1997, the total number of FTE residents in the fields of allopathic and osteopathic medicine in either a hospital or a nonhospital setting that meets the criteria listed in paragraph (f)(1)(ii) of this section may not exceed the number of such FTE residents in the hospital (or, in the case of a hospital located in a rural area, effective for discharges occurring on or after April 1, 2000, 130 percent of that number) with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

(B)(*1*) Effective for portions of cost reporting periods beginning on or after July 1, 2005, a hospital's otherwise applicable FTE resident cap may be reduced if its reference resident level, as determined under §413.79(c)(1)(ii)(A) of this subchapter, is less than its otherwise applicable FTE resident cap in a reference cost reporting period, in accordance with the provisions of §413.79(c)(3) of this subchapter. The reduction is 75 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level.

(*2*) Effective for portions of cost reporting periods beginning on or after July 1, 2011, a hospital's otherwise applicable FTE resident cap may be reduced if its reference resident level, as

determined under §413.79(c)(1)(ii)(B) of this subchapter, is less than its otherwise applicable FTE resident cap in a reference cost reporting period, in accordance with the provisions of §413.79(m) of this subchapter. The reduction shall take into account the hospital's FTE resident cap as reduced under paragraph (f)(1)(iv)(B)(*1*). The reduction is 65 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level.

(C)(*1*) Effective for portions of cost reporting periods beginning on or after July 1, 2005, a hospital may qualify to receive an increase in its otherwise applicable FTE resident cap (up to 25 additional FTEs) if the criteria specified in §413.79(c)(4) of this subchapter are met.

(*2*) Effective for portions of cost reporting periods beginning on or after July 1, 2011, a hospital may qualify to receive an increase in its otherwise applicable FTE resident cap (up to 75 additional FTEs) if the criteria specified in §413.79(n) of this subchapter are met.

(*3*) Effective for portions of cost reporting periods beginning on or after July 1, 2023, a hospital may qualify to receive an increase in its otherwise applicable FTE resident cap if the criteria specified in §413.79(p) of this subchapter are met.

(*4*) Effective for portions of cost reporting periods beginning on or after July 1, 2026, a hospital may qualify to receive an increase in its otherwise applicable FTE resident cap if the criteria specified in §413.79(q) of this subchapter are met.

(D) A rural hospital redesignated as urban after September 30, 2004, as a result of the most recent census data and implementation of the new labor market area definitions announced by OMB on June 6, 2003, may retain the increases to its full-time equivalent resident cap that it received under paragraphs (f)(1)(iv)(A) and (f)(1)(vii) of this section while it was located in a rural area. Effective October 1, 2014, if a rural hospital is redesignated as urban due to the most recent OMB standards for delineating statistical areas adopted by CMS, the redesignated urban hospital may retain any existing increases to its FTE resident cap that it had received prior to when the redesignation became effective. Effective October 1, 2014, if a rural hospital is redesignated as urban due to the most recent OMB standards for delineating statistical areas adopted by CMS, the redesignated urban hospital may receive an increase to its FTE resident cap for a new program, in accordance with paragraph (e) of this section, if it received a letter of accreditation for the new program and/or started training residents in the new program prior to the redesignation becoming effective.

(v)(A) For a hospital's cost reporting periods beginning on or after October 1, 1997, and before October 1, 1998, the total number of full-time equivalent residents for payment purposes is equal to the average of the actual full-time equivalent resident counts (subject to the requirements listed in paragraphs (f)(1)(ii)(C) and (f)(1)(iv) of this section) for that cost reporting period and the preceding cost reporting period.

(B) For a hospital's cost reporting periods beginning on or after October 1, 1998, the total number of full-time equivalent residents for payment purposes is equal to the average of the actual full-time equivalent resident count (subject to the requirements set forth in paragraphs (f)(1)(ii)(C) and (f)(1)(iv) of this section) for that cost reporting period and the preceding two cost reporting periods.

(C) For new programs started prior to October 1, 2012, if a hospital qualified for an adjustment to the limit established under paragraph (f)(1)(iv) of this section for new medical residency programs created under paragraph (f)(1)(vii) of this section, the count of residents participating in new medical residency training programs above the number included in the hospital's full-time equivalent count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in paragraph (f)(1)(v)(B) of this section for a period of years. Residents participating in new medical residency training programs are included in the hospital's full-time equivalent count before applying the averaging rules after the period of years has expired. For purposes of this paragraph, for each new program started, the period of years

equals the minimum accredited length for each new program. The period of years for each new program begins when the first resident begins training in each new program.

(D) For new programs started on or after October 1, 2012, for hospitals for which the full-time equivalent cap may be adjusted in accordance with §413.79(e) of this chapter, full-time equivalent residents participating in new medical residency training programs are excluded from the hospital's full-time equivalent count before applying the averaging rules 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. Beginning with 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 beginning with the applicable hospital's cost reporting period that coincides with or follows the start of the sixth program year of 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, full-time equivalent residents participating in new medical residency training programs are included in the hospital's full-time equivalent count before applying the averaging rules in paragraph (f)(1)(v)(B) of this section.

(E) Subject to the provisions of paragraph (f)(1)(ix) of this section, full-time equivalent residents that are displaced by the closure of either another hospital or another hospital's program are added to the full-time equivalent count after applying the averaging rules in paragraph (f)(1)(v)(B) of this section for the receiving hospital for the duration of time that the displaced residents are training at the receiving hospital.

(F) (*1*) Subject to the provisions of paragraph (f)(1)(x) of this section, effective for cost reporting periods beginning on or after April 1, 2000, and beginning before October 1, 2022, full-time equivalent residents at an urban hospital in a rural track program are included in the urban hospital's rolling average calculation described in paragraph (f)(1)(v)(B) of this section.

(*2*) Subject to the provisions of paragraph (f)(1)(x) of this section, for cost reporting periods beginning on or after October 1, 2022, full-time equivalent residents at an urban hospital or rural hospital in a Rural Track Program are excluded from the rolling average calculation described in paragraph (f)(1)(v)(B) of this section 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 each rural track.

(vi) Hospitals that are part of the same Medicare GME affiliated group or emergency Medicare GME affiliated group (as defined in §413.75(b) of this subchapter) may elect to apply the limit specified in paragraph (f)(1)(iv) of this section on an aggregate basis, as specified in §413.79(f) of this subchapter. Effective beginning on or after October 1, 2008, home and host hospitals with valid emergency Medicare GME affiliation agreements are exempt from the application of the ratio cap specified in paragraph (a)(1)(i) of this section.

(vii) (A) If a hospital establishes a new medical residency training program, as defined in §413.79(l) of this subchapter, the hospital's full-time equivalent cap may be adjusted in accordance with the provisions of §413.79(e) of this subchapter.

(B)(*1*) A hospital that, as of December 27, 2020, has a full-time equivalent cap of less than 1.0 FTE based on a cost reporting period beginning before October 1, 1997, that begins training residents in a new medical residency training program, as defined at §413.79(l) of this subchapter, in a cost reporting period beginning on or after December 27,

2020, and before December 26, 2025, may receive an adjustment to its full-time equivalent cap when it trains at least 1.0 FTE in such new medical residency training program(s), to be calculated in accordance with §413.79(e) of this subchapter.

(*2*) A hospital that has a full-time equivalent cap of no more than 3.0 FTEs based on a cost reporting period beginning on or after October 1, 1997, and before December 27, 2020, that begins training residents in a new medical residency training program, as defined at §413.79(l) of this subchapter, in a cost reporting period beginning on or after December 27, 2020 and before December 26, 2025, may receive an adjustment to its full-time equivalent cap when it trains more than 3.0 FTE in such new medical residency training program(s), to be calculated in accordance with the provisions of §413.79(e) of this subchapter.

(viii) A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on or after January 1, 1995 and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its full-time equivalent cap in accordance with the provisions of §413.79(g) of this subchapter.

(ix)(A) A hospital may receive a temporary adjustment to its FTE resident cap to reflect displaced residents added because of another hospital's closure if the hospital meets the criteria specified in §413.79(h)(1) and (2) of this subchapter. If a hospital that closes its residency training program agrees to temporarily reduce its FTE resident cap according to the criteria specified in §413.79(h)(1) and (h)(3)(ii)of this subchapter, another hospital(s) may receive a temporary adjustment to its FTE resident cap to reflect displaced residents added because of the closure of the residency training program if the criteria specified in §413.79(h)(1) and (h)(3)(i) of this subchapter are met.

(B) A hospital may receive a permanent adjustment to its FTE resident cap as a result of slots that were redistributed from a closed hospital, as defined at §413.79(h)(1)(i) of this subchapter, if the hospital meets the requirements at §413.79(o) of this subchapter.

(x) (A) For rural track programs started in a cost reporting period beginning before October 1, 2022, an urban hospital that establishes a new residency program (as defined in §413.79(l) of this subchapter), or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks in accordance with the applicable provisions of §413.79(k) of this subchapter.

(B) For cost reporting periods beginning on or after October 1, 2022, an urban hospital or rural hospital that establishes a new residency program (as defined in §413.79(l) of this subchapter) that is a Rural Track Program (as defined at §413.75(b) of this subchapter), or adds an additional site to a Rural Track Program, may include in its FTE count residents in the Rural Track Program in accordance with the applicable provisions of §413.79(k) of this subchapter.

(xi) Effective for discharges occurring in cost reporting periods beginning on or after November 29, 1999, a hospital may receive an adjustment to its FTE cap of up to three additional FTEs to the extent that the additional residents would have been counted as primary care residents for purposes of the hospital's FTE cap but for the fact that the additional residents were on maternity or disability leave or a similar approved leave of absence, in accordance with the provisions of §413.79(i) of this subchapter.

(xii) For discharges occurring on or after October 1, 1997, a non-Veterans Affairs (VA) hospital may receive a temporary adjustment to its FTE cap to reflect residents who had been previously trained at a VA hospital and were subsequently transferred to the non-VA hospital, if the hospital meets the criteria and other provisions of §413.79(j) of this subchapter.

(xiii) For a hospital that was paid under part 413 of this chapter as a hospital excluded from the hospital inpatient prospective payment system and that subsequently becomes subject to

the hospital inpatient prospective payment system, the limit on the total number of FTE residents for payment purposes is determined based on the data from the hospital's most recent cost reporting period ending on or before December 31, 1996.

(xiv) In the case of a merger of a hospital that is excluded from the hospital inpatient prospective payment system and an acute care hospital subject to the hospital inpatient prospective payment system, if the surviving hospital is a hospital subject to the hospital inpatient prospective payment system and no hospital unit that is excluded from the hospital inpatient prospective payment system is created as a result of the merger, the surviving hospital's number of FTE residents for payment purposes is equal to the sum of the FTE resident count of the hospital that is subject to the hospital inpatient prospective payment system as determined under paragraph (f)(1)(ii)(B) of this section and the limit on the total number of FTE residents for the excluded hospital as determined under paragraph (f)(1)(xiii) of this section.

(xv) Effective for discharges occurring on or after October 1, 2005, an urban hospital that reclassifies to a rural area under § 412.103 for fewer than 10 continuous years and then subsequently elects to revert back to urban classification will not be allowed to retain the adjustment to its IME FTE resident cap that it received as a result of being reclassified as rural.

(2) To include a resident in the full-time equivalent count for a particular cost reporting period, the hospital must furnish the following information. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

(i) A listing, by specialty, of all residents assigned to the hospital and providing services to the hospital during the cost reporting period.

(ii) The name and social security number of each resident.

(iii) The dates the resident is assigned to the hospital.

(iv) The dates the resident is assigned to other hospitals or other freestanding providers and any nonprovider setting during the cost reporting period.

(v) The proportion of the total time necessary to fill a residency slot that the resident is assigned to an area of the hospital listed under paragraph (f)(1)(ii) of this section.

(3) Fiscal intermediaries must verify the correct count of residents.

(g) *Indirect medical education payment for managed care enrollees.* For portions of cost reporting periods occurring on or after January 1, 1998, a payment is made to a hospital for indirect medical education costs, as determined under paragraph (e) of this section, for discharges associated with individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act or with a Medicare + Choice organization under title XVIII, Part C of the Act during the period, according to the applicable payment percentages described in §§ 413.76(c)(1) through (c)(5) of this subchapter.

[50 FR 12741, Mar. 29, 1985. Redesignated at 56 FR 43241, Aug. 30, 1991]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.105, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(a) *General considerations.* (1) The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location.

(i) The number of beds in a hospital is determined in accordance with § 412.105(b).

(ii) For purposes of this section, the number of patient days in a hospital includes only those days attributable to units or wards of the hospital providing acute care services generally payable under the prospective payment system and excludes patient days associated with—

(A) Beds in excluded distinct part hospital units;

(B) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or inpatient hospice services;

(C) Beds in a unit or ward that is not occupied to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system at any time during the 3 preceding months (the beds in the unit or ward are to be excluded from the determination of available bed days during the current month); and

(D) Beds in a unit or ward that is otherwise occupied (to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system) that could not be made available for inpatient occupancy within 24 hours for 30 consecutive days.

(iii) The hospital's location, in an urban or rural area, is determined in accordance with the definitions in §412.64, except that a reclassification that results from an urban hospital reclassified as rural as set forth in §412.103 is classified as rural.

(2) The payment adjustment is applied to 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 under subpart F of this part and additional payments made under the provisions of §412.105.

(b) *Determination of a hospital's disproportionate patient percentage*—(1) *General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

(2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—

(i) Determines the number of patient days that—

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;

(ii) Adds the results for the whole period; and

(iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that—

(A) Are associated with discharges that occur during that period; and

(B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).

(3) *First computation: Cost reporting period.* If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for patients who were not entitled to Medicare Part A, and who were either eligible for Medicaid on such days as described in paragraph (b)(4)(i) of this section or who were regarded as eligible for Medicaid on such days and the Secretary has determined to include those days in this computation as described in paragraph (b)(4)(ii)(A) or (B) of this section. The fiscal intermediary then divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is eligible for Medicaid on a given day if the patient is eligible on that day for inpatient hospital services under a State Medicaid plan approved under title XIX of the Act, regardless of whether particular items or services were covered or paid for on that day under the State plan.

(ii) For purposes of this computation, a patient is regarded as eligible for Medicaid on a given day if the patient receives health insurance authorized by a demonstration approved by the Secretary under section 1115(a)(2) of the Act for that day, where the cost of such health insurance may be counted as expenditures under section 1903 of the Act, or the patient has health insurance for that day purchased using premium assistance received through a

demonstration approved by the Secretary under section 1115(a)(2) of the Act, where the cost of the premium assistance may be counted as expenditures under section 1903 of the Act, and in either case regardless of whether particular items or services were covered or paid for on that day by the health insurance. Of these patients regarded as eligible for Medicaid on a given day, only the days of patients meeting the following criteria on that day may be counted in this second computation:

(A) Patients who are provided by a demonstration authorized under section 1115(a)(2) of the Act health insurance that covers inpatient hospital services; or

(B) Patients who purchase health insurance that covers inpatient hospital services using premium assistance provided by a demonstration authorized under section 1115(a)(2) of the Act and the premium assistance accounts for 100 percent of the premium cost to the patient.

(iii) Patients whose health care costs, including inpatient hospital services costs, for a given day are claimed for payment by a provider from an uncompensated, undercompensated, or other type of funding pool authorized under section 1115(a) of the Act to fund providers' uncompensated care costs are not regarded as eligible for Medicaid for purposes of paragraph (b)(4)(ii) of this section on that day and the days of such patients may not be included in this second computation.

(iv) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

(v) For cost reporting periods beginning on or after October 1, 2009, the hospital must report the days in the numerator of the fraction in the second computation in a cost reporting period based on the date of discharge, the date of admission, or the dates of service. If a hospital seeks to change its methodology for reporting days in the numerator of the fraction in the second computation, the hospital must notify CMS, through its fiscal intermediary or MAC, in writing at least 30 days before the beginning of the cost reporting period in which the change would apply. The written notification must specify the methodology the hospital will use, the cost reporting period to which the requested change would apply, and the current methodology being used. Such a change will be effective only on the first day of a cost reporting period. If a hospital changes its methodology for reporting such days, CMS or the fiscal intermediary or MAC may adjust the number of days reported for a cost reporting period if it determines that any of those days have been counted in a prior cost reporting period.

(5) *Disproportionate patient percentage.* The intermediary adds the results of the first computation made under either paragraph (b)(2) or (b)(3) of this section and the second computation made under paragraph (b)(4) of this section and expresses that sum as a percentage. This is the hospital's disproportionate patient percentage, and is used in paragraph (c) of this section.

(c) *Criteria for classification.* A hospital is classified as a ''disproportionate share'' hospital under any of the following circumstances:

(1) The hospital's disproportionate patient percentage, as determined under paragraph (b)(5) of this section, is at least equal to one of the following:

(i) 15 percent, if the hospital is located in an urban area, and has 100 or more beds, or is located in a rural area and has 500 or more beds.

(ii) 30 percent for discharges occurring before April 1, 2001, and 15 percent for discharges occurring on or after April 1, 2001, if the hospital is located in a rural area and either has more than 100 beds and fewer than 500 beds or is classified as a sole community hospital under § 412.92.

(iii) 40 percent for discharges before April 1, 2001, and 15 percent for discharges occurring on or after April 1, 2001, if the hospital is located in an urban area and has fewer than 100 beds.

(iv) 45 percent for discharges before April 1, 2001, and 15 percent for discharges occurring on or after April 1, 2001, if the hospital is located in a rural area and has 100 or fewer beds.

(2) The hospital is located in an urban area, has 100 or more beds, and can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients.

(d) *Payment adjustment factor*—(1) *Method of adjustment.* Subject to the reduction factor set forth in paragraph (e) of this section, if a hospital serves a disproportionate number of low-income patients, its DRG revenues for inpatient operating costs are increased by an adjustment factor as specified in paragraph (d)(2) of this section.

(2) *Payment adjustment factors.* (i) If the hospital meets the criteria of paragraph (c)(1)(i) of this section, the payment adjustment factor is equal to one of the following:

(A) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is as follows:

(*1*) For discharges occurring on or after April 1, 1990, and before January 1, 1991, 5.62 percent plus 65 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*2*) For discharges occurring on or after January 1, 1991, and before October 1, 1993, 5.62 percent plus 70 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*3*) For discharges occurring on or after October 1, 1993, and before October 1, 1994, 5.88 percent plus 80 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*4*) For discharges occurring on or after October 1, 1994, 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(B) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is as follows:

(*1*) For discharges occurring on or after April 1, 1990, and before October 1, 1993, 2.5 percent plus 60 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*2*) For discharges occurring on or after October 1, 1993, 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(ii) If the hospital meets the criteria of paragraph (c)(1)(ii) of this section, the payment adjustment factor is equal to one of the following:

(A) If the hospital is classified as a rural referral center—

(*1*) For discharges occurring before April 1, 2001, the payment adjustment factor is 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent.

(*2*) For discharges occurring on or after April 1, 2001, and before April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 19.3 percent and less than 30 percent, the applicable payment adjustment factor is 5.25 percent.

(*iii*) If the hospital's disproportionate patient percentage is greater than or equal to 30 percent, the applicable payment adjustment factor is 5.25 percent plus 60 percent of the difference between 30 percent and the hospital's disproportionate patient percentage.

(*3*) For discharges occurring on or after April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than or equal to 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(B) If the hospital is classified as a sole community hospital—

(*1*) For discharges occurring before April 1, 2001, the payment adjustment factor is 10 percent.

(*2*) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent and less than 30 percent, the applicable payment adjustment factor is 5.25 percent.

(*iii*) If the hospital's disproportionate patient percentage is equal to or greater than 30 percent, the applicable payment adjustment factor is 10 percent.

(*3*) For discharges occurring on or after April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than or equal to 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*iii*) The maximum payment adjustment factor is 12 percent.

(C) If the hospital is classified as both a rural referral center and a sole community hospital, the payment adjustment is—

(*1*) For discharges occurring before April 1, 2001, the greater of—

(*i*) 10 percent; or

(*ii*) 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent.

(*2*) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the greater of the adjustments determined under paragraphs (d)(2)(ii)(A) or (d)(2)(ii)(B) of this section.

(*3*) For discharges occurring on or after April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(D) If the hospital is classified as a rural hospital and is not classified as either a sole community hospital or a rural referral center, and has 100 or more beds—

(*1*) For discharges occurring before April 1, 2001, the payment adjustment factor is 4 percent.

(*2*) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between the hospital's disproportionate patient percentage and 15 percent.

(*ii*) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent, the applicable payment adjustment factor is 5.25 percent.

(*3*) For discharges occurring on or after April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than or equal to 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*iii*) The maximum payment adjustment factor is 12 percent.

(iii) If the hospital meets the criteria of paragraph (c)(1)(iii) of this section—

(A) For discharges occurring before April 1, 2001, the payment adjustment factor is 5 percent.

(B) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the following applies:

(*1*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between the hospital's disproportionate patient percentage and 15 percent.

(*2*) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent, the applicable payment adjustment factor is 5.25 percent.

(C) For discharges occurring on or after April 1, 2004, the following applies:

(*1*) If the hospital's disproportionate patient percentage is less than or equal to 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*2*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*3*) The maximum payment adjustment factor is 12 percent.

(iv) If the hospital meets the criteria of paragraph (c)(1)(iv) of this section—

(A) For discharges occurring before April 1, 2001, the payment adjustment factor is 4 percent.

(B) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the following applies:

(*1*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between the hospital's disproportionate patient percentage and 15 percent.

(*2*) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent, the applicable payment adjustment factor is 5.25 percent.

(C) For discharges occurring on or after April 1, 2004, the following applies:

(*1*) If the hospital's disproportionate patient percentage is less than or equal to 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*2*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*3*) Except as provided in paragraph (d)(2)(iv)(D) of this section, the maximum payment adjustment factor is 12 percent.

(D) Effective for discharges occurring on or after October 1, 2006, for a hospital that is classified as a Medicare-dependent, small rural hospital under §412.108, the payment adjustment factor limitation specified in paragraph (d)(2)(iv)(C)(3) does not apply.

(v) If the hospital meets the criteria of paragraph (c)(2) of this section, the payment adjustment factor is as follows:

(A) 30 percent for discharges occurring on or after April 1, 1990, and before October 1, 1991.

(B) 35 percent for discharges occurring on or after October 1, 1991.

(e) *Reduction in payments beginning FY 1998.* The amounts otherwise payable to a hospital under paragraph (d) of this section are reduced by the following:

(1) For FY 1998, 1 percent.

(2) For FY 1999, 2 percent.

(3) For FY 2000, 3 percent.

(4) For FY 2001:

(i) For discharges occurring on or after October 1, 2000 and before April 1, 2001, 3 percent.

(ii) For discharges occurring on or after April 1, 2001 and before October 1, 2001, 1 percent.

(5) For FY 2002, 3 percent.

(6) For FYs 2003 and thereafter, 0 percent.

(f) *Empirically justified Medicare DSH payments.* Effective for discharges on or after October 1, 2013, the amounts otherwise payable to a hospital under

paragraph (d) of this section are reduced by 75 percent.

(g) *Additional payment for uncompensated care.* (1) *Payment rules.* Hospitals that qualify for payments under this section for fiscal year 2014 and each subsequent year, will receive an additional amount equal to the product of the following three factors:

(i) *Factor 1.* For FY 2014 and each subsequent fiscal year, a factor equal to the difference between:

(A) The most recently available estimates, as calculated by CMS' Office of the Actuary, of the aggregate amount of payments that would be made to such hospitals under paragraphs (a) through (e) of this section if paragraph (f) of this section did not apply for the fiscal year; and

(B) The most recently available estimates, as calculated by CMS' Office of the Actuary, of the aggregate amount of payments that are made to such hospitals pursuant to paragraph (f) of this section for the fiscal year.

(ii) *Factor 2.* (A) For each of fiscal years 2014, 2015, 2016, and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured (and subtracting from the factor 0.1 percentage point for fiscal year 2014 and 0.2 percentage point for each of fiscal years 2015, 2016, and 2017), as determined by comparing—

(*1*) 18 percent, the percent of such individuals who are uninsured in 2013, based on the March 20, 2010, estimate of the ''Insured Share of the Nonelderly Population Including All Residents'' by the Congressional Budget Office.

(*2*) The percent of such individuals who are uninsured in the applicable fiscal year, based on the most recent estimate of the ''Insured Share of the Nonelderly Population Including All Residents'' by the Congressional Budget Office available at the time of development of the annual final rule for the hospital inpatient prospective payment system.

(B) For FY 2018 and subsequent fiscal years, a factor equal to 1 minus the percent change in the percent of individuals who are uninsured (and subtracting from the factor 0.2 percentage point for each of fiscal years 2018 and 2019), as determined by comparing the percent of individuals who are uninsured in—

(*1*) 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the CMS); and

(*2*) The most recent period for which data is available (as so estimated and certified).

(iii) *Factor 3.* A factor equal to the percent, for each inpatient prospective payment system hospital, that represents the quotient of:

(A) The amount of uncompensated care for such hospital as estimated by CMS.

(B) The aggregate amount of uncompensated care as estimated by CMS for all hospitals that are estimated to receive a payment under this section.

(C)(*1*) For fiscal years 2014 and 2015, CMS will base its estimates of the amount of hospital uncompensated care on the most recent available data on utilization for Medicaid and Medicare SSI patients, as determined by CMS in accordance with paragraphs (b)(2)(i) and (4) of this section.

(*2*) For fiscal year 2016, CMS will base its estimates of the amount of hospital uncompensated care on utilization data for Medicaid and Medicare SSI patients, as determined by CMS in accordance with paragraphs (b)(2)(i) and (4) of this section, using data on Medicaid utilization from 2012 or 2011 cost reports from the most recent HCRIS database extract, the 2012 cost report data submitted to CMS by IHS hospitals, and the most recent available data on Medicare SSI utilization.

(*3*) For fiscal year 2017, CMS will base its estimates of the amount of hospital uncompensated care on utilization data for Medicaid and Medicare SSI patients, as determined by CMS in accordance with paragraphs (b)(2)(i) and (4) of this section, using data on Medicaid utilization from 2011, 2012, and 2013 cost reports from the most recent HCRIS database extract, the 2011 and 2012 cost report data submitted to CMS by IHS hospitals, and the most recent available 3 years of data on Medicare SSI utilization (or, for Puerto Rico hospitals, a proxy for Medicare SSI utilization data).

(*4*) For fiscal year 2018, CMS will base its estimates of the amount of hospital uncompensated care on utilization data for Medicaid and Medicare SSI patients, as determined by CMS in accordance with paragraphs (b)(2)(i) and (b)(4) of this section, using data on Medicaid utilization from 2012 and 2013 cost reports from the most recent HCRIS database extract and 2012 cost report data submitted to CMS by IHS or Tribal hospitals and the most recent available 2 years of data on Medicare SSI utilization (or, for Puerto Rico hospitals, a proxy for Medicare SSI utilization data), and for hospitals other than Puerto Rico hospitals, IHS or Tribal hospitals, and all-inclusive rate providers, data on uncompensated care costs, defined as charity care costs plus non-Medicare bad debt costs from 2014 cost reports from the most recent HCRIS database extract.

(*5*) For fiscal year 2019, CMS will base its estimates of the amount of hospital uncompensated care on utilization data for Medicaid and Medicare SSI patients, as determined by CMS in accordance with paragraphs (b)(2)(i) and (4) of this section, using data on Medicaid utilization from 2013 cost reports from the most recent HCRIS database extract and the most recent available year of data on Medicare SSI utilization (or, for Puerto Rico hospitals, a proxy for Medicare SSI utilization data), and for hospitals other than Puerto Rico hospitals, IHS or Tribal hospitals, and all-inclusive rate providers, data on uncompensated care costs, defined as charity care costs plus non-Medicare and nonreimbursable Medicare bad debt costs from 2014 and 2015 cost reports from the most recent HCRIS database extract.

(*6*) For fiscal year 2020, CMS will base its estimates of the amount of hospital uncompensated care on data on uncompensated care costs, defined as charity care costs plus non-Medicare and nonreimbursable Medicare bad debt costs from 2015 cost reports from the most recent HCRIS database extract, except that, for Puerto Rico hospitals and Indian Health Service or Tribal hospitals, CMS will base its estimates on utilization data for Medicaid and Medicare SSI patients, as determined by CMS in accordance with paragraphs (b)(2)(i) and (b)(4) of this section, using data on Medicaid utilization from 2013 cost reports from the most recent HCRIS database extract and the most recent available year of data on Medicare SSI utilization (or, for Puerto Rico hospitals, a proxy for Medicare SSI utilization data).

(*7*) For fiscal year 2021, CMS will base its estimates of the amount of hospital uncompensated care on data on uncompensated care costs, defined as charity care costs plus non-Medicare and nonreimbursable Medicare bad debt costs from 2017 cost reports from the most recent Hospital Cost Report Information System (HCRIS) database extract, except that, for Puerto Rico hospitals and Indian Health Service or Tribal hospitals, CMS will base its estimates on utilization data for Medicaid and Medicare Supplemental Security Income (SSI) patients, as determined by CMS in accordance with paragraphs (b)(2)(i) and (b)(4) of this section, using data on Medicaid utilization from 2013 cost reports from the most recent HCRIS database extract and the most recent available year of data on Medicare SSI utilization (or, for Puerto Rico hospitals, a proxy for Medicare SSI utilization data).

(*8*) For fiscal year 2022, for all eligible hospitals, except Indian Health Service and Tribal hospitals and Puerto Rico hospitals that have a cost report for 2013, CMS will base its estimates of the amount of hospital uncompensated care on data on uncompensated care costs, defined as charity care costs plus non-Medicare and non-reimbursable Medicare bad debt costs from cost reports from the most recent cost reporting year for which audits have been conducted.

(*9*) For fiscal year 2022, for Indian Health Service and Tribal hospitals and Puerto Rico hospitals that have a cost report for 2013, CMS will base its estimates of the amount of hospital uncompensated care on utilization data for Medicaid and Medicare Supplemental Security Income (SSI) patients, as determined by CMS in accordance with paragraphs (b)(2)(i) and (b)(4) of this section, using data on Medicaid utilization from 2013 cost reports from the most recent HCRIS database extract and the most recent available

year of data on Medicare SSI utilization (or, for Puerto Rico hospitals, a proxy for Medicare SSI utilization data).

(*10*) For fiscal year 2023, for all eligible hospitals, CMS will base its estimates of the amount of hospital uncompensated care on data on uncompensated care costs, defined as charity care costs plus non-Medicare and nonreimbursable Medicare bad debt costs from cost reports from the two most recent cost reporting years for which audits have been conducted. If a hospital is a new hospital (that is, a hospital that began participation in the Medicare program after the two most recent cost reporting years for which audits have been conducted) or if the hospital is treated as a new hospital for purposes of Factor 3, the Medicare administrative contractor (MAC) will determine Factor 3 as the ratio of the hospital's uncompensated care costs from its FY 2023 cost report to the sum of uncompensated care costs for all DSH-eligible hospitals as estimated by CMS from the most recent cost reporting year for which audits have been conducted.

(*11*) For fiscal year 2024 and subsequent fiscal years, for all eligible hospitals, CMS will base its estimates of the amount of hospital uncompensated care on data on uncompensated care costs, defined as charity care costs plus non-Medicare and non-reimbursable Medicare bad debt costs from cost reports from the three most recent cost reporting years for which audits have been conducted. If a hospital is a new hospital (that is, a hospital that began participation in the Medicare program after the three most recent cost reporting years for which audits have been conducted) or if the hospital is treated as a new hospital for purposes of Factor 3, the Medicare administrative contractor (MAC) will determine Factor 3 as the ratio of the hospital's uncompensated care costs from its cost report for the applicable fiscal year to the sum of uncompensated care costs for all disproportionate share hospital (DSH)-eligible hospitals as estimated by CMS from the most recent cost reporting year for which audits have been conducted.

(2) *Preclusion of administrative and judicial review.* There is no administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, of the following:

(i) Any estimate of the Secretary for the purpose of determining the factors in paragraph (g)(1) of this section; and

(ii) Any period selected by the Secretary for such purposes.

(h) *Supplemental payment for Indian Health Service and Tribal hospitals and Puerto Rico hospitals.* (1) For fiscal year 2023 and each subsequent fiscal year, Indian Health Service and Tribal Hospitals and Puerto Rico hospitals that qualify for an additional payment for uncompensated care under paragraph (g) of this section for the applicable fiscal year may also qualify to receive a supplemental payment.

(2) Indian Health Service and Tribal Hospitals and Puerto Rico hospitals that do not have a Factor 3 amount for fiscal year 2022 determined under paragraph (g)(1)(iii)(C)(*9*) of this section are not eligible to receive a supplemental payment under this paragraph (h).

(3) The amount of the supplemental payment for a fiscal year is determined as the difference between the following:

(i) A base year amount defined as the FY 2022 uncompensated care payment determined for the hospital, in accordance with paragraph (g)(1) of this section, adjusted by 1 plus the percent change in the aggregate amount of uncompensated care payments as estimated by CMS in accordance with paragraphs (g)(1)(i) and (ii) of this section between fiscal year 2022 and the applicable fiscal year. If the hospital did not qualify for an additional payment for uncompensated care under paragraph (g) of this section for fiscal year 2022, CMS uses the Factor 3 determined for the hospital under paragraph (g)(1)(iii)(C)(*9*) of this section to estimate the amount of the additional payment for uncompensated care that the hospital would have received in fiscal year 2022 if the hospital had qualified for an additional payment for uncompensated care under paragraph (g)(1) of this section for that fiscal year.

(ii) The additional payment for uncompensated care determined for the hospital for the applicable fiscal year,

in accordance with paragraph (g)(1) of this section.

(4) If the base year amount under paragraph (h)(3)(i) of this section is equal to or lower than the additional payment for uncompensated care determined for the hospital for the applicable fiscal year in accordance with paragraph (g)(1) of this section, the hospital will not receive a supplemental payment under paragraph (h) of this section for that fiscal year.

(i) *Manner and timing of payments.* (1) Interim payments are made during the payment year to each hospital that is estimated to be eligible for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, subject to the final determination of eligibility at the time of cost report settlement for each hospital. For FY 2025, interim uncompensated care payments are calculated based on an average of the most recent 2 years of available historical discharge data. For FY 2026 and subsequent years, interim uncompensated care payments are calculated based on an average of the most recent 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]

§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 October 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 October 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 EACH's 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 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 anesthetist 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*.

§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 coinsurance 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 based on the submission of a discharge bill.

(2) Payments for inpatient hospital services furnished by an excluded psychiatric unit of a hospital (or by an excluded rehabilitation unit of a hospital for cost reporting periods beginning before January 1, 2002) are made as described in §§413.64(a), (c), (d), and (e) of this chapter.

(3) For cost reporting periods beginning on or after January 1, 2005, payments for inpatient hospital services furnished by an inpatient psychiatric facility that meets the conditions of §412.404 are made as described in §412.432.

(4) For cost reporting periods beginning on or after January 1, 2002, payments for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit that meets the conditions of §412.604 are made as described in §412.632.

(5) For cost reporting periods beginning on or after October 1, 2002, payments for inpatient hospital services furnished by a long-term care hospital that meets the conditions for payment of §§412.505 through 412.511 are made as described in §412.521.

(b) *Periodic interim payments*—(1) *Criteria for receiving periodic interim payments.* Effective with claims received on or after July 1, 1987, a hospital that meets the criteria in §413.64(h) of this chapter may request in writing to receive periodic interim payments as described in this paragraph. A hospital that is receiving periodic interim payments also receives payment on this basis for inpatient hospital services furnished by its excluded psychiatric or rehabilitation unit.

(i) *Failure of intermediary to make prompt payment.* Beginning with claims received in April 1987, the hospital's fiscal intermediary does not meet the requirements of section 1816(c)(2) of the Act, which provides for prompt payment of claims under Medicare Part A, for three consecutive calendar months. The hospital may continue to receive periodic interim payments until the intermediary meets the requirements of section 1816 (c)(2) of the Act for three consecutive calendar months. For purposes of this paragraph, a hospital that is receiving periodic interim payments as of June 30, 1987 and meets the requirements of §413.64(h) of this chapter may continue to receive payment on this basis until the hospital's intermediary meets the requirements of section 1816(c)(2) of the Act for three consecutive calendar months beginning with April 1987.

(ii) *Hospitals that serve a disproportionate share of low-income patients.* The hospital is receiving periodic interim payments as of June 30, 1987 and has a disproportionate share payment adjustment factor of at least 5.1 percent as determined under §412.106(c) for purposes of establishing the average standardized amounts for discharges occurring on or after October 1, 1986 and before October 1, 1987. The hospital's request must be made by a date prior to July 1, 1987, specified by the intermediary.

(iii) *Small rural hospitals.* The hospital is receiving periodic interim payments as of June 30, 1987, makes its request by a date prior to July 1, 1987, specified by

the intermediary, and, on July 1, 1987, the hospital—

(A) Is located in a rural area as defined in § 412.62(f); and

(B) Has 100 or fewer beds available for use.

(2) *Frequency of payment.* The intermediary estimates a hospital's prospective payments as described in paragraph (b)(3) of this section and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. Each payment is made two weeks after the end of a biweekly period of service, as described in § 413.64(h)(5) of this chapter. These payments are subject to final settlement.

(3) *Amount of payment.* (i) The biweekly interim payment amount is based on the total estimated Medicare discharges for the reporting period multiplied by the hospital's estimated average prospective payment amount as described in paragraph (b)(3)(ii) of this paragraph. These interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a hospital receives interim payments for less than a full reporting period.

(ii) For purposes of determining periodic interim payments under this paragraph, a hospital's estimated average prospective payment amount is computed as follows:

(A) If a hospital has no payment experience under the prospective payment system for operating costs, the intermediary computes the hospital's estimated average prospective payment amount for operating costs by multiplying its payment rates as determined under § 412.70(c), but without adjustment by a DRG weighting factor, by the hospital's case-mix index, and subtracting from this amount estimated deductibles and coinsurance.

(B) Effective for cost-reporting periods beginning on or after October 1, 1991, the intermediary computes a hospital's estimated average prospective payment amount for capital-related costs by multiplying its prospective payment rate as determined under § 412.340 or § 412.344(a), as applicable, and under § 412.308 for cost reporting periods beginning on or after October 1, 2001 but without adjustment by a DRG weighting factor, by the hospital's case-mix index. The intermediary may take into account estimated additional payments per discharge under § 412.348. If the hospital is paid under § 412.344(a)(1), the intermediary includes an estimated payment for old capital costs per discharge.

(C) If a hospital has payment experience under the prospective payment system for operating costs, and, for cost reporting periods beginning on or after October 1, 1991, for inpatient capital-related costs, the intermediary computes a hospital's estimated average prospective payment amount for operating costs and capital-related costs based on that payment experience, adjusted for projected changes, and subtracts from this amount estimated deductibles and coinsurance.

(4) *Termination of periodic interim payments*—(i) *Request by the hospital.* A hospital receiving periodic interim payments may convert to payments on a per discharge basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates periodic interim payments if—

(A) A hospital no longer meets the requirements of § 413.64(h);

(B) A hospital is receiving payment under the criterion in paragraph (b)(1)(i) of this section and the intemediary meets the prompt payment requirements of section 1816(c)(2) of the Act for three consecutive calendar months; or

(C) A hospital that is receiving payment under the criterion set forth in paragraph (b)(1)(iii) of this section no longer meets the criterion.

(iii) *Limitation on reelection.* If a hospital that is receiving periodic interim payments under the criterion set forth in paragraph (b)(1)(ii) or (b)(1)(iii) of this section is removed from that method of payment at its own request, it may reelect to receive periodic interim payments only under the criterion set forth in paragraph (b)(1)(i) of this section. However, if the hospital is removed from that method of payment by its intermediary because it no longer meets the requirements of § 413.64(h) of this chapter, that hospital may subsequently reelect to receive periodic interim payments if it qualifies under the provisions of paragraph

(b)(1)(ii) or (b)(1)(iii) of this section, subject to the requirements in §413.64(h) of this chapter.

(c) *Special interim payments for certain costs.* For capital-related costs for cost-reporting periods beginning before October 1, 1991, and the direct costs of medical education, which are not included in prospective payments but are reimbursed as specified in §§413.130 and 413.85 of this chapter, respectively, interim payments are made subject to final cost settlement. Interim payments for capital-related items for cost-reporting periods beginning before October 1, 1991, and the estimated cost of approved medical education programs (applicable to inpatient costs payable under Medicare Part A and for kidney acquisition costs in hospitals with approved kidney transplant programs) are determined by estimating the reimbursable amount for the year based on the previous year's experience and on substantiated information for the current year and divided into 26 equal biweekly payments. Each payment is made 2 weeks after the end of a biweekly period of services, as described in §413.64(h)(5) of this subchapter. The interim payments are reviewed by the intermediary at least twice during the reporting period and adjusted if necessary.

(d) *Special interim payment for unusually long lengths of stay*—(1) *First interim payment.* A hospital that is not receiving periodic interim payments under paragraph (b) of this section may request an interim payment after a Medicare beneficiary has been in the hospital at least 60 days. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.

(2) *Additional interim payments.* A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under paragraph (d)(1) of this section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of this paragraph (d).

(e) *Outlier payment and additional payments for new medical services and technologies.* Payments for outlier cases and additional payments for new medical services and technologies (described in subpart F of this part) are not made on an interim basis.

(f) *Accelerated payments*—(1) *General rule.* Upon request, an accelerated payment may be made to a hospital that is not receiving periodic interim payments under paragraph (b) of this section if the hospital is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the hospital.

(ii) Due to an exceptional situation, there is a temporary delay in the hospital's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* A hospital's request for an accelerated payment must be approved by the intermediary and CMS.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as hospital bills are processed or by direct payment by the hospital.

[53 FR 1627, Jan. 21, 1988, as amended at 53 FR 38532, Sept. 30, 1988; 54 FR 36495, Sept. 1, 1989; 56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992; 59 FR 36712, July 19, 1994; 59 FR 45400, Sept. 1, 1994; 66 FR 41387, Aug. 7, 2001; 67 FR 56049, Aug. 30, 2002; 68 FR 45470, Aug. 1, 2003; 69 FR 66977, Nov. 15, 2004; 71 FR 48140, Aug. 18, 2006; 86 FR 73512, Dec. 27, 2021]

§412.120 Reductions to total payments.

(a) *Deductible and coinsurance.* Subject to paragraph (a)(2) of this section, the total Medicare payments otherwise payable to a hospital are reduced by the applicable deductible and coinsurance amounts related to inpatient hospital services as determined in accordance with §§409.82, 409.83, and 409.87 of this chapter.

(b) *Payment by workers' compensation, automobile medical, no-fault or liability*

insurance or an employer group health plan primary to Medicare. If workers' compensation, automobile medical, no-fault, or liability insurance or an employer group health plan which is primary to Medicare pays in full or in part, the Medicare payment is determined in accordance with the following guidelines:

(1) If workers' compensation pays, in accordance with the applicable provisions of §§ 405.316 through 405.321 of this chapter.

(2) If automobile medical, no-fault, or liability insurance pays, in accordance with the applicable provisions of §§ 405.322 through 405.325 of this chapter.

(3) If an employer group health plan which is primary to Medicare pays for services to ESRD beneficiaries, in accordance with the applicable provisions of §§ 405.326 through 405.329 of this chapter.

(4) If an employer group health plan which is primary to Medicare pays for services to employees age 65–69 and their spouses age 65–69, in accordance with the applicable provisions of §§ 405.340 through 405.344 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 55 FR 36071, Sept. 4, 1990; 56 FR 573, Jan. 7, 1991; 57 FR 39825, Sept. 1, 1992]

§ 412.125 Effect of change of ownership on payments under the prospective payment systems.

When a hospital's ownership changes, as described in § 489.18 of this chapter, the following rules apply:

(a) Payment for the operating and capital-related costs of inpatient hospital services for each patient, including outlier payments, as provided in § 412.112, and payments for hemophilia clotting factor costs under § 412.115(b), are made to the entity that is the legal owner on the date of discharge. Payments are not prorated between the buyer and seller.

(1) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a beneficiary regardless of when the beneficiary's coverage began or ended during a stay, or of how long the stay lasted.

(2) Each bill submitted must include all information necessary for the intermediary to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.

(b) Other payments under § 412.113 and payments for bad debts as described in § 412.115(a), are made to each owner or operator of the hospital (buyer and seller) in accordance with the principles of reasonable cost reimbursement.

[50 FR 12741, Mar. 29, 1985, as amended at 56 FR 43449, Aug. 30, 1991]

§ 412.130 Retroactive adjustments for incorrectly excluded hospitals and units.

(a) *Hospitals for which adjustment is made.* The intermediary makes the payment adjustment described in paragraph (b) of this section for the following hospitals:

(1) A hospital that was excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system specified in § 412.1(a)(3), as a new rehabilitation hospital for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.29(c) regarding the inpatient population the hospital planned to treat during that cost reporting period, if the inpatient population actually treated in the hospital during that cost reporting period did not meet the requirements of § 412.29(b).

(2) A hospital that has a unit excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system specified in § 412.1(a)(3), as a new rehabilitation unit for a cost reporting period beginning on or after October 1, 1991, based on a certification under § 412.29(c) regarding the inpatient population the hospital planned to treat in that unit during the period, if the inpatient population actually treated in the unit during that cost reporting period did not meet the requirements of § 412.29(b).

(3) A hospital that added new beds to its existing rehabilitation unit for a cost reporting period beginning on or

after October 1, 1991 based on a certification under §412.29(c) regarding the inpatient population the hospital planned to treat in these new beds during that cost reporting period, if the inpatient population actually treated in the new beds during that cost reporting period did not meet the requirements of §412.29(b).

(b) *Adjustment of payment.* (1) For cost reporting periods beginning before January 1, 2002, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid during the cost reporting period for which the hospital, unit, or beds were first excluded as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital based on the exclusion and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1).

(2) For cost reporting periods beginning on or after January 1, 2002, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid under subpart P of this part during the cost reporting period for which the hospital, unit, or beds were first classified as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital under subpart P of this part and the amount that would have been paid under the prospective payment systems specified in §412.1(a)(1).

[56 FR 43241, Aug. 30, 1991, as amended at 57 FR 39825, Sept. 1, 1992; 59 FR 45400, Sept. 1, 1994; 60 FR 45848, Sept. 1, 1995; 66 FR 41387, Aug. 7, 2001; 70 FR 66977, Nov. 15, 2005; 78 FR 47934, Aug. 6, 2013]

§412.140 Participation, data submission, and validation requirements under the Hospital Inpatient Quality Reporting (IQR) Program.

(a) *Participation in the Hospital IQR Program.* In order to participate in the Hospital IQR Program, a section 1886(d) of the hospital must–

(1) Register on QualityNet website, before it begins to report data;

(2) Identify and register a QualityNet security official as part of the registration process under paragraph (a)(1) of this section; and

(3) Submit a completed Notice of Participation Form to CMS if the hospital is participating in the program for the first time, has previously withdrawn from the program and would like to participate again, or has received a new CMS Certification Number (CCN).

(i) A hospital that would like to participate in the program for the first time (and to which paragraph (a)(3)(ii) of this section does not apply), or that previously withdrew from the program and would now like to participate again, must submit to CMS a completed Notice of Participation Form by December 31 of the calendar year preceding the first quarter of the calendar year in which data submission is required for any given fiscal year.

(ii) A hospital that has received a new CCN and would like to participate in the program must submit a completed Notice of Participation Form to CMS no later than 180 days from the date identified as the open date on the approved CMS Quality Improvement Evaluation System (QIES).

(b) *Withdrawal from the Hospital IQR Program.* CMS will accept Hospital IQR Program withdrawal forms from hospitals on or before—

(1) Prior to the FY 2016 payment determination, August 15 of the fiscal year preceding the fiscal year for which a Hospital IQR determination will be made.

(2) Beginning with the FY 2016 payment determination, May 15 of the fiscal year preceding the fiscal year for which a Hospital IQR payment determination will be made.

(c) *Submission and validation of Hospital IQR Program data.* (1) *General rule.* Except as provided in paragraph (c)(2) of this section, subsection (d) hospitals that participate in the Hospital IQR Program must submit to CMS data on measures selected under section 1886(b)(3)(B)(viii) of the Act in a form and manner, and at a time, specified by CMS. A hospital must begin submitting data on the first day of the quarter following the date that the hospital submits a completed Notice of Participation form under paragraph (a)(3) of this section.

(2) *Extraordinary circumstance exception (ECE)*—(i) *General rule.* CMS may grant an ECE with respect to the reporting requirements under this section in the event of extraordinary circumstances beyond the control of the hospital. For purposes of this paragraph (c)(2), an extraordinary circumstance is an event beyond the control of a hospital (for example, a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing) that affected the ability of the hospital to comply with one or more applicable reporting requirements with respect to a fiscal year.

(ii) *Process for requesting an ECE.* (A) A hospital may request an ECE within 60 calendar days of the date that the extraordinary circumstance occurred by submitting the information specified by CMS at QualityNet or a successor website.

(B) CMS notifies the hospital of its decision on the request, in writing, via email. In the event that CMS grants an ECE to the hospital, the written decision specifies whether the hospital is exempted from one or more reporting requirements or whether CMS has granted the hospital an extension of time to comply with one or more reporting requirements.

(iii) *Authority to grant an ECE.* CMS may grant an ECE to one or more hospitals that have not requested an ECE if CMS determines that—

(A) A systemic problem with a CMS data collection system directly impacted the ability of the hospital to comply with a quality data reporting requirement; or

(B) An extraordinary circumstance has affected an entire region or locale. Any ECE granted under this paragraph (c)(2)(iii) specifies whether the affected hospitals are exempted from one or more reporting requirements or whether CMS has granted the hospitals an extension of time to comply with one or more reporting requirements.

(d) *Validation of Hospital IQR Program data.* CMS may validate one or more measures selected under section 1886(b)(3)(B)(viii) of the Act by reviewing patient charts submitted by selected participating hospitals.

(1) Upon written request by CMS or its contractor, a hospital must submit to CMS a sample of patient charts that the hospital used for purposes of data submission under the program. The specific sample that a hospital must submit will be identified in the written request. A hospital must submit the patient charts to CMS or its contractor within 30 days of the date identified on the written request.

(2)(i) A hospital meets the chart-abstracted validation requirement with respect to a fiscal year if it achieves a 75-percent score, as determined by CMS.

(ii)(A) Prior to the FY 2028 payment determination, a hospital meets the eCQM validation requirement with respect to a fiscal year if it submits 100 percent of sampled eCQM measure medical records in a timely and complete manner, as determined by CMS.

(B) For the FY 2028 payment determination and later years, a hospital meets the eCQM validation requirement with respect to a fiscal year if it achieves a 75-percent score, as determined by CMS.

(e) *Reconsiderations and appeals of Hospital IQR Program decisions.* (1) A hospital may request reconsideration of a decision by CMS that the hospital has not met the requirements of the Hospital IQR Program for a particular fiscal year. Except as provided in paragraph (c)(2) of this section, a hospital must submit a reconsideration request to CMS no later than 30 days from the

date identified on the Hospital Inpatient Quality Reporting Program Annual Payment Update Notification Letter provided to the hospital.

(2) A reconsideration request must contain the following information:

(i) The hospital's CMS Certification Number (CCN);

(ii) The name of the hospital;

(iii) Contact information for the hospital's chief executive officer and QualityNet security official, including each individual's name, e-mail address, telephone number, and physical mailing address;

(iv) A summary of the reason(s), as set forth in the Hospital Inpatient Quality Reporting Program Annual Payment Update Notification Letter, that CMS concluded the hospital did not meet the requirements of the Hospital IQR Program;

(v) A detailed explanation of why the hospital believes that it complied with the requirements of the Hospital IQR Program for the applicable fiscal year;

(vi) Any evidence that supports the hospital's reconsideration request, including copies of patient charts, e-mails and other documents; and

(vii) If the hospital has requested reconsideration on the basis that CMS concluded it did not meet the validation requirement set forth in paragraph (d) of this section, the reconsideration request must contain a detailed explanation identifying which data the hospital believes was improperly validated by CMS and why the hospital believes that such data are correct.

(A) A copy of each patient chart that the hospital timely submitted to CMS or its contractor in response to a request made under paragraph (d)(1) of this section; and

(B) A detailed explanation identifying which data the hospital believes was improperly validated by CMS and why the hospital believes that such data are correct.

(3) A hospital that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R of this chapter.

(f) *Patient experience of care data (HCAHPS survey).* HCAHPS is the Hospital Consumer Assessment of Healthcare Providers and Systems survey that measures patient experience of care after a recent hospital stay.

(1) Approved HCAHPS survey vendors and self-administering hospitals must fully comply with all HCAHPS oversight activities, including allowing CMS and its HCAHPS Project Team to perform site visits at the hospitals' and survey vendors' company locations.

(2) CMS approves an application for an entity to administer the HCAHPS survey as an approved HCAHPS survey vendor on behalf of one or more hospitals when an applicant has met the Minimum Survey Requirements and Rules of Participation that can be found on the official HCAHPS On-Line Web site, and agree to comply with the current survey administration protocols that can be found on the official HCAHPS On-Line Web site. An entity must be an approved HCAHPS survey vendor in order to administer and submit HCAHPS data to CMS on behalf of one or more hospitals.

(g) *Retention and removal of quality measures under the Hospital IQR Program*—(1) *General rule for the retention of quality measures.* Quality measures adopted for the Hospital IQR Program measure set for a previous payment determination year are retained for use in subsequent payment determination years, except when they are removed, suspended, or replaced as set forth in paragraphs (g)(2) and (3) of this section.

(2) *Immediate measure removal.* For cases in which CMS believes that the continued use of a measure raises specific patient safety concerns, CMS will immediately remove a quality measure from the Hospital IQR Program and will promptly notify hospitals and the public of the removal of the measure and the reasons for its removal through the Hospital IQR Program ListServ and the QualityNet website, as applicable.

(3) *Measure removal, suspension, or replacement through the rulemaking process.* Unless a measure raises specific safety concerns as set forth in paragraph (g)(2) of this section, CMS will use the regular rulemaking process to remove, suspend, or replace quality measures in the Hospital IQR Program to allow for public comment.

(i) *Factors for consideration of removal of quality measures.* CMS will weigh whether to remove a measure based on the following factors:

(A) *Factor 1.* Measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (''topped out'' measure).

(B) *Factor 2.* A measure does not align with current clinical guidelines or practice.

(C) *Factor 3.* The availability of a more broadly applicable measure (across settings or populations), or the availability of a measure that is more proximal in time to desired patient outcomes for the particular topic.

(D) *Factor 4.* Performance or improvement on a measure does not result in better patient outcomes.

(E) *Factor 5.* The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic.

(F) *Factor 6.* Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

(G) *Factor 7.* It is not feasible to implement the measure specifications.

(H) *Factor 8.* The costs associated with a measure outweigh the benefit of its continued use in the program.

(ii) *Criteria to determine topped-out measures.* For the purposes of the Hospital IQR Program, a measure is considered to be topped-out under paragraph (g)(3)(i)(A) of this section when it meets both of the following criteria:

(A) Statistically indistinguishable performance at the 75th and 90th percentiles (defined as when the difference between the 75th and 90th percentiles for a hospital's measure is within 2 times the standard error of the full data set).

(B) A truncated coefficient of variation less than or equal to 0.10.

(iii) *Application of measure removal factors.* The benefits of removing a measure from the Hospital IQR Program will be assessed on a case-by-case basis.

[76 FR 51782, Aug. 18, 2011, as amended at 77 FR 53674, Aug. 31, 2012; 78 FR 50966, Aug. 19, 2013; 79 FR 50354, Aug. 22, 2014; 81 FR 57267, Aug. 22, 2016; 82 FR 38511, Aug. 14, 2017; 86 FR 45520, Aug. 13, 2021; 87 FR 49404, Aug. 10, 2022; 88 FR 59332, Aug. 28, 2023; 89 FR 69912, Aug. 28, 2024; 90 FR 37201, Aug. 4, 2025]

Subpart I—Adjustments to the Base Operating DRG Payment Amounts Under the Prospective Payment Systems for Inpatient Operating Costs

SOURCE: 77 FR 53674, Aug. 31, 2012, unless otherwise noted.

§ 412.150 Basis and scope of subpart.

(a) Section 1886(q) of the Act requires the Secretary to establish a Hospital Readmissions Reduction program, under which payments to applicable hospitals are reduced in order to account for certain excess readmissions, effective for discharges beginning on October 1, 2012. The rules for determining the payment adjustment under the Hospital Readmission Reductions Program are specified in §§ 412.152 and 412.154.

(b) Section 1886(o) of the Act requires the Secretary to establish a Value-Based Purchasing (VBP) Program for inpatient hospitals (Hospital VBP Program), which requires CMS to make value-based incentive payments to hospitals that meet performance standards for applicable performance periods, effective for discharges beginning on October 1, 2012. The rules for determining the payment adjustment under the Hospital Value-Based Purchasing Program are specified in §§ 412.160 through 412.167.

(c) Section 1886(p) of the Act requires the Secretary to establish an adjustment to hospital payments for hospital-acquired conditions, or a Hospital-Acquired Condition Reduction Program, under which payments to applicable hospitals are adjusted to provide an incentive to reduce hospital-acquired conditions, effective for discharges beginning on October 1, 2014. The rules for determining the payment

adjustment under the Hospital-Acquired Condition Reduction Program are specified in §§ 412.170 and 412.172.

[77 FR 53674, Aug. 31, 2012, as amended at 78 FR 50966, Aug. 19, 2013]

PAYMENT ADJUSTMENTS UNDER THE HOSPITAL READMISSIONS REDUCTION PROGRAM

§ 412.152 Definitions for the Hospital Readmissions Reduction Program.

As used in this section and in § 412.154, the following definitions apply:

Aggregate payments for all discharges is, for a hospital for the applicable period, the sum of the base operating DRG payment amounts for all discharges for all conditions from such hospital for such applicable period.

Aggregate payments for excess readmissions is, for a hospital for the applicable period, the sum, for the applicable conditions, of the product for each applicable condition of:

(1) The base operating DRG payment amount for the hospital for the applicable period for such condition or procedure;

(2) The number of admissions for such condition or procedure for the hospital for the applicable period;

(3) The excess readmission ratio for the hospital for the applicable period minus the peer-group median excess readmission ratio (ERR); and

(4) The neutrality modifier, a multiplicative factor that equates total Medicare savings under the current stratified methodology to the previous non-stratified methodology.

Applicable condition is a condition or procedure selected by the Secretary—

(1) Among the conditions and procedures for which—

(i) Readmissions represent conditions or procedures that are high volume or high expenditures; and

(ii) Measures of such readmissions have been endorsed by the entity with a contract under section 1890(a) of the Act and such endorsed measures have exclusions for readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital); or

(2) Among other conditions and procedures as determined appropriate by the Secretary. In expanding the applicable conditions, the Secretary will seek endorsement of the entity with a contract under section 1890(a) of the Act, but may apply such measures without such an endorsement in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

Applicable period is, with respect to a fiscal year, the 2-year or 3-year period (specified by the Secretary) from which data are collected in order to calculate excess readmission ratios and adjustments under the Hospital Readmissions Reduction Program.

(1) The applicable period for FY 2022 is the 3-year period from July 1, 2017 through June 30, 2020;

(2) Beginning with the FY 2023 program year, the applicable period is the 3-year period advanced by 1-year from the prior year's period from which data are collected in order to calculate excess readmission rations and adjustments under the Hospital Readmissions Reduction Program, unless otherwise specified by the Secretary; and

(3) Beginning with the FY 2027 program year, the applicable period is the 2-year period advanced by 1-year from the prior year's period from which data are collected in order to calculate excess readmission ratios and adjustments under the Hospital Readmissions Reduction Program, unless otherwise specified by the Secretary.

Applicable period for dual eligibility is the 2-year or 3-year data period corresponding to the applicable period for the Hospital Readmissions Reduction Program, unless otherwise established by the Secretary.

Base operating DRG payment amount is the wage-adjusted DRG operating payment plus any applicable new technology add-on payments under subpart F of this part. This amount is determined without regard to any payment adjustments under the Hospital Value-Based Purchasing Program, as specified under § 412.162. This amount does

not include any additional payments for indirect medical education under § 412.105, the treatment of a disproportionate share of low-income patients under § 412.106, outliers under subpart F of this part, and a low volume of discharges under § 412.101. With respect to a sole community hospital that receives payments under § 412.92(d) this amount also does not include the difference between the hospital-specific payment rate and the Federal payment rate determined under subpart D of this part. With respect to a Medicare-dependent, small rural hospital that receives payments under § 412.108(c), this amount includes the difference between the hospital-specific payment rate and the Federal payment rate determined under subpart D of this part. With respect to a hospital that is paid under section 1814(b)(3) of the Act, this amount is an amount equal to the wage-adjusted DRG payment amount plus new technology payments that would be paid to such hospitals, absent the provisions of section 1814(b)(3) of the Act.

Dual-eligible—(1) For payment adjustment factor calculations prior to the FY 2021 program year, is a patient beneficiary who has been identified as having full benefit status in both the Medicare and Medicaid programs in the State Medicare Authorization Act (MMA) files for the month the beneficiary was discharged from the hospital; and

(2) For payment adjustment factor calculations beginning in the FY 2021 program year, is a patient beneficiary who has been identified as having full benefit status in both the Medicare and Medicaid programs in data sourced from the State MMA files for the month the beneficiary was discharged from the hospital, except for those patient beneficiaries who die in the month of discharge, which will be identified using the previous month's data as sourced from the State MMA files.

Excess readmissions ratio is a hospital-specific ratio for each applicable condition for an applicable period, which is the ratio (but not less than 1.0) of risk-adjusted readmissions based on actual readmissions for an applicable hospital for each applicable condition to the risk-adjusted expected readmissions for the applicable hospital for the applicable condition.

Floor adjustment factor is the value that the readmissions adjustment factor cannot be less than for a given fiscal year. The floor adjustment factor is set at 0.99 for FY 2013, 0.98 for FY 2014, and 0.97 for FY 2015 and subsequent fiscal years.

Proportion of dual-eligibles is the number of dual-eligible patients among all Medicare Fee-for-Service and Medicare Advantage stays during the applicable period.

Readmission is the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period of 30 days from the date of such discharge.

Readmissions adjustment factor is equal to the greater of:

(1) 1 minus the ratio of the aggregate payments for excess readmissions to aggregate payments for all discharges; or

(2) The floor adjustment factor.

Wage-adjusted DRG operating payment is the applicable average standardized amount adjusted for resource utilization by the applicable MS–DRG relative weight and adjusted for differences in geographic costs by the applicable area wage index (and by the applicable cost-of-living adjustment for hospitals located in Alaska and Hawaii). This amount includes an applicable payment adjustment for transfers under § 412.4(f).

[77 FR 53674, Aug. 31, 2012, as amended at 78 FR 50967, Aug. 19, 2013; 83 FR 41704, Aug. 17, 2018; 84 FR 42613, Aug. 16, 20191 85 FR 59022, Sept. 18, 2020; 90 FR 37201, Aug. 4, 2025]

§ 412.154 Payment adjustments under the Hospital Readmissions Reduction Program.

(a) *Scope.* This section sets forth the requirements for determining the payment adjustments under the Hospital Readmissions Reduction Program for applicable hospitals to account for excess readmissions in the hospital.

(b) *Payment adjustment.* (1) *General.* To account for excess readmissions, except as provided for in paragraph (d) of this section, an applicable hospital's base operating DRG payment amount

is adjusted for each discharge occurring during the fiscal year. The payment adjustment for each discharge is determined by subtracting the product of the base operating DRG payment amount (as defined in §412.152) for such discharge by the hospital's readmission payment adjustment factor for the fiscal year (determined under paragraph (c) of this section) from the base operating DRG payment amount for such discharge.

(2) *Special treatment for sole community hospitals.* In the case of a sole community hospital that receives payments under §412.92(d) based on the hospital-specific rate, the difference between the hospital-specific rate payment and the Federal rate payment determined under subpart D of this part is not affected by this payment adjustment.

(c) *Methodology to calculate the readmissions payment adjustment factor.* A hospital's readmissions payment adjustment factor is the higher of the ratio described in paragraph (c)(1) of this section or the floor adjustment factor set forth in paragraph (c)(2) of this section.

(1) *Ratio.* The ratio is equal to 1 minus the ratio of the aggregate payments for excess readmissions as defined in §412.152 and the aggregate payments for all discharges as defined in §412.152.

(2) *Floor adjustment factor.* The floor adjustment factor is:

(i) For FY 2013, 0.99;

(ii) For FY 2014, 0.98; and

(iii) For FY 2015 and subsequent fiscal years, 0.97.

(d) *Extraordinary circumstance exception (ECE)*—(1) *General rule.* CMS may grant an ECE with respect to the reporting requirements under this section in the event of extraordinary circumstances beyond the control of the hospital. For purposes of this paragraph (d), an extraordinary circumstance is an event beyond the control of a hospital (for example, a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing) that affected the ability of the hospital to comply with one or more applicable reporting requirements with respect to a fiscal year.

(2) *Process for requesting an ECE.* (i) A hospital may request an ECE within 60 calendar days of the date that the extraordinary circumstance occurred by submitting the information specified by CMS at QualityNet or a successor website.

(ii) CMS notifies the hospital of its decision on the request, in writing, via email. In the event that CMS grants an ECE to the hospital, the written decision specifies whether the hospital is exempted from one or more reporting requirements or whether CMS has granted the hospital an extension of time to comply with one or more reporting requirements.

(3) *Authority to grant an ECE.* CMS may grant an ECE to one or more hospitals that have not requested an ECE if CMS determines that a systemic problem with a CMS data collection system directly impacted the ability of the hospital to comply with a quality data reporting requirement, or that an extraordinary circumstance has affected an entire region or locale. Any ECE granted under this paragraph (d)(3) specifies whether the affected hospitals are exempted from one or more reporting requirements or whether CMS has granted the hospitals an extension of time to comply with one or more reporting requirements.

(e) *Limitations on review.* There is no administrative or judicial review under this subpart of the following:

(1) The determination of base operating DRG payment amounts.

(2) The methodology for determining the adjustment factor under paragraph (c) of this section, including the excess readmissions ratio, aggregate payments for excess readmissions, and aggregate payments for all discharges.

(3) The applicable period.

(4) The neutrality modifier.

(5) The proportion of dual-eligibles.

(6) The applicable conditions.

(f) *Reporting of hospital-specific information.* CMS will make information available to the public regarding readmissions rates of each applicable hospital (as defined in §412.152) under the Hospital Readmissions Reduction Program.

(1) To ensure that an applicable hospital has the opportunity to review and

submit corrections for its excess readmission ratios for the applicable conditions for a fiscal year that are used to determine its readmissions payment adjustment factor under paragraph (c) of this section, CMS will provide each applicable hospital with confidential hospital-specific reports and discharge level information used in the calculation of its excess readmission ratios.

(2) Applicable hospitals will have a period of 30 days after receipt of the information provided in paragraph (f)(1) of this section to review and submit corrections for the excess readmission ratios for each applicable condition that are used to calculate the readmissions payment adjustment factor under paragraph (c) of this section for the fiscal year.

(3) The administrative claims data used to calculate an applicable hospital's excess readmission ratios for the applicable conditions for a fiscal year are not subject to review and correction under paragraph (f)(1) of this section.

(4) CMS posts the excess readmission ratios for the applicable conditions for a fiscal year for each applicable hospital on the Hospital Compare website or successor website(s).

[77 FR 53674, Aug. 31, 2012, as amended at 78 FR 50967, Aug. 19, 2013; 79 FR 50354, Aug. 22, 2014; 84 FR 42614, Aug. 16, 2019; 86 FR 45520, Aug. 13, 2021; 90 FR 37201, Aug. 4, 2025]

§§ 412.155–412.159 [Reserved]

INCENTIVE PAYMENTS UNDER THE HOSPITAL VALUE-BASED PURCHASING PROGRAM

§ 412.160 Definitions for the Hospital Value-Based Purchasing (VBP) Program.

As used in this section and in §§ 412.161 through 412.168:

Achievement threshold (or achievement performance standard) means the median (50th percentile) of hospital performance on a measure during a baseline period with respect to a fiscal year, for Hospital VBP Program measures other than the measures in the Efficiency and Cost Reduction domain, and the median (50th percentile) of hospital performance on a measure during the performance period with respect to a fiscal year, for the measures in the Efficiency and Cost Reduction domain.

Applicable percent means the following:

(1) For FY 2013, 1.0 percent;

(2) For FY 2014, 1.25 percent;

(3) For FY 2015, 1.50 percent;

(4) For FY 2016, 1.75 percent; and

(5) For FY 2017 and subsequent fiscal years, 2.0 percent.

Base operating DRG payment amount means the following:

(1) With respect to a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Act), the wage-adjusted DRG operating payment plus any applicable new technology add-on payments under subpart F of this part. This amount is determined without regard to any payment adjustments under the Hospital Readmissions Reduction Program, as specified under § 412.154. This amount does not include any additional payments for indirect medical education under § 412.105, the treatment of a disproportionate share of low-income patients under § 412.106, outliers under subpart F of this part, or a low volume of discharges under § 412.101.

(2) With respect to a Medicare-dependent, small rural hospital that receives payments under § 412.108(c) or a sole community hospital that receives payments under § 412.92(d), the wage-adjusted DRG operating payment plus any applicable new technology add-on payments under subpart F of this part. This amount does not include any additional payments for indirect medical education under § 412.105, the treatment of a disproportionate share of low-income patients under § 412.106, outliers under subpart F of this part, or a low volume of discharges under § 412.101. With respect to a Medicare-dependent, small rural hospital that receives payments under § 412.108(c) (for discharges occurring in FY 2013) or a sole community hospital that receives payments under § 412.92(d), this amount also does not include the difference between the hospital-specific payment rate and the Federal payment rate determined under subpart D of this part.

Benchmark means the arithmetic mean of the top decile of hospital performance on a measure during the baseline period with respect to a fiscal

year, for Hospital VBP Program measures other than the measures in the Efficiency and Cost Reduction domain, and the arithmetic mean of the top decile of hospital performance on a measure during the performance period with respect to a fiscal year, for the measures in the Efficiency and Cost Reduction domain.

Cited for deficiencies that pose immediate jeopardy means that, during the applicable performance period, the Secretary cited the hospital for immediate jeopardy on at least three surveys using the Form CMS–2567, Statement of Deficiencies and Plan of Correction. CMS assigns an immediate jeopardy citation to a performance period as follows:

(1) If the Form CMS–2567 only contains one or more EMTALA-related immediate jeopardy citations, CMS uses the date that the Form CMS–2567 is issued to the hospital;

(2) If the Form CMS–2567 only contains one or more Medicare conditions of participation immediate jeopardy citations, CMS uses the survey end date generated in ASPEN; and

(3) If the Form CMS–2567 contains both one or more EMTALA-related immediate jeopardy citations and one or more Medicare conditions of participation immediate jeopardy citations, CMS uses the survey end date generated in ASPEN.

Domain means a grouping of measures used for purposes of calculating the Total Performance Score for each hospital with respect to a fiscal year.

Domain score means the total number of points awarded to a hospital for a domain.

Hospital means a hospital described in section 1886(d)(1)(B) of the Act, but does not include a hospital, with respect to a fiscal year, for which one or more of the following applies:

(1) The hospital is subject to the payment reduction under section 1886(b)(3)(B)(viii)(I) of the Act for the fiscal year;

(2) The Secretary cited the hospital for deficiencies that pose immediate jeopardy to the health or safety of patients during the performance period that applies with respect to the fiscal year;

(3) There are not a minimum number of measures that apply to the hospital for the performance period for the fiscal year; or

(4) There are not a minimum number of cases for the measures that apply to the hospital for the performance period for the fiscal year.

Immediate jeopardy has the same meaning as that term is defined in §489.3 of this chapter.

Improvement threshold (or improvement performance standard) means an individual hospital's performance level on a measure during the baseline period with respect to a fiscal year.

Linear Exchange Function is the means to translate a hospital's total performance score into a value-based incentive payment percentage such that:

(1) Each eligible hospital's value-based incentive payment percentage is based on its total performance score; and

(2) The total amount of value-based incentive payments to all hospitals in a fiscal year is equal to the total amount available for value-based incentive payments in such fiscal year.

Measure performance scaler means the sum of the points awarded to a hospital for each domain for the fiscal year based on the hospital's performance on the measures in those domains.

Performance period means the time period during which data are collected for the purpose of calculating hospital performance on measures with respect to a fiscal year.

Performance standards are the levels of performance that hospitals must meet or exceed in order to earn points under the Hospital VBP Program, and are calculated with respect to a measure for a fiscal year no later than 60 days prior to the start of the performance period for that measure for that fiscal year. The performance standards for a measure may be updated as follows:

(1) To make a single correction to correct a calculation error, data issue, or other problem that would significantly change the performance standards; or

(2) To incorporate nonsubstantive technical updates made to the measure

between the time that CMS first displays the performance standards for that measure for a fiscal year and the time that CMS calculates hospital performance on that measure at the conclusion of the performance period for that measure for a fiscal year.

Total Performance Score means the numeric score awarded to each hospital based on its performance under the Hospital VBP Program with respect to a fiscal year.

Underserved multiplier means the mathematical result of applying a logistic function to the number of hospital inpatient stays for patients in the underserved population out of the hospital's total Medicare inpatient population during the calendar year that is 2 years prior to the applicable fiscal year.

Underserved population, as used in this section, means hospital inpatients who are Medicare beneficiaries and also dually eligible for full Medicaid benefits during the month of discharge or, if a patient died during that month, during the previous month.

Value-based incentive payment adjustment factor is the number that will be multiplied by the base operating DRG payment amount for each discharge from a hospital, during a fiscal year, in order to adjust the hospital's payment as a result of its performance under the Hospital VBP Program.

Value-based incentive payment percentage means the percentage of the base operating DRG payment amount for each discharge that a hospital has earned with respect to a fiscal year, based on its Total Performance Score for that fiscal year.

Wage-adjusted DRG operating payment is the applicable average standardized amount adjusted for—

(1) Resource utilization by the applicable MS-DRG relative weight;

(2) Differences in geographic costs by the applicable area wage index (and by the applicable cost-of-living adjustment for hospitals located in Alaska and Hawaii); and

(3) Any applicable payment adjustment for transfers under § 412.4(f).

[77 FR 53674, Aug. 31, 2012, as amended at 78 FR 50967, Aug. 19, 2013; 79 FR 50354, Aug. 22, 2014; 81 FR 57268, Aug. 22, 2016; 86 FR 45520, Aug. 13, 2021; 88 FR 59333, Aug. 28, 2023; 90 FR 37202, Aug. 4, 2025]

§ 412.161 Applicability of the Hospital Value-Based Purchasing (VBP) Program.

The Hospital VBP Program applies to hospitals, as that term is defined in § 412.160.

[79 FR 50355, Aug. 22, 2014]

§ 412.162 Process for reducing the base operating DRG payment amount and applying the value-based incentive payment amount adjustment under the Hospital Value-Based Purchasing (VBP) Program.

(a) *General.* If a hospital meets or exceeds the performance standards that apply to the Hospital VBP Program for a fiscal year, CMS will make value-based incentive payments to the hospital under the requirements and conditions specified in this section.

(b) *Value-based incentive payment amount.* (1) *Available amount.* The value-based incentive payment amount for a discharge is the portion of the payment amount that is attributable to the Hospital VBP Program. The total amount available for value based incentive payments to all hospitals for a fiscal year is equal to the total amount of base-operating DRG payment reductions for that fiscal year, as estimated by the Secretary.

(2) *Calculation of the value-based incentive payment amount.* The value-based incentive payment amount is calculated by multiplying the base operating DRG payment amount by the value-based incentive payment percentage.

(3) *Calculation of the value-based incentive payment percentage.* The value-based incentive payment percentage is calculated as the product of all of the following:

(i) The applicable percent as defined in § 412.160.

(ii)(A) For fiscal years before FY 2026, the hospital's Total Performance Score divided by 100; or

(B) Beginning with FY 2026, the hospital's Total Performance Score divided by 110; and

(iii) The linear exchange function slope.

(c) *Methodology to calculate the value-based incentive payment adjustment factor.* The value-based incentive payment adjustment factor for each discharge is determined by subtracting the applicable percent as specified in §412.160 from the value-based incentive payment percentage and then adding that difference to one.

[77 FR 53674, Aug. 31, 2012, as amended at 88 FR 59333, Aug. 28, 2023]

§412.163 Process for making hospital-specific performance information under the Hospital Value-Based Purchasing (VBP) Program available to the public.

(a) CMS will make information available to the public regarding the performance of each hospital under the Hospital VBP Program.

(b) To ensure that a hospital has the opportunity to review and submit corrections for the information to be made public under this section, CMS will provide each hospital with confidential hospital-specific reports and discharge level information used in the calculation of its performance with respect to each measure, condition, and domain, and the calculation of its Total Performance Score.

(c) Hospitals will have a period of 30 days after CMS provides the information specified in paragraph (b) of this section to review and submit corrections for the information.

(d) CMS will post the information specified in paragraph (b) for each hospital on the the *Hospital Compare* website, which can be accessed via the Care Compare website at *https://www.medicare.gov/care-compare/*.

[50 FR 12741, Mar. 29, 1985, as amended at 86 FR 45520, Aug. 13, 2021]

§412.164 Measure selection under the Hospital Value-Based Purchasing (VBP) Program.

(a) CMS will select measures, other than measures of readmissions, for purposes of the Hospital VBP Program. The measures will be selected from the measures specified under section 1886(b)(3)(B)(viii) of the Act (the Hospital Inpatient Quality Reporting Program).

(b) CMS will post data on each measure on the *Hospital Compare* website, which can be accessed via the Care Compare website at *https://www.medicare.gov/care-compare/*, for at least 1 year prior to the beginning of a performance period for the measure under the Hospital VBP Program.

(c)(1) *Updating of measure specifications.* CMS uses rulemaking to make substantive updates to the specifications of measures used in the Hospital VBP Program. CMS announces technical measure specification updates through the QualityNet website (*https://qualitynet.cms.gov*) and listserv announcements.

(2) *Measure retention.* All measures selected under paragraph (a) of this section remain in the measure set unless CMS, through rulemaking, removes or replaces them.

(3) *Measure removal factors*—(i) *General rule.* CMS may remove or replace a measure based on one of the following factors:

(A) *Factor 1.* Measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (''topped out'' measures), defined as: statistically indistinguishable performance at the 75th and 90th percentiles; and truncated coefficient of variation ≤0.10.

(B) *Factor 2.* A measure does not align with current clinical guidelines or practice.

(C) *Factor 3.* The availability of a more broadly applicable measure (across settings or populations) or the availability of a measure that is more proximal in time to desired patient outcomes for the particular topic.

(D) *Factor 4.* Performance or improvement on a measure does not result in better patient outcomes.

(E) *Factor 5.* The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic.

(F) *Factor 6.* Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

(G) *Factor 7.* It is not feasible to implement the measure specifications.

(H) *Factor 8.* The costs associated with a measure outweigh the benefit of its continued use in the program.

(ii) *Application of measure removal factors.* CMS assesses the benefits of removing a measure from the Hospital VBP Program on a case-by-case basis.

(iii) *Patient safety exception.* Upon a determination by CMS that the continued requirement for hospitals to submit data on a measure raises specific patient safety concerns, CMS may elect to immediately remove the measure from the Hospital VBP measure set. CMS will, upon removal of the measure—

(A) Provide notice to hospitals and the public at the time CMS removes the measure, along with a statement of the specific patient safety concerns that would be raised if hospitals continued to submit data on the measure; and

(B) Provide notice of the removal in the FEDERAL REGISTER.

[77 FR 53674, Aug. 31, 2012, as amended at 83 FR 41704, Aug. 17, 2018; 86 FR 45520, Aug. 13, 2021; 88 FR 59333, Aug. 28, 2023]

§ 412.165 Performance scoring under the Hospital Value-Based Purchasing (VBP) Program.

(a) *Points awarded based on hospital performance.* (1) CMS will award points to hospitals for performance on each measure for which the hospital reports the applicable minimum number of cases during the applicable performance period. The applicable minimum number of cases are set forth as follows:

TABLE 1 TO PARAGRAPH (a)(1)—MINIMUM CASE NUMBER REQUIREMENTS FOR HOSPITAL VBP PROGRAM

Measure short name	Minimum number of cases
Person and Community Engagement Domain	
HCAHPS	Hospitals must report a minimum number of 100 completed Hospital Consumer Assessment of Healthcare providers and Systems (HCAHPS) surveys.
Clinical Outcomes Domain	
MORT–30–AMI	Hospitals must report a minimum number of 25 cases.
MORT–30–HF	Hospitals must report a minimum number of 25 cases.
MORT–30–PN (updated cohort)	Hospitals must report a minimum number of 25 cases.
MORT–30–COPD	Hospitals must report a minimum number of 25 cases.
MORT–30–CABG	Hospitals must report a minimum number of 25 cases.
COMP–HIP–KNEE	Hospitals must report a minimum number of 25 cases.
Safety Domain	
CAUTI	Hospitals have a minimum of 1.000 predicted infections as calculated by the Centers for Disease Control and Prevention (CDC).
CLABSI	Hospitals have a minimum of 1.000 predicted infections as calculated by the CDC.
Colon and Abdominal Hysterectomy SSI.	Hospitals have a minimum of 1.000 predicted infections as calculated by the CDC.
MRSA Bacteremia	Hospitals have a minimum of 1.000 predicted infections as calculated by the CDC.
CDI	Hospitals have a minimum of 1.000 predicted infections as calculated by the CDC.
SEP–1	Hospitals must report a minimum number of 25 cases.
Efficiency and Cost Reduction Domain	
MSPB	Hospitals must report a minimum number of 25 cases.

(2) CMS will award from 1 to 9 points for achievement to each hospital whose performance on a measure during the applicable performance period meets or exceeds the achievement threshold but is less than the benchmark for that measure.

(3) CMS will award from 0 to 9 points for improvement to each hospital whose performance on a measure during the applicable performance period exceeds the improvement threshold but is less than the benchmark for that measure.

(4) CMS will award 10 points to a hospital whose performance on a measure during the applicable performance period meets or exceeds the benchmark for that measure.

(b) *Calculation of the Total Performance Score.* The hospital's Total Performance Score for a program year is calculated as follows:

(1) CMS will calculate a domain score for a hospital when it reports the minimum number of measures in the domain.

(2) CMS will sum all points awarded for each measure in a domain to calculate an unweighted domain score.

(3) CMS will normalize each domain score to ensure that it is expressed as a percentage of points earned out of 100.

(4) CMS will weight the domain scores with the finalized domain weights for each fiscal year.

(5) The hospital's Total Performance Score for the fiscal year is the sum of the weighted domain scores up to a maximum score of 100.

(c) *Extraordinary circumstance exception (ECE)*—(1) *General rule.* CMS may grant an ECE with respect to the reporting requirements under this section in the event of extraordinary circumstances beyond the control of the hospital. For purposes of this paragraph (c), an extraordinary circumstance is an event beyond the control of a hospital (for example, a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing) that affected the ability of the hospital to comply with one or more applicable reporting requirements with respect to a fiscal year.

(2) *Process for requesting an ECE.* (i) A hospital may request an ECE within 60 calendar days of the date that the extraordinary circumstance occurred by submitting the information specified by CMS at QualityNet or a successor website.

(ii) CMS notifies the hospital of its decision on the request, in writing, via email. In the event that CMS grants an ECE to the hospital, the written decision will specify whether the hospital is exempted from one or more reporting requirements or whether CMS has granted the hospital an extension of time to comply with one or more reporting requirements.

(3) *Authority to grant an ECE.* CMS may grant an ECE to one or more hospitals that have not requested an ECE if CMS determines that a systemic problem with a CMS data collection system directly impacted the ability of the hospital to comply with a quality data reporting requirement or that an extraordinary circumstance has affected an entire region or locale. Any ECE granted under this paragraph (c)(3) specifies whether the affected hospitals are exempted from one or more reporting requirements or whether CMS has granted the hospitals an extension of time to comply with one or more reporting requirements.

[50 FR 12741, Mar. 29, 1985, as amended at 85 FR 27621, May, 8, 2020; 86 FR 45520, Aug. 13, 2021; 88 FR 59333, Aug. 28, 2023; 90 FR 37202, Aug. 4, 2025]

§412.167 Appeal under the Hospital Value-Based Purchasing (VBP) Program.

(a) A hospital may appeal the following issues:

(1) CMS' decision to deny a hospital's correction request that the hospital submitted under the review and corrections process;

(2) Whether the achievement/improvement points were calculated correctly;

(3) Whether CMS properly used the higher of the achievement/improvement points in calculating the hospital's measure/dimension score;

(4) Whether CMS correctly calculated the domain scores, including the normalization calculation;

(5) Whether CMS used the proper lowest dimension score in calculating the hospital's HCAHPS consistency points;

(6) Whether CMS calculated the HCAHPS consistency points correctly;

(7) Whether the correct domain scores were used to calculate the Total Performance Score;

(8) Whether each domain was weighted properly;

(9) Whether the weighted domain scores were properly summed to arrive at the Total Performance Score; and,

(10) Whether the hospital's open/closed status (including mergers and

acquisitions) is properly specified in CMS' systems.

(b) Appeals must be submitted within 30 days of CMS' decision to deny a corrections request under § 412.163 or within 30 days of the conclusion of the review and corrections period, as applicable, and must contain the following information:

(1) Hospital's CMS Certification Number (CCN).

(2) Hospital name.

(3) Hospital's basis for requesting an appeal. This must identify the hospital's specific reason(s) for appealing the hospital's Total Performance Score or performance assessment with respect to the performance standards.

(4) CEO contact information, including name, email address, telephone number, and mailing address (must include the physical address, not just the post office box).

(5) QualityNet security official contact information, including name, email address, telephone number, and mailing address (must include the physical address, not just the post office box).

(c) If a hospital is dissatisfied with CMS' decision on an appeal request submitted under paragraph (b) of this section, the hospital may request an independent CMS review of that decision.

(d) *Limitations on review.* There is no administrative or judicial review of the following:

(1) The methodology used to determine the amount of the value-based incentive payment under section 1886(o)(6) of the Act and the determination of such amount.

(2) The determination of the amount of funding available for value-based incentive payments under section 1886(o)(7)(A) of the Act and the payment reduction under section 1886(o)(7)(B)(i) of the Act.

(3) The establishment of the performance standards under section 1886(o)(3) of the Act and the performance period under section 1886(o)(4) of the Act.

(4) The measures specified under section 1886(b)(3)(B)(viii) of the Act and the measures selected under section 1886(o)(2) of the Act.

(5) The methodology developed under section 1886(o)(5) of the Act that is used to calculate hospital performance scores and the calculation of such scores.

(6) The validation methodology that is specified under section 1886(b)(3)(B)(viii)(XI) of the Act.

[50 FR 12741, Mar. 29, 1985, as amended at 78 FR 75196, Dec. 10, 2013; 86 FR 45520, Aug. 13, 2021]

§ 412.168 Special rules for FY 2022 and FY 2023.

(a) This section sets forth the scoring and payment methodology for each of fiscal years 2022 and 2023Hospital VBP Program.

(b) CMS calculates a measure rate for all measures selected under § 412.164(a) for fiscal year 2022 but only applies § 412.165(a) to the measures included in the Clinical Outcomes Domain for that fiscal year, which are the following:

(1) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization (MORT–30–AMI).

(2) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization (MORT–30–HF).

(3) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization (MORT–30–PN (updated cohort)).

(4) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (MORT–30–COPD).

(5) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (MORT–30–CABG).

(6) Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (COMP–HIP–KNEE).

(c) CMS calculates a domain score for the measures described in paragraph (b)(1) of this section for hospitals that report the minimum number of measures in the Clinical Outcomes Domain.

(d) CMS does not award a Total Performance Score to any hospital.

(e) The total amount available for value-based incentive payments for fiscal year 2022 is equal to the total

amount of base-operating DRG payment reductions for that fiscal year, as estimated by the Secretary.

(f) CMS awards value-based incentive payment percentages (as defined in § 412.160) for all hospitals to ensure that each hospital receives an incentive payment amount equal to the amount of the reduction made to its base-operating DRG payment amounts.

(g) CMS calculates a measure rate for all measures selected under § 412.164(a) for fiscal year 2023 but only applies § 412.165(a) to the measures included in the Clinical Outcomes Domain and the Efficiency and Cost Reduction Domain for that fiscal year, which are the following:

(1) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization (MORT–30–AMI).

(2) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization (MORT–30–HF).

(3) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization (MORT–30–PN (updated cohort)).

(4) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (MORT–30–COPD).

(5) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (MORT–30–CABG).

(6) Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (COMP–HIP–KNEE).

(7) Medicare Spending Per Beneficiary (MSPB)—Hospital.

(h) CMS calculates—

(1) A Clinical Outcomes Domain score for fiscal year 2023 for hospitals that report the minimum number of cases and measures with respect to the measures described in paragraphs (g)(1) through (6) of this section; and

(2) An Efficiency and Cost Reduction Domain score for fiscal year 2023 for hospitals that report the minimum number of cases with respect to the measure described in paragraph (g)(7) of this section.

(i) CMS does not award a Total Performance Score to any hospital for fiscal year 2023.

(j) The total amount available for value-based incentive payments for fiscal year 2023 is equal to the total amount of base-operating DRG payment reductions for that fiscal year, as estimated by the Secretary.

(k) CMS awards a value-based incentive payment percentage (as defined in § 412.160) for fiscal year 2023 to all hospitals to ensure that each hospital receives a value-based incentive payment amount equal to the amount of the reduction made to its base-operating DRG payment amounts.

[86 FR 45520, Aug. 13, 2021, as amended at 87 FR 49404, Aug. 10, 2022]

§ 412.169 [Reserved]

Payment Adjustments Under the Hospital-Acquired Condition Reduction Program

§ 412.170 Definitions for the Hospital-Acquired Condition Reduction Program.

As used in this section and § 412.172, the following definitions apply:

Applicable hospital is a hospital described in section 1886(d)(1)(B) of the Act (including a hospital in Maryland that is paid under the waiver under section 1814(b)(3) of the Act and that, absent the waiver specified by section 1814(b)(3) of the Act, would have been paid under the hospital inpatient prospective payment system) as long as the hospital meets the criteria specified under § 412.172(e).

Applicable period is, unless otherwise specified by the Secretary, with respect to a fiscal year, the 2-year period (specified by the Secretary) from which data are collected in order to calculate the total hospital-acquired condition score under the Hospital-Acquired Condition Reduction Program.

(1) The applicable period for FY 2022—

(i) For the CMS PSI 90 measure, is the 24-month period from July 1, 2018 through June 30, 2020; and

(ii) For the CDC NHSN HAI measures, is the 24-month period from January 1, 2019 through December 31, 2020.

(2) Beginning with the FY 2023 program year, the applicable period is the 24-month period advanced by 1-year from the prior fiscal year's period from which data are collected in order to calculate the total hospital-acquired condition score under the Hospital-Acquired Condition Reduction Program, unless otherwise specified by the Secretary.

CDC NHSN HAI stands for Centers for Disease Control and Prevention National Healthcare Safety Network healthcare-associated infection measures.

CMS PSI 90 stands for Patient Safety and Adverse Events Composite for Selected Indicators (modified version of PSI 90).

Hospital-acquired condition is a condition as described in section 1886(d)(4)(D)(iv) of the Act and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital, as determined by the Secretary.

[78 FR 50967, Aug. 19, 2013, as amended at 81 FR 57268, Aug. 22, 2016; 85 FR 59022, Sept. 18, 2020]

§ 412.172 Payment adjustments under the Hospital-Acquired Condition Reduction Program.

(a) *Scope.* This section sets forth the requirements for determining the payment adjustments under the Hospital-Acquired Condition Reduction Program for hospitals that meet the criteria described under paragraph (e) of this section.

(b) *Payment adjustment.* With respect to all discharges from an applicable hospital occurring during FY 2015 or a subsequent year, the amount of payment under this section, or section 1814(b)(3) of the Act as applicable, for such discharges during the fiscal year will be equal to 99 percent of the amount of payment that would otherwise apply to these discharges under this section or section 1814(b)(3) of the Act (determined after the application of the payment adjustment under the Hospital Readmissions Reduction Program under § 412.154 and the adjustment made under the Hospital Value-Based Purchasing Program under § 412.162 and section 1814(l)(4) of the Act but without regard to section 1886(p) of the Act).

(c) *Extraordinary circumstance exception (ECE)*—(1) *General rule.* CMS may grant an ECE with respect to the reporting requirements under this section in the event of extraordinary circumstances beyond the control of the hospital. For purposes of this paragraph (c), an extraordinary circumstance is an event beyond the control of a hospital (for example, a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing) that affected the ability of the hospital to comply with one or more applicable reporting requirements with respect to a fiscal year.

(2) *Process for requesting an ECE.* (i) A hospital may request an ECE within 60 calendar days of the date that the extraordinary circumstance occurred by submitting the information specified by CMS at QualityNet or a successor website.

(ii) CMS notifies the hospital of its decision on the request, in writing, via email. In the event that CMS grants an ECE to the hospital, the written decision specifies whether the hospital is exempted from one or more reporting requirements or whether CMS has granted the hospital an extension of time to comply with one or more reporting requirements.

(3) *Authority to grant an ECE.* CMS may grant an ECE to one or more hospitals that have not requested an ECE if CMS determines that a systemic problem with a CMS data collection system directly impacted the ability of the hospital to comply with a quality data reporting requirement, or that an extraordinary circumstance has affected an entire region or locale. Any ECE granted under this paragraph (c)(3) will specify whether the affected hospitals are exempted from one or more reporting requirements or whether CMS has granted the hospitals an extension of time to comply with one or more reporting requirements.

(d) *Risk adjustment.* In carrying out the provisions of paragraph (e) of this section, CMS will establish and apply an appropriate risk-adjustment methodology.

(e) *Criteria for applicable hospitals.* (1) *General.* With respect to a subsection (d) hospital, CMS will identify the top quartile of all subsection (d) hospitals with respect to hospital-acquired conditions as measured during the applicable period.

(2) *Use of total hospital-acquired condition scores.* CMS will use total hospital-acquired condition scores to identify applicable hospitals. CMS will identify the 25 percent of hospitals with the highest total scores.

(3) *Methodology for calculating total hospital-acquired condition scores.* CMS will calculate the total hospital-acquired condition scores by weighing the selected measures according to the established methodology.

(f) *Reporting of hospital-specific information.* CMS will make information available to the public regarding hospital-acquired condition rates of all hospitals under the Hospital-Acquired Condition Reduction Program.

(1) CMS will provide each hospital with confidential hospital-specific reports and discharge level information used in the calculation of its total hospital-acquired condition score.

(2) Hospitals will have a period of 30 days after the receipt of the information provided under paragraph (f)(1) of this section to review and submit corrections for the hospital-acquired condition program score*s* for each condition that is used to calculate the total hospital-acquired condition score for the fiscal year.

(3) The administrative claims data used to calculate a hospital's total hospital-acquired condition score for a condition for a fiscal year are not subject to review and correction under paragraph (f)(2) of this section.

(4) CMS posts the total hospital-acquired condition score, the domain score, and the score on each measure for each hospital on the Hospital Compare website or successor website.

(g) *Limitations on review.* There is no administrative or judicial review under §412.170 and this section for the following:

(1) The criteria describing applicable hospitals.

(2) The applicable period.

(3) The specification of hospital-acquired conditions.

(4) The provision of reports to hospitals and the information made available to the public.

[78 FR 50967, Aug. 19, 2013, as amended at 79 FR 50355, Aug. 22, 2014; 84 FR 42614, Aug. 16, 2019; 86 FR 45520, Aug. 13, 2021; 90 FR 37202, Aug. 4, 2025]

§412.190 Overall Hospital Quality Star Rating.

(a) *Purpose.* (1) The Overall Hospital Quality Star Rating (Overall Star Rating) is a summary of certain publicly reported hospital measure data for the benefit of stakeholders, such as patients, consumers, and hospitals.

(2) The guiding principles of the Overall Star Rating are as follows. In developing and maintaining the Overall Star Ratings, we strive to:

(i) Use scientifically valid methods that are inclusive of hospitals and measure information and able to accommodate underlying measure changes;

(ii) Align with *Hospital Compare* or its successor website and CMS programs;

(iii) Provide transparency of the methods for calculating the Overall Star Rating; and

(iv) Be responsive to stakeholder input.

(b) *Data included in Overall Star Rating*—(1) *Source of data.* The Overall Star Rating is calculated based on measure data collected and publicly reported on *Hospital Compare* or its successor site under the following CMS hospital inpatient and outpatient programs:

(i) Hospital Inpatient Quality Reporting (IQR) Program—section 1886(b)(3)(B)(viii)(VII) of the Act.

(ii) Hospital-Acquired Condition Reduction Program—section 1886(p)(6)(A) of the Act.

(iii) Hospital Value-based Purchasing Program—section 1886(o)(10)(A) of the Act.

(iv) Hospital Readmissions Reduction Program—section 1886(q)(6)(A) of the Act.

(v) Hospital Outpatient Quality Reporting (OQR) Program—section 1833(t)(17)(e) of the Act.

(2) *Hospitals included in Overall Star Rating.* Subsection (d) hospitals subject to the CMS quality programs specified in paragraph (b)(1) of this section that also have their data publicly reported

on one of CMS' websites are included in the Overall Star Rating.

(3) *Critical Access Hospitals.* Critical Access Hospitals (CAHs) that wish to be voluntarily included in the Overall Star Rating must have elected to—

(i) Voluntarily submit quality measures included in and as specified under CMS hospital programs; and

(ii) Publicly report their quality measure data on *Hospital Compare* or its successor site.

(c) Frequency of publication and data used. The Overall Star Rating are published once annually using data publicly reported on Hospital Compare or its successor website from a quarter within the previous 12 months.

(d) *Methodology*—(1) *Selection of measures.* Measures are selected from those publicly reported on *Hospital Compare* or its successor website through certain CMS quality programs under paragraph (b)(1) of this section.

(i) From this group of measures, measures falling into one or more of the exclusions in paragraphs (d)(1)(i)(A) through (E) of this section will be removed from consideration:

(A) Measures that 100 hospitals or less publicly report. These measures would not produce reliable measure group scores based on too few hospitals;

(B) Measures that cannot be standardized to a single, common scale and otherwise not amenable to inclusion in a summary score calculation alongside process and outcome measures or measures that cannot be combined in a meaningful way. This includes measures that cannot be as easily combined with other measures captured on a continuous scale with more granular data;

(C) Non-directional measures for which it is unclear whether a higher or lower score is better. These measures cannot be standardized to be combined with other measures and form an aggregate measure group score;

(D) Measures not required for reporting on *Hospital Compare* or its successor websites through CMS programs; or

(E) Measures that overlap with another measure in terms of cohort or outcome, including component measures that are part of an already-included composite measure.

(ii) [Reserved]

(2) *Measure score standardization.* All measure scores are standardized by calculating Z-scores so that all measures are on a single, common scale to be consistent in terms of direction (that is, higher scores are better) and numerical magnitude. This is calculated by subtracting the national mean measure score from each hospital's measure score and dividing the difference by the measure standard deviation in order to standardize measures.

(3) *Grouping measures.* Measures are grouped into one of the five clinical groups as follows:

(i) Mortality.

(ii) Safety of Care.

(iii) Readmission.

(iv) Patient Experience.

(v) Timely and Effective Care.

(4) *Calculate measure group scores.* A score is calculated for each measure group for which a hospital has measure data using a simple average of measure scores, as follows:

(i) Each measure group score is standardized by calculating Z-scores for each measure group so that all measure group scores are centered near zero with a standard deviation of one.

(ii) We take 100 percent divided by the number of measures reported in a measure group to determine the percentage of each measure's weight.

(iii) The measure weight is then multiplied by the standardized measure score to calculate the measure's weighted score.

(iv) Then, all of the individual measure weighted scores within a measure group are added together to calculate the measure group score.

(5) *Reporting thresholds.* In order to receive an Overall Star Rating, a hospital must report at least three measures within at least three measure groups, one of which must specifically be the Mortality or Safety of Care outcome group.

(6) *Hospital summary score.* A summary score is calculated by multiplying the standardized measure group scores by the assigned measure group weights and then summing the weighted measure group scores.

(i) *Standard measure group weighting.* (A) Each of the Mortality, Safety of

Care, Readmission, and Patient Experience groups are weighted 22 percent; and

(B) The Timely and Effective Care group is weighted 12 percent.

(ii) *Reweighting.* (A) Hospitals may have too few cases to report particular measures and, in those cases, may not report enough measures in one or more measure groups.

(B) When a hospital does not have enough measures in one or more measure groups due to too few cases CMS may re-distribute one or more of the missing measure group's weight proportionally across the remaining measure groups by subtracting the standard weight percentage of the group or groups with insufficient measures from 100 percent; and then dividing the resulting percentage across the remaining measure groups, giving new re-proportioned weights.

(7) *Peer grouping.* Hospitals are assigned to one of three peer groups based on the number of measure groups for which they report at least three measures: three, four, or five measure groups.

(8) *Star ratings assignment.* Hospitals in each peer group are then assigned between one and five stars where one star is the lowest and five stars is the highest using k-means clustering to complete convergence.

(e) *Preview period prior to publication.* CMS provides hospitals the opportunity to preview their Overall Star Rating prior to publication. Hospitals have at least 30 days to preview their results, and if necessary, can reach out to CMS with questions.

(f) *Suppression of Overall Star Rating*—(1) *Subsection (d) hospitals.* CMS may consider suppressing Overall Star Rating for subsection (d) hospitals only under extenuating circumstances that affect numerous hospitals (as in, not an individualized or localized issue) as determined by CMS, or when CMS is at fault, including but not limited to when:

(i) There is an Overall Star Rating calculation error by CMS;

(ii) There is a systemic error at the CMS quality program level that substantively affects the Overall Star Rating calculation; or

(iii) If a Public Health Emergency, as defined in §400.200 of this chapter, substantially affects the underlying measure data.

(2) *CAHs.* (i) CAHs may request to withhold their Overall Star Rating from publication on *Hospital Compare* or its successor website so long as the request for withholding is made, at the latest, during the Overall Star Rating preview period.

(ii) CAHs may request to have their Overall Star Rating withheld from publication on *Hospital Compare* or its successor website, as well as their data from the public input file, so long as the request is made during the CMS quality program-level 30-day confidential preview period for the *Hospital Compare* refresh data used to calculate the Overall Star Ratings.

[85 FR 86300, Dec. 29, 2020, as amended at 87 FR 72287, Nov. 23, 2022]

Subpart J [Reserved]

Subpart K—Prospective Payment System for Inpatient Operating Costs for Hospitals Located in Puerto Rico

SOURCE: 52 FR 33058, Sept. 1, 1987, unless otherwise noted.

§412.200 General provisions.

Beginning with discharges occurring on or after October 1, 1987, hospitals located in Puerto Rico are subject to the rules governing the prospective payment system for inpatient operating costs. Except as provided in this subpart, the provisions of subparts A, B, C, F, G, and H of this part apply to hospitals located in Puerto Rico. Except for §412.60, which deals with DRG classification and weighting factors, or as otherwise specified, the provisions of subparts D and E, which describe the methodology used to determine prospective payment rates for inpatient operating costs for hospitals, do not apply to hospitals located in Puerto Rico. Instead, the methodology for determining prospective payment rates for inpatient operating costs for these

hospitals is set forth in §§ 412.204 through 412.212.

[83 FR 41704, Aug. 17 2018]

§ 412.204 Payment to hospitals located in Puerto Rico.

(a) *FY 1988 through FY 1997.* For discharges occurring on or after October 1, 1987 and before October 1, 1997, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(1) 75 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.210; and

(2) 25 percent of a national prospective payment rate for inpatient operating costs, as determined under § 412.212.

(b) *FY 1998 through March 31, 2004.* For discharges occurring on or after October 1, 1997 and before April 1, 2004, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(1) 50 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.210; and

(2) 50 percent of a national prospective payment rate for inpatient operating costs, as determined under § 412.212.

(c) *Period of April 1, 2004 through September 31, 2004.* For discharges occurring on or after April 1, 2004 and before October 1, 2004, payment for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(1) 37.5 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.210; and

(2) 62.5 percent of the national prospective payment rate for inpatient operating costs, as determined under § 412.212.

(d) *FY 2005 through December 31, 2015.* For discharges occurring on or after October 1, 2004 and before January 1, 2016, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(1) 25 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.211; and

(2) 75 percent of a national prospective payment rate for inpatient operating costs, as determined under § 412.212.

(e) *January 1, 2016 and thereafter.* For discharges occurring on or after January 1, 2016, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to 100 percent of a national prospective payment rate for inpatient operating costs, as determined under § 412.212.

[62 FR 46030, Aug. 29, 1997, as amended at 69 FR 49247, Aug. 11, 2004; 81 FR 57268, Aug. 22, 2016]

§ 412.208 Puerto Rico rates for Federal fiscal year 1988.

(a) *General rule.* CMS determines the Puerto Rico adjusted DRG prospective payment rate for inpatient operating costs for each inpatient hospital discharge occurring in Federal fiscal year 1988 for a prospective payment hospital. These rates are determined as described in paragraphs (b) through (i) of this section.

(b) *Determining target amounts.* For each hospital subject to the prospective payment system for inpatient operating costs, CMS determines the Medicare target amount, as described in § 413.40(c) of this chapter, for the hospital's cost reporting period beginning in fiscal year 1987. Revisions in the target amounts made subsequent to establishment of the standardized amounts under paragraph (d) of this section do not affect the standardized amounts.

(c) *Updating the target amounts for fiscal year 1988.* CMS updates each target amount determined under paragraph (b) of this section for fiscal year 1988 by prorating the applicable percentage increase (as defined in § 412.63(f) of this chapter) for fiscal year 1988 to the midpoint of fiscal year 1988 (April 1, 1988).

(d) *Standardizing amounts.* CMS standardizes the amount updated under paragraph (c) of this section for each hospital by—

(1) Adjusting for variations in case mix among hospitals;

(2) Excluding an estimate of indirect medical education costs;

(3) Adjusting for area variations in hospital wage levels; and

(4) Excluding an estimate of the payments for hospitals that serve a disproportionate share of low-income patients.

(e) *Computing urban and rural averages.* CMS computes separate discharge-weighted averages of the standardized amounts determined under paragraph (d) of this section for urban and rural hospitals in Puerto Rico.

(f) *Geographic classification.* (1) For purposes of this paragraph (e) of this section, the following definitions apply:

(i) The term *urban area* means a Metropolitan Statistical Area (MSA), as defined by the Executive Office of Management and Budget.

(ii) The term *large urban area* means an MSA with a population of more than 1,000,000.

(iii) The term *rural area* means any area outside an urban area.

(2) A hospital classified as rural is deemed to be urban and receives the urban Puerto Rico payment amount if the county in which it is located meets the following criteria:

(i) At least 95 percent of the perimeter of the rural county is contiguous with urban counties.

(ii) The county was reclassified from an urban area to a rural area after April 20, 1983, as described in §412.62(f)(1)(iv).

(iii) At least 15 percent of employed workers in the county commute to the central county of one of the adjacent MSAs.

(g) *Reducing for value of outlier payments.* CMS reduces each of the average standardized amounts determined under paragraphs (c) through (e) of this section by a proportion equal to the proportion (estimated by CMS) of the total amount of payments based on DRG prospective payment rates that are additional payments to hospitals located in Puerto Rico for outlier cases under subpart F of this part.

(h) *Computing Puerto Rico rates established under the prospective payment system for inpatient operating costs for urban and rural hospitals.* For each discharge classified within a DRG, CMS establishes a Puerto Rico prospective payment rate, as follows:

(1) For hospitals located in an urban area, the rate equals the product of—

(i) The average standardized amount (computed under paragraphs (c) through (g) of this section) for hospitals located in an urban area; and

(ii) The weighting factor determined under §412.60(b) for that DRG.

(2) For hospitals located in a rural area, the rate equals the product of—

(i) The average standardized amount (computed under paragraphs (c) through (g) of this section) for hospitals located in a rural area; and

(ii) The weighting factor determined under §412.60(b) for that DRG.

(i) *Adjusting for different area wage levels.* CMS adjusts the proportion (as estimated by CMS from time to time) of Puerto Rico rates computed under paragraph (h) of this section that are attributable to wages and labor-related costs, for area differences in hospital wage levels, by a factor (established by CMS) reflecting the relative hospital wage level in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (f) of this section) of the hospital compared to the national average hospital wage level.

[52 FR 33058, Sept. 1, 1987; 52 FR 35350, Sept. 18, 1987, as amended at 53 FR 38533, Sept. 30, 1988; 57 FR 39825, Sept. 1, 1992]

§412.210 Puerto Rico rates for Federal fiscal years 1989 through 2003.

(a) *General rule.* (1) CMS determines the Puerto Rico adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge occurring in Federal fiscal years 1989 through 2003 that involves inpatient hospital services of a hospital in Puerto Rico subject to the prospective payment system for which payment may be made under Medicare Part A.

(2) The rate is determined for hospitals located in large urban, other urban, or rural areas within Puerto Rico, as described in paragraphs (b) through (e) of this section.

(b) *Geographic classifications.* (1) For purposes of this section, the definitions set forth in § 412.208(f)(1) apply.

(2) For discharges occurring on or after October 1, 1988, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greatest number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final standards for classification of MSAs published in the FEDERAL REGISTER on January 3, 1980 (45 FR 956), and available from CMS, East High Rise Building, Room 132, 6325 Security Boulevard, Baltimore, Maryland 21207.

(3) For discharges occurring on or after October 1, 1988, for hospitals that consist of two or more separately located inpatient hospital facilities, the national adjusted prospective payment rate for inpatient operating costs is based on the geographic location of the hospital at which the discharge occurs.

(c) *Updating previous standardized amounts.* CMS computes separate average standardized amounts for hospitals in large urban, other urban, and rural areas within Puerto Rico equal to the respective average standardized amount computed for fiscal year 1988 under § 412.208(e)—

(1) Increased by the applicable percentage changes determined under § 412.63 (g) and (h); and

(2) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts to hospitals located in Puerto Rico attributable to outlier cases under subpart F of this part.

(d) *Computing Puerto Rico rates for large urban, other urban, and rural hospitals.* For each discharge classified within a DRG, CMS establishes for the fiscal year a Puerto Rico prospective payment rate for inpatient operating costs as follows:

(1) For hospitals located in a large urban or other urban area in Puerto Rico, the rate equals the product of—

(i) The average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in a large urban or other urban area; and

(ii) The weighting factor determined under § 412.60(b) for that DRG.

(2) For hospitals located in a rural area in Puerto Rico, the rate equals the product of—

(i) The average standardized amount (computed under paragraph (c) of this section) for the fiscal year for hospitals located in a rural area; and

(ii) The weighting factor (determined under § 412.60(b)) for that DRG.

(e) *Adjusting for different area wage levels.* CMS adjusts the proportion (as estimated by CMS from time to time) of Puerto Rico rates computed under paragraph (d) of this section that is attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS) reflecting the relative hospital wage level in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the Peurto Rico average hospital wage level.

[52 FR 33058, Sept. 1, 1987, as amended at 53 FR 38533, Sept. 30, 1988; 57 FR 39825, Sept. 1, 1992; 62 FR 46030, Aug. 29, 1997; 69 FR 49247, Aug. 11, 2004]

§ 412.211 Puerto Rico rates for Federal fiscal year 2004 and subsequent fiscal years.

(a) *General rule.* CMS determines the Puerto Rico adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge occurring in Federal fiscal year 2004 and subsequent fiscal years that involves inpatient hospital services of a hospital in Puerto Rico subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term *urban area* means a Metropolitan Statistical Area (MSA) as defined by the Executive Office of Management and Budget.

(ii) The term *rural area* means any area outside of an urban area.

(2) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the FEDERAL REGISTER on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(c) *Computing the standardized amount.* CMS computes a Puerto Rico standardized amount that is applicable to all hospitals located in all areas. The applicable percentage change for updating the Puerto Rico specific standardized amount is as follows:

(1) For fiscal year 2004 through fiscal year 2009, increased by the applicable percentage change specified in §412.64(d)(1)(ii)(A).

(2) For fiscal year 2010, increased by the market basket index for prospective payment hospitals (as defined in §413.40(a) of this subchapter) for hospitals in all areas.

(3) For fiscal year 2011, increased by the applicable percentage change specified in §412.64(d)(1)(iii).

(4) For fiscal year 2012 and subsequent fiscal years, the applicable percentage increase specified in §412.64(d).

(d) *Computing Puerto Rico Federal rates for inpatient operating costs for hospitals located in all areas.* For each discharge classified within a DRG, CMS establishes for the fiscal year a Puerto Rico prospective payment rate for inpatient operating costs equal to the product of—

(1) The average standardized amount for the fiscal year for hospitals located in all areas; and

(2) The weighting factor determined under §412.60(b) for that DRG.

(e) *Adjusting for different area wage levels.* CMS adjusts the proportion of the Puerto Rico rate for inpatient operating costs that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the Puerto Rico average level of hospital wages and wage-related costs. The adjustment specified in this paragraph (e) also takes into account the earnings and paid hours of employment by occupational category.

(1) The wage index is updated annually.

(2) CMS determines the proportion of the Puerto Rico rate that is attributable to wages and labor-related costs from time to time, employing a methodology that is described in the annual update of the prospective payment system for payment of inpatient hospital operating costs published in the FEDERAL REGISTER.

(3) For discharges occurring on or after October 1, 2004, CMS employs 62 percent as the proportion of the rate that is adjusted for the relative level of hospital wages and wage-related costs, unless employing that percentage would result in lower payments for the hospital than employing the proportion determined under the methodology described in paragraph (e)(2) of this section.

(f) *Adjusting the wage index to account for commuting patterns of hospital workers*—(1) *General criteria.* For discharges occurring on or after October 1, 2004, CMS adjusts the hospital wage index for hospitals located in qualifying areas to recognize the commuting patterns of hospital employees. A qualifying area is an area that meets all of the following criteria:

(i) Hospital employees in the area commute to work in an MSA (or MSAs) with a wage index (or wage indices) higher than the wage index of the area.

(ii) At least 10 percent of the county's hospital employees commute to an MSA (or MSAs) with a higher wage index (or wage indices).

(iii) The 3-year average hourly wage of the hospital(s) in the area equals or exceeds the 3-year average hourly wage of all hospitals in the MSA or rural area in which the county is located.

(2) *Amount of adjustment.* A hospital located in an area that meets the criteria under paragraphs (f)(1)(i) through (f)(1)(iii) of this section will receive an increase in its wage index that is equal to a weighted average of the difference between the prereclassified wage index of the MSA (or MSAs) with the higher wage index (or wage indices) and the prereclasssified wage index of the qualifying area, weighted by the overall percentage of the hospital employees residing in the qualifying area who are employed in any MSA with a higher wage index.

(3) *Process for determining the adjustment.* (i) CMS will use the most accurate data available, as determined by CMS, to determine the out-migration percentage for each area.

(ii) CMS will include, in its annual proposed and final notices of updates to the hospital inpatient prospective payment system, a listing of qualifying areas and the hospitals that are eligible to receive the adjustment to their wage indexes for commuting hospital employees, and the wage index increase applicable to each qualifying area.

(iii) Any wage index adjustment made under this paragraph (f) is effective for a period of 3 fiscal years, except that hospitals in a qualifying county may elect to waive the application of the wage index adjustment. A hospital may waive the application of the wage index adjustment by notifying CMS in writing within 45 days of the date of public display of the annual notice of proposed rulemaking for the hospital inpatient prospective payment system at the Office of the **Federal Register.**

(iv) A hospital in a qualifying area that receives a wage index adjustment under this paragraph (f) is not eligible for reclassification under Subpart L of this part.

[69 FR 49248, Aug. 11, 2004, as amended at 75 FR 50414, Aug. 16, 2010; 76 FR 51783, Aug. 18, 2011; 82 FR 38512, Aug. 14, 2017]

§ 412.212 National rate.

(a) *General rule.* For purposes of payment to hospitals located in Puerto Rico, the national prospective payment rate for inpatient operating costs is determined as described in paragraphs (b) through (d) of this section.

(b) *Computing Puerto Rico standardized amounts.* (1) For Federal fiscal years before FY 2004, CMS computes a discharge-weighted average of the—

(i) National urban adjusted standardized amount determined under § 412.63(j)(1); and

(ii) National rural adjusted average standardized amount determined under § 412.63(j)(2)(i).

(2) For fiscal years 2004 and subsequent fiscal years, CMS computes a discharge-weighted average of the national adjusted standardized amount determined under § 412.64(e).

(c) *Computing a national rate.* For each discharge classified within a DRG, the national rate equals the product of—

(1) The national average standardized amount computed under paragraph (b) of this section; and

(2) The weighting factor (determined under § 412.60(b)) for that DRG.

(d) *Adjusting for different area wage levels.* CMS adjusts the proportion (as estimated by CMS from time to time) of the national rate computed under paragraph (c) of this section that is attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

[52 FR 33058, Sept. 1, 1987, as amended at 53 FR 38533, Sept. 30, 1988; 57 FR 39825, Sept. 1, 1992; 69 FR 49248, Aug. 11, 2004]

§ 412.220 Special treatment of certain hospitals located in Puerto Rico.

Subpart G of this part sets forth rules for special treament of certain facilities under the prospective payment system for inpatient operating costs.

The following sections in subpart G of this part do not apply to hospitals located in Puerto Rico:

(a) Section 412.92, sole community hospitals.

(b) Section 412.96, referral centers.

[52 FR 33058, Sept. 1, 1987, as amended at 57 FR 39825, Sept. 1, 1992]

Subpart L—The Medicare Geographic Classification Review Board

SOURCE: 55 FR 36766, Sept. 6, 1990, unless otherwise noted.

CRITERIA AND CONDITIONS FOR REDESIGNATION

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

(a) *General*—(1) *Purposes*. Except as specified in paragraph (a)(5)—

(i) For fiscal years prior to fiscal year 2005, an individual hospital may be redesignated from a rural area to an urban area, from a rural area to another rural area, or from an urban area to another urban area for the purposes of using the other area's standardized amount for inpatient operating costs, the wage index value, or both.

(ii) Effective for fiscal year 2005 and subsequent fiscal years, an individual hospital may be redesignated from an urban area to another urban area, from a rural area to another rural area, or from a rural area to another urban area for the purposes of using the other area's wage index value.

(iii) An urban hospital that has been granted redesignation as rural under § 412.103 is considered to be located in the rural area of the state for the purposes of this section.

(2) *Proximity*. Except as provided in paragraph (a)(3) of this section, to be redesignated to another rural area or an urban area, a hospital must demonstrate a close proximity to the area to which it seeks redesignation by meeting the criteria in paragraph (b) of this section, and submitting data requested under paragraph (c) of this section.

(3) *Special rules for sole community hospitals and rural referral centers*. To be redesignated under the special rules in this paragraph, a hospital must be approved as a sole community hospital or a rural referral center as of the date of the MGCRB's review.

(i) A hospital that is approved as a rural referral center or a sole community hospital, or both, does not have to demonstrate a close proximity to the area to which it seeks redesignation.

(ii) If a hospital that is approved as a rural referral center or a sole community hospital, or both, qualifies for urban redesignation, it is redesignated to the urban area that is closest to the hospital or to the hospital's geographic home area. If the hospital is closer to another rural area than to any urban area, it may seek redesignation to either the closest rural area or the closest urban area.

(iii) If a sole community hospital or rural referral center loses its special status as a result of redesignation, the hospital is considered to retain its special status for the purpose of applicability of the special rules in paragraph (a)(3) of this section.

(iv) A hospital that is redesignated under paragraph (a)(3) of this section may not be redesignated in the same fiscal year under paragraph (a)(2) of this section.

(4) *Application of criteria*. In applying the numeric criteria contained in paragraphs (b)(1) and (2) and (d)(1)(iii) and (iv) of this section, rounding of numbers to meet the mileage or qualifying percentage standards is not permitted.

(5) *Limitations on redesignation*. The following limitations apply to redesignation:

(i) An individual hospital may not be redesignated to another area for purposes of the wage index if the pre-reclassified average hourly wage for that area is lower than the pre-reclassified average hourly wage for the area in which the hospital is located. An urban hospital that has been granted redesignation as rural under § 412.103 is considered to be located either in its geographic area or in the rural area of the State for the purposes of this paragraph (a)(5)(i).

(ii) A hospital may not be redesignated to more than one area, except for an urban hospital that has been granted redesignation as rural under § 412.103

and receives an additional reclassification by the MGCRB.

(iii) Beginning with wage index reclassification applications for FY 2003, if a hospital is already reclassified to a given geographic area for wage index purposes for a 3-year period, and submits an application for reclassification to the same area for either the second or third year of the 3-year period, that application will not be approved.

(b) *Proximity criteria.* A hospital demonstrates a close proximity with the area to which it seeks redesignation if one of the following conditions applies:

(1) The distance from the hospital to the area is no more than 15 miles for an urban hospital and no more than 35 miles for a rural hospital.

(2) At least 50 percent of the hospital's employees reside in the area.

(c) *Appropriate proximity data.* For redesignation to an area, the hospital must submit appropriate data relating to its proximity to that area.

(1) To demonstrate proximity to the area, the hospital must submit evidence of the shortest route over improved roads to the area and the distance of that route.

(2) For employee address data, the hospital must submit current payroll records that include information that establishes the home addresses by zip code of its employees.

(d) *Use of urban or other rural area's wage index*—(1) *Criteria for use of area's wage index.* Except as provided in paragraphs (d)(3) and (d)(4) of this section, to use an area's wage index, a hospital must demonstrate the following:

(i) The hospital's incurred wage costs are comparable to hospital wage costs in an urban or other rural area;

(ii) The hospital has the necessary geographic relationship as specified in paragraphs (a) and (b) of this section;

(iii) One of the following conditions apply:

(A) With respect to redesignations for Federal fiscal years 1994 through 2001, the hospital's average hourly wage is at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located;

(B) With respect to redesignations for Federal fiscal years 2002 through 2005, the hospital's average hourly wage is, in the case of a hospital located in a rural area, at least 106 percent and in the case of a hospital located in an urban area, at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located; or

(C) With respect to redesignations for Federal fiscal year 2006 and subsequent years, the hospital's average hourly wage is, in the case of a hospital located in a rural area, at least 106 percent and in the case of a hospital located in an urban area, at least 108 percent of the average hourly wage of all other hospitals in the area in which the hospital is located;

(iv) One of the following conditions apply:

(A) For redesignations effective before fiscal year 1999, the hospital's average hourly wage weighted for occupational categories is at least 90 percent of the average hourly wages of hospitals in the area to which it seeks redesignation.

(B) With respect to redesignations for fiscal year 1994 through 2001, the hospital's average hourly wage is equal to at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

(C) With respect to redesignations for fiscal years 2002 through 2009, the hospital's average hourly wage is equal to, in the case of a hospital located in a rural area, at least 82 percent, and in the case of a hospital located in an urban area, at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

(D) With respect to redesignations for fiscal year 2010, the hospital's average hourly wage is equal to, in the case of a hospital located in a rural area, at least 84 percent, and in the case of a hospital located in an urban area, at least 86 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

(E) With respect to redesignations for fiscal year 2011 and later fiscal years, the hospital's average hourly wage is equal to, in the case of a hospital located in a rural area, at least 82 percent, and in the case of a hospital located in an urban area, at least 84 percent of the average hourly wage of hospitals in the area to which it seeks redesignation.

(2) *Appropriate wage data.* For a wage index change, the hospital must submit appropriate wage data as follows:

(i) For redesignations effective through FY 2002:

(A) For hospital-specific data, the hospital must provide data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospital requests reclassification.

(B) For data for other hospitals, the hospital must provide data concerning the average hourly wage in the area in which the hospital is located and the average hourly wage in the area to which the hospital seeks reclassification. The wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospital requests reclassification.

(ii) For redesignations effective beginning FY 2003:

(A) For hospital-specific data, the hospital must provide a weighted 3-year average of its average hourly wages using data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

(*1*) For the limited purpose of qualifying for geographic reclassification based on wage data from cost reporting periods beginning prior to FY 2000, a hospital may request that its wage data be revised if the hospital is in an urban area that was subject to the rural floor for the period during which the wage data the hospital wishes to revise were used to calculate its wage index.

(*2*) Once a hospital has accumulated at least 1 year of wage data in the applicable 3-year average hourly wage period used by the MGCRB, the hospital is eligible to apply for reclassification based on those data.

(B) For data for other hospitals, the hospital must provide a weighted 3-year average of the average hourly wage in the area in which the hospital is located and a weighted 3-year average of the average hourly wage in the area to which the hospital seeks reclassification. The wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

(iii) For applications submitted for reclassifications effective in FYs 2006 through 2008, a campus of a multicampus hospital may seek reclassification only to a CBSA in which another campus(es) is located. If the campus is seeking reclassification to a CBSA in which another campus(es) is located, as part of its reclassification request, the requesting entity must submit the composite wage data for the entire multicampus hospital as its hospital-specific data.

(iv) For purposes of this paragraph (d)(2), if a new owner does not accept assignment of the existing hospital's provider agreement in accordance with § 489.18 of this chapter, the hospital will be treated as a new provider with a new provider number. In this case, the wage data associated with the previous hospital's provider number cannot be used in calculating the new hospital's 3-year average hourly wage. Once a new hospital has accumulated at least 1 year of wage data, it is eligible to apply for reclassification on the basis of those data.

(v) For applications submitted for reclassification effective in FY 2009 and thereafter, a campus of a multicampus hospital that is located in a geographic area different from the area associated with the provider number of the entire multicampus hospital may seek reclassification to another CBSA using the composite wage data of the entire multicampus hospital as its hospital-specific data.

(3) *Rural referral center exceptions.* (i) If a hospital was ever approved as a rural referral center, it does not have to demonstrate that it meets the average hourly wage criterion set forth in paragraph (d)(1)(iii) of this section.

(ii) If a hospital was ever approved as a rural referral center, it is required to meet only the criterion that applies to rural hospitals under paragraph (d)(1)(iv) of this section, regardless of its actual location in an urban or rural area.

(4) *Special dominating hospital exception.* The requirements of paragraph (d)(1)(i) and (d)(1)(iii) of this section do

not apply if a hospital meets the following criteria:

(i) Its average hourly wage is at least 108 percent of the average hourly wage of all other hospitals in the area in which the hospital is located.

(ii) It pays at least 40 percent of the adjusted uninflated wages in the MSA.

(iii) It was approved for redesignation under this paragraph (d) for each year from fiscal year 1992 through fiscal year 1997.

(5) *Single hospital MSA exception.* The requirements of paragraph (d)(1)(iii) of this section do not apply if a hospital is the single hospital in its MSA with published 3-year average hourly wage data included in the current fiscal year inpatient prospective payment system final rule.

[55 FR 36766, Sept. 6, 1990]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.230, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

§ 412.232 Criteria for all hospitals in a rural county seeking urban redesignation.

(a) *Criteria.* For all hospitals in a rural county to be redesignated to an urban area, the following conditions must be met:

(1) The county in which the hospitals are located—

(i) For fiscal years prior to fiscal year 2006, must be adjacent to the MSA or NECMA to which they seek redesignation.

(ii) For fiscal years beginning with fiscal year 2006, must be adjacent to the MSA to which they seek redesignation.

(2) All hospitals in a rural county must apply for redesignation as a group.

(3) The hospitals must demonstrate that the rural county in which they are located currently meets the criteria for metropolitan character under paragraph (b) of this section and the wage criteria under paragraph (c) of this section.

(4) The hospital may be redesignated only if one of the following conditions is met:

(i) The prereclassified average hourly wage for the area to which they seek redesignation is higher than the prereclassified average hourly wage for the area in which they are currently located.

(ii) For fiscal years prior to fiscal year 2006, the standardized amount for the area to which they seek redesignation is higher than the standardized amount for the area in which they are located.

(b) *Metropolitan character.* (1) For fiscal years prior to FY 2005, the group of hospitals must demonstrate that the county in which the hospitals are located meets the standards for redesignation to an MSA or an NECMA as an outlying county that were published in the FEDERAL REGISTER on March 30, 1990 (55 FR 12154) using Bureau of the Census data or Bureau of Census estimates made after 1990.

(2) For fiscal years beginning with FY 2005, the group of hospitals must demonstrate that the county in which the hospitals are located meets the standards for redesignation to an MSA as an outlying county using the most recent OMB standards for delineating statistical areas adopted by CMS and the most recent Census Bureau data.

(c) *Wage criteria.* In applying the following numeric criteria, rounding of numbers to meet the qualifying percentages is not permitted.

(1) *Aggregate hourly wage for fiscal years before fiscal year 2010*—(i) *Aggregate hourly wage.* With respect to redesignations effective beginning fiscal year 1999 and before fiscal year 2010, the aggregate average hourly wage for all hospitals in the rural county must be equal to at least 85 percent of the average hourly wage in the adjacent urban area.

(ii) *Aggregate hourly wage weighted for occupational mix.* For redesignations effective before fiscal year 1999, the aggregate hourly wage for all hospitals in the rural county, weighed for occupational categories, is at least 90 percent of the average hourly wage in the adjacent urban area.

(2) *Aggregate hourly wage for fiscal year 2010.* With respect to redesignations effective for fiscal year 2010, the aggregate average hourly wage for all hospitals in the rural county must be

equal to at least 86 percent of the average hourly wage in the adjacent urban area.

(3) *Aggregate hourly wage for fiscal year 2011 and later fiscal years.* With respect to redesignations effective for fiscal year 2011 and later fiscal years, the aggregate average hourly wage for all hospitals in the rural county must be equal to at least 85 percent of the average hourly wage in the adjacent urban area.

(d) *Appropriate data*—(1) *Metropolitan character.* (i) To meet the criteria in paragraph (b) of this section, the hospitals may submit data, estimates, or projections, made by the Bureau of the Census concerning population density or growth, or changes in designation of urban areas.

(ii) The MGCRB only considers data developed by the Bureau of the Census.

(2) *Appropriate wage data.* The hospitals must submit appropriate data as follows:

(i) For redesignations effective through FY 2002:

(A) For hospital-specific data, the hospitals must provide data from the CMS wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospitals request reclassification.

(B) For data for other hospitals, the hospitals must provide the following:

(*1*) The average hourly wage in the adjacent area, which is taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes during the fiscal year prior to the fiscal year for which the hospitals request reclassification.

(*2*) Occupational-mix data to demonstrate the average occupational mix for each employment category in the adjacent area. Occupational-mix data can be obtained from surveys conducted by the American Hospital Association.

(ii) For redesignations effective beginning FY 2003:

(A) For hospital-specific data, the hospital must provide a weighted 3-year average of its average hourly wages using data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

(B) For data for other hospitals, the hospital must provide a weighted 3-year average of the average hourly wage in the area in which the hospital is located and a weighted 3-year average of the average hourly wage in the area to which the hospital seeks reclassification. The wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

(iii) For redesignations effective beginning FY 2009, the wage data of an individual campus of a multicampus hospital will be determined by allocating, on the basis of full-time equivalent staff or discharges, the wage data of the entire multicampus hospital between or among the individual campuses of the multicampus hospital. The provision of this paragraph (d)(2)(iii) applies only in the case where an individual campus is located in a geographic area different from the area associated with the provider number of the entire multicampus hospital.

[55 FR 36766, Sept. 6, 1990, as amended at 57 FR 39826, Sept. 1, 1992; 58 FR 46339, Sept. 1, 1993; 59 FR 45399, Sept. 1, 1994; 60 FR 45849, Sept. 1, 1995; 62 FR 46031, Aug. 29, 1997; 66 FR 39934, Aug. 1, 2001; 69 FR 49249, Aug. 11, 2004; 69 FR 60252, Oct. 7, 2004; 72 FR 47412, Aug. 22, 2007; 73 FR 48756, Aug. 19, 2008; 75 FR 50415, Aug. 16, 2010; 79 FR 50355, Aug. 22, 2014]

§412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

(a) *General criteria.* For all prospective payment hospitals in an .urban county to be redesignated to another urban area, the following conditions must be met:

(1) All hospitals in an urban county must apply for redesignation as a group.

(2) The county in which the hospitals are located must be adjacent to the urban area to which they seek redesignation.

(3)(i) For Federal fiscal years before fiscal year 2006, the counties in which the hospitals are located must be part of the Consolidated Metropolitan Statistical Area (CMSA) that includes the urban area to which they seek redesignation.

(ii) For Federal fiscal year 2006, hospitals located in counties that are in the same Combined Statistical Area (CSA) (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation; or in the same Consolidated Metropolitan Statistical Area (CMSA) (under the standards published by the OMB on March 30, 1990) as the urban area to which they seek designation qualify as meeting the proximity requirements for reclassification to the urban area to which they seek redesignation.

(iii) For Federal fiscal year 2007, hospitals located in counties that are in the same Combined Statistical Area (CSA) (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.

(iv) For Federal fiscal year 2008 and thereafter, hospitals located in counties that are in the same Combined Statistical Area (CSA) or Core-Based Statistical Area (CBSA) (under the most recent OMB standards for delineating statistical areas adopted by CMS and the most recent Census Bureau data) as the urban area to which they seek redesignation qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.

(4) The hospital may be redesignated only if one of the following conditions is met:

(i) The prereclassified average hourly wage for the area to which they seek redesignation is higher than the prereclassified average hourly wage for the area in which they are currently located.

(ii) For fiscal years prior to fiscal year 2005, the standardized amount for the area to which they seek redesignation is higher than the standardized amount for the area in which they are located.

(b) *Wage criteria.* In applying the following numeric criteria, rounding of numbers to meet the qualifying percentages is not permitted.

(1) *Aggregate hourly wage for fiscal years before fiscal year 2010*—(i) *Aggregate hourly wage.* With respect to redesignations effective beginning fiscal year 1999 and before fiscal year 2010, the aggregate average hourly wage for all hospitals in the urban county must be at least 85 percent of the average hourly wage in the urban area to which the hospitals in the county seek reclassification.

(ii) *Aggregate hourly wage weighted for occupational mix.* For redesignations effective before fiscal year 1999, the aggregate hourly wage for all hospitals in the county, weighed for occupational categories, is at least 90 percent of the average hourly wage in the adjacent urban area.

(2) *Aggregate hourly wage for fiscal year 2010.* With respect to redesignations effective for fiscal year 2010, the aggregate average hourly wage for all hospitals in the urban county must be at least 86 percent of the average hourly wage in the urban area to which the hospitals in the county seek reclassification.

(3) *Aggregate hourly wage for fiscal year 2011 and later fiscal years.* With respect to redesignations effective for fiscal year 2011 and later fiscal years, the aggregate average hourly wage for all hospitals in the urban county must be at least 85 percent of the average hourly wage in the urban area to which the hospitals in the county seek reclassification.

(c) *Appropriate wage data.* (1) The hospitals must submit appropriate wage data as provided for in § 412.230(d)(2).

(2) For redesignations effective beginning FY 2009, the appropriate wage data of an individual campus located in a geographic area different from the area associated with the provider number of the entire multicampus hospital are the wage data described in § 412.232(d)(2)(iii).

[56 FR 25488, June 4, 1991, as amended at 57 FR 39826, Sept. 1, 1992; 58 FR 46339, Sept. 1, 1993; 60 FR 45849, Sept. 1, 1995; 62 FR 46031, Aug. 29, 1997; 69 FR 49249, Aug. 11, 2004; 70 FR 47487, Aug. 12, 2005; 71 FR 48140, Aug. 18, 2006; 72 FR 47412, Aug. 22, 2007; 73 FR 48756, Aug. 19, 2008; 75 FR 50415, Aug. 16, 2010; 79 FR 50355, Aug. 22, 2014]

§ 412.235 Criteria for all hospitals in a State seeking a statewide wage index redesignation.

(a) *General criteria.* For all prospective payment system hospitals in a State to be redesignated to a statewide wage index, the following conditions must be met:

(1) All prospective payment system hospitals in the State must apply as a group for reclassification to a statewide wage index through a signed single application.

(2) All prospective payment system hospitals in the State must agree to the reclassification to a statewide wage index through a signed affidavit on the application.

(3) All prospective payment system hospitals in the State must agree, through an affidavit, to withdrawal of an application or to termination of an approved statewide wage index reclassification.

(4) All hospitals in the State must waive their rights to any wage index classification that they would otherwise receive absent the statewide wage index classification, including a wage index that any of the hospitals might have received through individual geographic reclassification.

(5) New hospitals that open within the State prior to the deadline for submitting an application for a statewide wage index reclassification (September 1), regardless of whether a group application has already been filed, must agree to the use of the statewide wage index as part of the group application. New hospitals that open within the State after the deadline for submitting a statewide wage index reclassification application or during the approved reclassification period will be considered a party to the statewide wage index application and reclassification.

(b) *Effect on payments.* (1) An individual hospital within the State may receive a wage index that could be higher or lower under the statewide wage index reclassification in comparison to its otherwise redesignated wage index.

(2) Any new prospective payment system hospital that opens in the State during the effective period of an approved statewide wage index reclassification will be designated to receive the statewide wage index for the duration of that period.

(c) *Terms of the decision.* (1) A decision by the MGCRB on an application for a statewide wage index reclassification will be effective for 3 years beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year following the Federal fiscal year in which the hospitals filed a complete application.

(2) The procedures and timeframes specified in § 412.273 apply to withdrawals of applications for redesignation to a statewide wage index and terminations of approved statewide wage index reclassifications, including the requirement that, to withdraw an application or terminate an approved reclassification, the request must be made in writing by all hospitals that are party to the application, except hospitals reclassified into the State for purposes of receiving the statewide wage index.

[66 FR 39935, Aug. 1, 2001]

COMPOSITION AND PROCEDURES

§ 412.246 MGCRB members.

(a) *Composition.* The Medicare Geographical Classification Review Board (MGCRB) consists of five members, including a Chairman, all of whom are appointed by the Secretary. The members include two members who are representative of prospective payment system hospitals located in rural areas, and at least one individual who is knowledgeable in analyzing the costs of inpatient hospital services.

(b) *Term of office.* The term of office for an MGCRB member may not exceed 3 years. A member may serve more than one term. The Secretary may terminate a member's tenure prior to its full term.

[55 FR 36766, Sept. 6, 1990, as amended at 61 FR 46224, Aug. 30, 1996; 61 FR 51217, Oct. 1, 1996]

§ 412.248 Number of members needed for a decision or a hearing.

(a) *A quorum.* A quorum, consisting of at least a majority of the MGCRB members, one of whom is representative of rural hospitals if possible, is required for making MGCRB decisions.

(b) *Number of members for a hearing.* If less than a quorum is present for an oral hearing, the chairman with the consent of the hospital may allow those members present to conduct the hearing and to prepare a recommended decision, which is then submitted to a quorum.

§ 412.250 Sources of MGCRB's authority.

(a) *Compliance.* The MGCRB, in issuing decisions under section 1886(d)(10)(C) of the Act, complies with all the provisions of title XVIII and related provisions of the Act and implementing regulations, including the criteria and conditions located at § 412.230 through § 412.236, issued by the Secretary under the authority of section 1886(d)(10)(D) of the Act; and CMS Rulings issued under the authority of the Administrator.

(b) *Affords great weight.* The MGCRB affords great weight to other interpretive rules, general statements of policy and rules of agency organization, procedure, and practice established by CMS.

[55 FR 36766, Sept. 6, 1990, as amended at 56 FR 25488, June 4, 1991]

§ 412.252 Applications.

(a) *By one hospital.* An individual prospective payment system hospital seeking redesignation to a different rural or urban area has the right to submit an application to the MGCRB.

(b) *By a group of hospitals.* A group of hospitals has the right to submit an application to the MGCRB requesting redesignation of all prospective payment hospitals in a county if all prospective payment hospitals located in a county agree to the request.

[55 FR 36766, Sept. 6, 1990, as amended at 69 FR 49250, Aug. 11, 2004]

§ 412.254 Proceedings before MGCRB.

(a) *On-the-record decision.* The MGCRB will ordinarily issue an on-the-record decision without conducting an oral hearing. The MGCRB will issue a decision based upon all documents, data, and other written evidence and comments submitted timely to the MGCRB by the parties.

(b) *Oral hearing.* The MGCRB may hold an oral hearing on its own motion or if a party demonstrates to the MGCRB's satisfaction that an oral hearing is necessary.

§ 412.256 Application requirements.

(a) *Written application.* A request for reclassification must be in writing and must constitute a complete application in accordance with paragraph (b) of this section.

(1) An application must be submitted to the MGCRB according to the method prescribed by the MGCRB.

(2) A complete application must be received not later than the first day of the 13-month period preceding the Federal fiscal year for which reclassification is requested.

(3) The filing date of an application is the date the application is received by the MGCRB.

(b) *Criteria for a complete application.* An application is complete if the application from an individual hospital or from all hospitals in a county includes the following information:

(1) The Federal fiscal year for which the hospital is applying for redesignation.

(2) Which criteria constitute the basis of the request for reclassification.

(3) An explanation of how the hospital or hospitals meet the relevant criteria in §§ 412.230 through 412.236, including any necessary data to support the application.

(c) *Opportunity to complete a submitted application.* (1) The MGCRB will review an application within 15 days of receipt to determine if the application is complete. If the MGCRB determines that an application is incomplete, the MGCRB will notify the hospital, with a copy to CMS, within the 15 day period, that it has determined that the application is incomplete and may dismiss the application if a complete application is not filed by September 1.

(2) At the request of the hospital, the MGCRB may, for good cause, grant a hospital that has submitted an application by September 1, an extension beyond September 1 to complete its application.

(d) *Appeal of MGCRB dismissal.* (1) The hospital may appeal the MGCRB dismissal to the Administrator within 15

days of the date of the notice of dismissal.

(2) Within 20 days of receipt of the hospital's request for appeal, the Administrator will affirm the dismissal or reverse the dismissal and remand the case to the MGCRB to determine whether reclassification is appropriate.

(e) *Notification of complete application.* When the MGCRB determines that the hospital's application contains all the necessary elements for a complete application, it notifies the hospital in writing, with a copy to CMS, that the application is complete and that the case may proceed to an MGCRB decision.

[55 FR 36766, Sept. 6, 1990, as amended at 56 FR 25488, June 4, 1991; 62 FR 46031, Aug. 29, 1997; 63 FR 26357, May 12, 1998; 64 FR 41541, July 30, 1999; 81 FR 57268, Aug. 22, 2016; 84 FR 42614, Aug. 16, 2019]

§ 412.258 Parties to MGCRB proceeding.

(a) The party or parties to an MGCRB proceeding are the hospital or group of hospitals requesting a change in geographic designation.

(b) CMS has 30 days from the date of receipt of notice of a complete application to submit written comments and recommendations (with a copy to the hospital) for consideration by the MGCRB.

(c) The hospital has 15 days from the date of receipt of CMS's comments to submit written comments to the MGCRB, with a copy to CMS, for the purpose of responding to CMS's comments.

§ 412.260 Time and place of the oral hearing.

If the MGCRB decides that an oral hearing is necessary, it sets the time and place for the hearing and notifies the parties in writing, with a copy to CMS, not less than 10 days before the time scheduled for the hearing. The MGCRB may reschedule, adjourn, postpone, or reconvene the hearing provided that reasonable written notice is given to the parties, with a copy to CMS.

§ 412.262 Disqualification of an MGCRB member.

(a) *Grounds for disqualification.* An MGCRB member may not participate in any decision in a case in which he or she may be prejudiced or partial with respect to a party or has any other interest in the case.

(b) *Request for disqualification.* If a party believes that an MGCRB member should not participate in a decision, the party submits the objection in writing to the MGCRB at its earliest opportunity, explaining the grounds for the request. CMS may also submit such a suggestion to the MGCRB.

(c) *Consideration by the MGCRB member.* The MGCRB member will consider the objection and, at his or her discretion, either will proceed or withdraw.

(d) *Consideration by the MGCRB* If the member does not withdraw, a party may petition the MGCRB for withdrawal and the MGCRB will consider the objection and rule on whether the member may participate in the decision before it decides the case.

§ 412.264 Evidence and comments in MGCRB proceeding.

(a) *Submission by the parties.* Before a decision is issued and during an oral hearing, the parties may present evidence or comments to the MGCRB regarding the matters at issue in the case.

(b) *Content of evidence and comments.* The MGCRB may receive evidence and comments without regard for the rules of evidence applicable to court procedures.

(c) *Ex parte communications.* (1) The members of the MGCRB and its staff may not consult or be consulted by an individual representing the interests of an applicant hospital or by any other individual on any matter in issue before the MGCRB without notice to the hospital or CMS. If such communication occurs, the MGCRB will disclose it to the hospital or CMS, as appropriate, and make it part of the record after the hospital or CMS has had an opportunity to comment. MGCRB members and staff may not consider any information outside the record about matters concerning a hospital's application for reclassification.

(2) The provisions in paragraph (c)(1) of this section do not apply to the following:

(i) Communications among MGCRB members and staff.

(ii) Communications concerning the MGCRB's administrative functions or procedures.

(iii) Requests from the MGCRB to a party or CMS for a document.

(iv) Material that the MGCRB includes in the record after notice and an opportunity to comment.

(d) *MGCRB rulings on evidence and comments.* The MGCRB rules upon the admissibility of evidence and comments and excludes irrelevant, immaterial, or unduly repetitious evidence and comments.

§ 412.266 Availability of wage data.

A hospital may obtain the average hourly wage data necessary to prepare its application to the MGCRB from FEDERAL REGISTER documents published in accordance with the provisions of § 412.8(b).

[60 FR 45849, Sept. 1, 1995]

§ 412.268 Subpoenas.

(a) *In general.* When reasonably necessary for the full presentation of a case, and only after a pre-decision request for information or data has failed to produce the necessary evidence, either upon its own motion or upon the request of a party, the MGCRB may issue subpoenas for the attendance and testimony of witnesses, for an oral hearing or the production of books, records, correspondence, papers, or other documents that are relevant and material to any matter at issue.

(b) *Content of request.* The request must designate which witnesses or documents are to be produced, and describe addresses or locations with sufficient particularly to permit these witnesses or documents to be found. The request for a subpoena must state the pertinent facts that the party expects to establish by the requested witnesses or documents and whether these facts could be established by other evidence without the use of a subpoena.

(c) *Issuance.* Subpoenas are issued as provided in section 205(d) of the Act.

(d) *Payment for subpoena cost.* CMS pays for the cost of issuing subpoenas and the fees and mileage of any witness who is subpoenaed, as provided in section 205(d) of the Act.

§ 412.270 Witnesses.

Witnesses at an oral hearing testify under oath or affirmation, unless excused by the MGCRB for cause. The MGCRB may examine the witnesses and may allow the parties or their representatives to also examine any witnesses called.

§ 412.272 Record of proceedings before the MGCRB.

A complete record of the proceedings before the MGCRB is made in all cases. The record will not be closed until a decision has been issued by the MGCRB. A transcription of an oral hearing will be made at a party's request, at the expense of the requesting party.

§ 412.273 Withdrawing an application, terminating an approved 3-year reclassification, or reinstating a previous termination.

(a) *Definitions.* For purposes of this section, the following definitions apply.

Termination refers to the termination of an approved 3-year MGCRB reclassification. A termination is effective only for the full fiscal year(s) remaining in the 3-year period at the time the request is received. Requests for terminations for part of a fiscal year are not considered.

Withdrawal refers to the withdrawal of a 3-year MGCRB reclassification where the MGCRB has not yet issued a decision on the application.

(b) *General rule.* The MGCRB allows a hospital, or group of hospitals, to withdraw its application or to terminate an already existing 3-year reclassification, in accordance with this section.

(c) *Timing.* (1) A request for withdrawal must be received by the MGCRB at any time before the MGCRB issues a decision on the application.

(2) A request for termination must be received by the MGCRB within 45 days of the date of filing for public inspection of the proposed rule at the website of the Office of the Federal Register, or within 7 calendar days of receiving a

decision of the Administrator's in accordance with § 412.278, whichever is later concerning changes to the inpatient hospital prospective payment system and proposed payment rates for the fiscal year for which the termination is to apply.

(d) *Reapplication within the approved 3-year period, reinstatement of terminations, and prohibition on overlapping reclassification approvals*—(1) *Reinstatement of terminations.* Subject to the provisions of this section, a hospital (or group of hospitals) may cancel a termination, effective for the subsequent year, and request the MGCRB to reinstate the wage index reclassification for the remaining fiscal year(s) of the 3-year period.

(2) *Timing and process of reinstatement request.* Reinstatement requests must be submitted in writing to the MGCRB according to the method prescribed by the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year, as specified in § 412.256(a)(2).

(3) *Reapplications.* A hospital may apply for reclassification to a different area (that is, an area different from the one to which it was originally reclassified for the 3-year period). If the application is approved, the reclassification will be effective for 3 years. Once a 3-year reclassification becomes effective, a hospital may no longer reinstate a termination of another 3-year reclassification, regardless of whether the termination request is made within 3 years from the date of the withdrawal or termination.

(4) *Termination of existing 3-year reclassification.* In a case in which a hospital with an existing 3-year wage index reclassification applies to be reclassified to another area, its existing 3-year reclassification will be terminated when a second 3-year wage index reclassification goes into effect for payments for discharges on or after the following October 1. The terminated reclassification in such a case is not eligible for reinstatement.

(e) *Written request only.* (1) A request to withdraw an application must be submitted in writing to the MGCRB according to the method prescribed by the MGCRB by all hospitals that are party to the application.

(2) A request to terminate or reinstate an approved individual reclassification must be submitted in writing to the MGCRB according to the method prescribed by the MGCRB.

(3) A request to terminate or reinstate an approved group reclassification must be submitted in writing to the MGCRB according to the method prescribed by the MGCRB.

(i) A request to terminate or reinstate an approved group reclassification that has not yet gone into effect must include all hospitals party to the reclassification.

(ii) Termination requests for group reclassification for the second or third year of the 3-year wage index reclassification and reinstatement requests for a group reclassification effective for the third year of the 3-year wage index reclassification may be submitted by an individual hospital that is party to the reclassification.

(f) *Appeal of the MGCRB's denial of a hospital's request for withdrawal or termination, or for cancellation of a withdrawal or termination.* (1) A hospital may file an appeal of the MGCRB's denial of its request for withdrawal or termination, or of the MGCRB's denial of its request for a cancellation of such withdrawal or termination, to the Administrator. The appeal must be received within 15 days of the date of the notice of the denial.

(2) Within 20 days of receipt of the hospital's request for appeal, the Administrator affirms or reverses the denial.

[75 FR 50415, Aug. 16, 2010, as amended at 82 FR 38512, Aug. 14, 2017; 87 FR 49404, Aug. 10, 2022; 89 FR 69912, Aug. 28, 2024; 90 FR 37202, Aug. 4, 2025]

§ 412.274 Scope and effect of an MGCRB decision.

(a) *Scope of decision.* The MGCRB may affirm or change a hospital's geographic designation. The MGCRB's decision is based upon the evidence of record, including the hospital's application and other evidence obtained or received by the MGCRB.

(b) *Effective date and term of the decision.* (1) For reclassifications prior to fiscal year 2005, a standardized amount classification change is effective for 1

year beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year following the Federal fiscal year in which the complete application is filed and ending effective at the end of that Federal fiscal year (the end of the next September 30).

(2) A wage index classification change is effective for 3 years beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year in which the complete application is filed.

[55 FR 36766, Sept. 6, 1990, as amended at 62 FR 46031, Aug. 29, 1997; 66 FR 39935, Aug. 1, 2001; 69 FR 49250, Aug. 11, 2004]

§ 412.276 Timing of MGCRB decision and its appeal.

(a) *Timing.* The MGCRB notifies the parties in writing, with a copy to CMS, and issues a decision within 180 days after the first day of the 13-month period preceding the Federal fiscal year for which a hospital has filed a complete application. The hospital has 15 days from the date of the decision to request Administrator review.

(b) *Appeal.* The decision of the MGCRB is final and binding upon the parties unless it is reviewed by the Administrator and the decision is changed by the Administrator in accordance with § 412.278.

[55 FR 36766, Sept. 6, 1990, as amended at 64 FR 41541, July 30, 1999]

§ 412.278 Administrator's review.

(a) *Hospitals requests for review.* A hospital or group of hospitals dissatisfied with the MGCRB's decision regarding its geographic designation may request the Administrator to review the MGCRB decision. (A hospital or group of hospitals may also request that the Administrator review the MGCRB's dismissal of an application as untimely filed or incomplete, as provided in § 412.256(d).)

(b) *Procedures for hospital's request for review.*(1) The hospital's request for review must be in writing and sent to the Administrator, in care of the Office of the Attorney Advisor, in the manner directed by the Office of the Attorney Advisor. The request must be received by the Administrator within 15 days after the date the MGCRB issues its decision. The hospital must also submit an electronic copy of its request for review to CMS's Hospital and Ambulatory Policy Group.

(2) The request for review may contain proposed findings of fact and conclusions of law, exceptions to the MGCRB's decision, and supporting reasons therefor.

(3) Within 15 days of receipt of the hospital's request for review, CMS may submit to the Administrator, in writing, with a copy to the party, comments and recommendations concerning the hospital's submission.

(4) Within 10 days of receipt of CMS's submission, the hospital may submit in writing, with a copy to CMS, a response to the Administrator.

(c) *Discretionary review by the Administrator.* (1) The Administrator may, at his or her discretion, review any final decision of the MGCRB.

(2) The Administrator promptly notifies the hospital that he or she has decided to review a decision of the MGCRB. The notice of review indicates the particular issues to be considered and includes copies of any comments submitted to the Administrator by CMS staff concerning the MGCRB decision.

(3) Within 15 days of the receipt of the Administrator's notice of review, the hospital may submit a response in writing to the Administrator, with a copy of CMS.

(d) *Criteria for discretionary review.* In deciding whether to review an MGCRB decision, the Administrator normally considers whether it appears that any of the following situations apply:

(1) The MGCRB made an erroneous interpretation of law, regulation, or CMS Ruling.

(2) The MGCRB's decision is not supported by substantial evidence.

(3) The case presents a significant policy issue having a basis in law and regulations, and review is likely to lead to issuance of a CMS Ruling or other directive needed to clarify a provision in the law or regulations.

(4) The decision of the MGCRB requires clarification, amplication, or an alternative legal basis.

(5) The MGCRB has incorrectly extended its authority to a degree not

provided for by law, regulation, or CMS Ruling.

(e) *Communication procedures.* All communications between CMS staff and the Administrator concerning the Administrator's review of an MGCRB decision must be in writing. As specified in paragraphs (b) and (c) of this section, copies of comments by CMS staff are sent to applicant hospitals within 15 days of receipt of a hospital's request for review, or, in cases in which the Administrator decides to review a case at his or her discretion, are included with the Administrator's notice of review. In the event there are additional communications between CMS staff and the Administrator concerning MGCRB decisions reviewed by the Administrator under paragraphs (b) or (c) of this section, CMS furnishes copies of the communications to the hospital or group of hospitals.

(f) *Administrator's decision.* (1) The Administrator may not receive or consider any new evidence and must issue a decision based only upon the record as it appeared before the MGCRB and comments submitted under paragraphs (b)(2), (b)(3), (b)(4), (c)(2), and (c)(3) of this section.

(2) The Administrator issues a decision in writing to the party with a copy to CMS—

(i) Not later than 90 days following receipt of the party's request for review, except the Administrator may, at his or her discretion, for good cause shown, toll such 90 days; or

(ii) Not later than 105 days following issuance of the MGCRB decision in the case of review at the discretion of the Administrator, except the Administrator may, at his or her discretion, for good cause shown, toll such 105 days.

(3) The Administrator's decision issued under §412.278 (a) or (c) is the final Departmental decision, unless it is amended under §412.278(g). The final Departmental decision is not subject to judicial review.

(4) The Administrator's decision is not subject to judicial review.

(g) *Amendment of Administrator decision*—(1) *Hospital's request for amendment.* The hospital may request the Administrator to amend the decision for the limited purpose of correcting mathematical or computational errors, or to correct the decision if the evidence that was considered in making the decision clearly shows on its face that an error was made. The following procedure is followed:

(i) The hospital's request for amendment must be received by the Administrator within 10 days after the date the Administrator issues a decision. The request for amendment must be in writing, with a copy to CMS.

(ii) The Administrator promptly reviews the hospital's request and amends the decision, if necessary, within 5 days following receipt of the hospital's request for amendment.

(2) *Discretionary review by the Administrator.* Within 15 days following the issuance of the Administrator's decision, the Administrator, at his or her discretion, may amend the decision to correct mathematical or computational errors, or to correct the decision if the evidence that was considered in making the decision clearly shows on its face that an error was made. The Administrator's amended decision is final and is not subject to judicial review.

[55 FR 36766, Sept. 6, 1990, as amended at 56 FR 25489, June 4, 1991; 57 FR 39826, Sept. 1, 1992; 68 FR 45471, Aug. 1, 2003; 70 FR 47487, Aug. 12, 2005; 85 FR 59023, Sept. 18, 2020; 86 FR 45520, Aug. 13, 2021]

§412.280 Representation.

(a) *General.* A party may be represented by legal counsel or by any other person appointed to act as its representative at any proceeding before the MGCRB or the Administrator.

(b) *Rights of a representative.* A representative appointed by a party may accept or give on behalf of the party any request or notice connected with any proceeding before the MGCRB or the Administrator. A representative is entitled to present evidence and argument as to facts and law in any MGCRB proceeding affecting the party represented and to obtain information to the same extent as the party represented. Notice of any action or decision sent to the representative of a party has the same effect as if it had been sent to the party itself.

Subpart M—Prospective Payment System for Inpatient Hospital Capital Costs

SOURCE: 56 FR 43449, Aug. 30, 1991, unless otherwise noted.

GENERAL PROVISIONS

§ 412.300 Scope of subpart and definition.

(a) *Purpose.* This subpart implements section 1886(g)(1)(A) of the Act by establishing a prospective payment system for inpatient hospital capital-related costs. Under this system, payment is made on the basis described in § 412.304 through § 412.374 for inpatient hospital capital-related costs furnished by hospitals subject to the prospective payment system under subpart B of this part.

(b) *Definition.* For purposes of this subpart, a new hospital means a hospital that has operated (under previous or present ownership) for less than 2 years. The following hospitals are not new hospitals:

(1) A hospital that builds new or replacement facilities at the same or another location even if coincidental with a change of ownership, a change in management, or a lease arrangement.

(2) A hospital that closes and subsequently reopens.

(3) A hospital that has been in operation for more than 2 years but has participated in the Medicare program for less than 2 years.

(4) A hospital that changes its status from a hospital that is excluded from the prospective payment systems to a hospital that is subject to the capital prospective payment systems.

[56 FR 43449, Aug. 30, 1991, as amended at 57 FR 39827, Sept. 1, 1992]

§ 412.302 Introduction to capital costs.

(a) *New capital costs.* New capital costs are allowable Medicare inpatient hospital capital-related costs under subpart G of part 413 of this chapter that are related to assets that were first put in use for patient care after December 31, 1990 (except for such costs deemed to be old capital costs based on prior obligations as described in paragraph (c) of this section) and those allowable capital-related costs related to assets in use prior to December 31, 1990 that are excluded from the definition of old capital costs described in paragraphs (b) (2) through (5) of this section, or are betterment or improvement costs related to those old capital assets.

(b) *Old capital costs.* Except as provided in paragraph (c) of this section with respect to capital obligations that qualify for recognition as old capital, old capital costs are allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before December 31, 1990. However, for a new hospital as defined in § 412.300(b), old capital costs are defined as those allowable capital-related costs for land and depreciable assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of the hospital's base year cost reporting period under § 412.328(a)(2). Old capital costs include the following:

(1) Allowable depreciation on assets based on the useful life guidelines used to determine depreciation expense in the hospital's base period.

(2) Allowable capital-related interest expense. Except as provided below, the amount of allowable capital-related interest expense that will be recognized as old capital is limited to the amount the hospital was legally obligated to pay as of December 31, 1990. Any allowable interest expense in excess of this limitation will be recognized as new capital.

(i) An increase in interest expense is recognized if the increase is due to periodic fluctuations of rates in variable interest rate loans or at the time of conversion from a variable rate loan to a fixed rate loan when no other changes in the terms of the loan are made.

(ii) If the terms of a debt instrument are revised after December 31, 1990, the amount of interest that will be recognized as old capital during the transition cannot exceed the amount that would have been recognized during the same period prior to the revision of the debt instrument.

(iii) If short-term financing was used to acquire old capital assets and the

debt is extended or ''rolled-over'', a portion of the extended debt will be recognized as old capital. The portion will equal the ratio of the net book value as of the beginning of the applicable cost reporting period for depreciable assets that were in use in the base year, to the net book value as of the beginning of the base year cost reporting period for those assets. The net book value for the base year will not be adjusted to exclude assets that have been fully depreciated or removed from service since the base year. If the debt is related to specific assets, the ratio will be determined based on the values for those assets. The ratio will exclude assets that were acquired with other identifiable debt instruments. For purposes of this paragraph, short term financing is a debt that becomes due in no later than the earlier of 5 years or half of the average useful life of the assets to which the debt is related.

(iv) If old capital indebtedness is commingled with new capital debt, the allowable interest expense will be apportioned to old capital costs based on the ratio of the portion of the loan principal related to old capital indebtedness to the total loan principal.

(v) Investment income, excluding income from funded depreciation accounts, is used to reduce old capital interest expense based on the ratio of total old capital interest expense to total allowable interest expense in each cost reporting period.

(3) Allowable capital-related lease and rental costs for land and depreciable assets that were obligated as of December 31, 1990.

(i) Lease renewals up to the annual lease payment level obligated as of December 31, 1990 are recognized provided the same asset remains in use, the asset has a useful life of at least 3 years, and the annual lease payment is $1,000 or more for each item or service.

(ii) If a hospital-owned asset is sold or given to another party and that same asset is then leased back by the hospital, the amount of allowable capital-related costs recognized as old capital costs is limited to the amount allowed for that asset in the last cost reporting period that it was owned by the hospital.

(iii) If an entire hospital is leased without assumption of the hospital's asset costs after December 31, 1990, the amount of allowable capital-related costs recognized as old capital costs is limited to the amount allowed for old capital costs in the base year or the last cost reporting period these costs were recognized under this subpart, whichever is later.

(4) The portion of allowable costs for other capital-related expenses (including but not limited to, taxes, insurance, license and royalty fees on depreciable assets) resulting from applying the ratio of the hospital's gross old asset value to total asset value in each cost reporting period.

(5) The appropriate portion of the capital-related costs of related organizations under §413.17 that would be recognized as old capital costs if these costs had been incurred directly by the hospital.

(6) Obligated capital costs that are recognized as old capital costs in accordance with paragraph (c) of this section.

(7) If a hospital had nonreimbursable costs applicable to an old capital asset as of December 31, 1990 that subsequently become allowable inpatient capital-related costs, the allowable costs for such an asset that are attributable to inpatient hospital services are recognized as old capital costs if a portion of the asset was in use for inpatient hospital care on December 31, 1990 and the costs meet all other provisions for recognition of old capital costs contained in this section.

(c) *Obligated capital costs*—(1) *General rule.* Under the conditions described below, capital-related costs attributable to assets that are put in use after December 31, 1990 may be recognized as old capital costs. Any allowable capital-related costs for these assets that are not recognized as old capital costs are recognized as new capital costs.

(i) *Fixed assets.* The costs of capital-related items and services defined in subpart G of part 413 for which there was a contractual obligation entered into by a hospital or related party with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a fixed asset may be

recognized as old capital costs if all the following conditions are met:

(A) The obligation must arise from a binding written agreement that was executed on or before December 31, 1990 and that obligates the hospital on or before December 31, 1990.

(B) The capital asset must be put in use for patient care before October 1, 1994 except as provided in paragraph (c)(1)(iv) of this section.

(C) The hospital notifies the intermediary of the existence of obligated capital costs as provided in paragraph (c)(1)(v) of this section.

(D) The amount that is recognized as old capital cost is limited to the lesser of the actual allowable costs when the asset is put in use or the estimated costs of the capital expenditure at the time it was obligated as provided in paragraph (c)(1)(vi) of this section.

(ii) *Moveable equipment.* Moveable equipment is recognized as old capital only if all of the conditions specified in paragraphs (c)(1)(i) (B) through (D) of this section are met and one of the following conditions is met:

(A) There was a binding contractual agreement that was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990 for the lease or purchase of the item of equipment on or before December 31, 1990.

(B) There was a binding contractual agreement that was executed on or before December 31, 1990 and obligates the hospital on or before December 31, 1990 for financing the acquisition of the equipment; the item of equipment costs at least $100,000; and the item was specifically listed in an equipment purchase plan approved by the Board of Directors on or before December 31, 1990.

(iii) *Agreements not recognized.* Agreements for planning, design or feasibility that do not commit the hospital to undertake a project are not recognized as obligating capital expenditures for purposes of this subsection.

(iv) *Extension of deadline.* CMS may extend the deadline in paragraph (c)(1)(i)(B) of this section, under which an asset must be put in use for patient care before October 1, 1994, to no later than September 30, 1996 for extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include, but are not limited to, a construction strike or atypically severe weather that significantly delayed completion of a construction project. Normal construction delays do not constitute extraordinary circumstances.

(A) The hospital must submit its request for an extended deadline with documentation of the extraordinary circumstances by the later of January 1, 1993 or 180 days after the extraordinary circumstance.

(B) The intermediary reviews the request and verifies the hospital's documentation, and forwards the request to CMS within 60 days. Within 90 days, CMS notifies the intermediary of its decision and, if an extension is granted, of the revised deadline for putting the asset in use for patient care service.

(v) The hospital must submit to its intermediary the binding agreement and supporting documents that relate to the obligated capital expenditure by the later of October 1, 1992, or within 90 days after the start of the hospital's first cost reporting period beginning on or after October 1, 1991. This documentation must include a project description (including details of any phased construction or financing) and an estimate of costs that were prepared no later than December 31, 1990.

(vi) *Cost limitation*—(A) *Leases, rentals or purchases.* The amount of obligated capital costs recognized as old capital costs cannot exceed the amount specified in the lease, rental, or purchase agreement. If moveable equipment is recognized as old capital under paragraph (c)(1)(ii)(B) of this section, the amount recognized as old capital costs cannot exceed the estimated cost identified in the equipment purchase plan approved by the hospital's Board of Directors.

(B) *Construction contracts.* The amount of obligated capital costs recognized as old capital costs cannot exceed the estimated construction costs for the project as of December 31, 1990. Additional costs will be recognized as old capital costs only if the additional costs are directly attributable to changes in life safety codes or other building requirements established by

government ordinance that occurred after the project was obligated.

(C) *Financing costs.* The amount of obligated interest expense that will be recognized as old capital costs cannot exceed the amount for which the hospital was legally obligated as of December 31, 1990 or, in the case of financing that is arranged after December 31, 1990 for a capital acquisition that was legally obligated as of December 31, 1990, the amount specified in a detailed financing plan approved by the hospital's Board of Directors prior to January 1, 1991.

(vii) *Determining old capital costs.* (A) The intermediary determines whether the applicable criteria are met for recognition of obligated capital costs as old capital costs and the maximum allowable cost that will be recognized as old capital costs.

(B) The intermediary advises the hospital of its determination by the later of the end of the hospital's first cost reporting period subject to the capital prospective payment system or 9 months after the receipt of the hospital's notification under paragraph (c)(1)(v) of this section.

(C) The actual amount that will be recognized as old capital costs is based on the lesser of the allowable costs for the asset when it is put into patient use or the amounts determined under paragraph (c)(1)(vi) of this section.

(viii) *Multi-phase project.* If the hospital has a multi-phase capital project, the provisions of paragraphs (c)(1) (i) through (vii) of this section apply independently to each phase of the project.

(2) *Lengthy certificate-of-need process.* (i) If a hospital does not meet the criteria under paragraph (c)(1)(i) or paragraph (c)(1)(ii) of this section, but meets all of the following criteria, the estimated cost for the project as of December 31, 1990 may be recognized as old capital costs:

(A) The hospital is required under State law to obtain preapproval of the capital project or acquisition by a designated State or local planning authority in the State in which it is located.

(B) The hospital filed an initial application for a certificate of need on or before December 31, 1989 that includes a detailed description of the project and its estimated cost and had not received approval or disapproval on or before September 30, 1990. If the hospital received conditional approval on or before September 30, 1990, the hospital's intermediary assesses the nature of the conditions. The hospital will be considered to have received approval for the project as of September 30, 1990 if the intermediary determines that the hospital received sufficient approval for the project to proceed without significant delay.

(C) The hospital expended the lesser of $750,000 or 10 percent of the estimated cost of the project on or before December 31, 1990; and

(D) The hospital put the asset into patient use on or before the later of September 30, 1996 or 4 years from the date the certificate of need was approved.

(ii) The provisions of paragraphs (c)(1) (iv) through (viii) of this section apply to projects that meet the criteria in paragraph (c)(2)(i) of this section.

(3) *Construction in process.* (i) If a hospital that initiates construction on a capital project does not meet the requirements of paragraphs (c)(1)(i) or (ii) or (c)(2)(i) of this section, the project costs may be recognized as old capital costs if all the following conditions are met:

(A) The hospital received any required certificate of need approval on or before December 31, 1990.

(B) The hospital's Board of Directors formally authorized the project with a detailed description of its scope and costs on or before December 31, 1990.

(C) The estimated cost of the project as of December 31, 1990 exceeds 5 percent of the hospital's total patient revenues during its base year.

(D) The capitalized cost that had been incurred for the project as of December 31, 1990 exceeded the lesser of $750,000 or 10 percent of the estimated project cost.

(E) The hospital began actual construction or renovation (''groundbreaking'') on or before March 31, 1991.

(F) The project is completed before October 1, 1994.

(ii) The provisions of paragraphs (c)(1) (iv) through (viii) of this section apply to projects that meet the criteria in paragraph (c)(3)(i) of this section.

(d) *Consistency in cost reporting*—(1) *General rule.* For cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001, the hospital must follow consistent cost finding methods for classifying and allocating capital-related costs, except as otherwise provided in paragraph (d)(4) of this section.

(2) *Old capital costs.* Unless there is a change of ownership, the hospital must continue the same cost finding methods for old capital costs, including its practices for the direct assignment of capital-related costs and its cost allocation bases, that were in effect in the hospital's last cost reporting period ending on or before October 1, 1991. If there is a change of ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices.

(3) *New capital costs.* If a hospital desires to change its cost finding methods for new capital costs, the request for change must be made in writing to the intermediary prior to the beginning of the cost reporting period for which the change is to apply. The request must include justification as to why the change will result in more accurate and more appropriate cost finding. The intermediary will not approve the change unless it determines that there is reasonable justification for the change.

(4) Hospitals may elect the simplified cost allocation methodology under the terms and conditions provided in the instructions for CMS Form 2552.

[56 FR 43449, Aug. 30, 1991, as amended at 57 FR 3016, Jan. 27, 1992; 57 FR 39827, Sept. 1, 1992; 57 FR 46510, Oct. 9, 1992; 59 FR 45399, Sept. 1, 1994; 61 FR 46224, Aug. 30, 1996; 61 FR 51217, Oct. 1, 1996]

§ 412.304 Implementation of the capital prospective payment system.

(a) *General rule.* As described in §§ 412.312 through 412.370, effective with cost reporting periods beginning on or after October 1, 1991, CMS pays an amount determined under the capital prospective payment system for each inpatient hospital discharge as defined in § 412.4. This amount is in addition to the amount payable under the prospective payment system for inpatient hospital operating costs as determined under subpart D of this part.

(b) *Cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001.* For cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, the capital payment amount is based on either a combination of payments for old capital costs and new capital costs or a fully prospective rate, as determined under § 412.324 through § 412.348.

(c) *Cost reporting periods beginning on or after October 1, 2001*—(1) *General.* Except as provided in paragraph (c)(2) of this section, for cost reporting periods beginning on or after October 1, 2001, the capital payment amount is based solely on the Federal rate determined under §§ 412.308(a) and (b) and updated under § 412.308(c).

(2) *Payment to new hospitals.* For cost reporting periods beginning on or after October 1, 2002—

(i) A new hospital, as defined under § 412.300(b), is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its cost report ending at least 2 years after the hospital accepts its first patient, unless the new hospital elects to be paid under the capital prospective payment system based on 100 percent of the Federal rate.

(A) If the new hospital elects to be paid based on 100 percent of the Federal rate, the new hospital must submit a written request to the fiscal intermediary by the later of December 1, 2002 or 60 days before the beginning of its cost reporting period.

(B) Once a new hospital elects to be paid based on 100 percent of the Federal rate, it may not revert to payment at 85 percent of its allowable Medicare inpatient hospital capital-related costs.

(ii) For the third year and subsequent years, the hospital is paid based on the Federal rate as described under § 412.312.

(d) *Interim payments.* Interim payments are made to the hospital as provided in § 412.116.

[56 FR 43449, Aug. 30, 1991, as amended at 67 FR 50113, Aug. 1, 2002; 70 FR 47487, Aug. 12, 2005]

BASIC METHODOLOGY FOR DETERMINING THE FEDERAL RATE FOR CAPITAL-RELATED COSTS

§412.308 Determining and updating the Federal rate.

(a) *FY 1992 national average cost per discharge.* CMS determines the FY 1992 estimated national average cost per discharge by updating the discharge weighted national average Medicare inpatient hospital capital-related cost per discharge for FY 1989 by the estimated increase in Medicare inpatient hospital capital costs per discharge.

(b) *Standard Federal rate.* The standard Federal rate is used to determine the Federal rate for each fiscal year in accordance with the formula specified in paragraph (c) of this section.

(1) CMS determines the standard Federal rate by adjusting the FY 1992 updated national average cost per discharge by a factor so that estimated aggregate payments based on the standard Federal rate adjusted by the payment adjustments described in §412.312(b) equal estimated aggregate payments based solely on the national average cost per discharge.

(2) Effective FY 1994, the standard Federal rate used to determine the Federal rate each year under paragraph (c) of this section is reduced by 7.4 percent.

(3) Effective FY 1996, the standard Federal rate used to determine the Federal rate each year under paragraph (c) of this section is reduced by 0.28 percent to account for the effect of the revised policy for payment of transfers under §412.4(d).

(4) Effective FY 1998, the unadjusted standard Federal capital payment rate in effect on September 30, 1997, used to determine the Federal rate each year under paragraph (c) of this section is reduced by 15.68 percent.

(5) For discharges occurring on or after October 1, 1997 through September 30, 2002, the unadjusted standard Federal capital payment rate as in effect on September 30, 1997, used to determine the Federal rate each year under paragraph (c) of this section is further reduced by 2.1 percent.

(6) For discharges occurring on or after October 1, 2002, the 2.1 percent reduction provided for under paragraph (b)(5) of this section is eliminated from the unadjusted standard Federal rate in effect on September 30, 2002, used to determine the Federal rate each year under paragraph (c) of this section.

(c) *The Federal rate.* CMS determines the Federal rate each year by adjusting the standard Federal rate by the following factors.

(1) *Update factor.* After FY 1992, CMS updates the standard Federal rate as follows:

(i) *FY 1993 through FY 1995.* For FY 1993 through FY 1995, the standard Federal rate is updated based on a moving two-year average of actual increases in capital-related costs per discharge for the period three and four years before the fiscal year in question, excluding the portion of the increase attributable to changes in case mix.

(ii) *Effective FY 1996.* Effective FY 1996, the standard Federal rate is updated based on an analytical framework. The framework includes a capital input price index, which measures the annual change in the prices associated with capital-related costs during the year. CMS adjusts the capital input price index rate of change to take into account forecast errors, changes in the case mix index, the effect of changes to DRG classification and relative weights, and allowable changes in the intensity of hospital services.

(2) *Outlier payment adjustment factor.* CMS reduces the updated standard Federal rate by an adjustment factor equal to the estimated additional payments under the Federal rate for outlier cases under subpart F of this part, determined as a proportion of total capital payments under the Federal rate.

(3) *Exceptions payment adjustment factor.* CMS reduces the updated standard Federal rate by an adjustment factor equal to the estimated additional payments for exceptions under §412.348 determined as a proportion of total payments under the hospital-specific rate and Federal rate.

(4) *Budget neutrality adjustment factor.* (i) For FY 1992 through FY 1995, CMS adjusts the updated standard Federal rate by a budget neutrality factor determined under §412.352.

(ii) CMS makes an adjustment to the Federal rate so that estimated aggregate payments for the fiscal year based

on the Federal rate after any changes resulting from the annual reclassification and recalibration of the DRG weight in accordance with § 412.60(e) and in the geographic adjustment factors described in § 412.312(b)(2) equal estimated aggregate payments based on the Federal rate that would have been made without such changes.

[56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992, as amended at 58 FR 46339, Sept. 1, 1993; 59 FR 45399, Sept. 1, 1994; 60 FR 45849, Sept. 1, 1995; 62 FR 46031, Aug. 29, 1997; 67 FR 50113, Aug. 1, 2002]

§ 412.312 Payment based on the Federal rate.

(a) *General.* The payment amount for each discharge based on the Federal rate determined under § 412.308(c) is determined under the following formula: [Federal rate × DRG weight × Geographic adjustment factor × Large urban add-on × (1 + Capital disproportionate share adjustment factor + capital indirect medical education adjustment factor) × (for hospitals located in Alaska and Hawaii, a cost-of-living adjustment factor)] + (Any applicable outlier payment).

(b) *Payment adjustments*—(1) *DRG weights.* The relative resource requirements of the discharge are taken into account by applying the DRG weighting factor that is assigned to the discharge under § 412.60.

(2) *Geographic adjustment factors*—(i) *Local cost variation.* A geographic adjustment factor is applied that takes into account geographic variation in costs.

(ii) *Large urban add-on.* An additional adjustment is made for hospitals located in a large urban area to reflect the higher costs incurred by hospitals located in those areas. For purposes of the payment adjustment under this paragraph, the definition of large urban area set forth at § 412.63(c)(6) continues to be in effect for discharges occurring on or after September 30, 2004.

(iii) *Cost-of-living adjustment.* An additional adjustment is made for hospitals located in Alaska and Hawaii to account for the higher cost-of-living in those States.

(3) *Disproportionate share adjustment.* For hospitals with at least 100 beds located in an urban area and serving low-income patients, a disproportionate share adjustment factor is applied that reflects the higher costs attributable to furnishing services to low income patients.

(4) *Indirect medical education adjustment.* An additional adjustment is made based on the ratio of residents to the average daily patient census of the hospital to account for the indirect costs of medical education.

(c) *Additional payment for outlier cases.* Payment is made for day outlier cases as provided for in § 412.82 and for cost outlier cases if both capital-related and operating-related costs exceed the cost outlier threshold as provided for in § 412.84.

(d) *Payment for transfer cases.* Payment is made for transfer cases as provided for in § 412.4.

(e) *Payment for extraordinary circumstances.* For cost reporting periods beginning on or after October 1, 2001—

(1) Payment for extraordinary circumstances is made as provided for in § 412.348(f).

(2) Although no longer independently in effect, the minimum payment levels established under § 412.348(c) continue to be used in the calculation of exception payments for extraordinary circumstances, according to the formula in § 412.348(f).

(3) Although no longer independently in effect, the offsetting amounts established under § 412.348(e) continue to be used in the calculation of exception payments for extraordinary circumstances. However, for cost reporting periods beginning during FY 2005 and subsequent fiscal years, the offsetting amounts in § 412.348(e) are determined based on the lesser of—

(i) The preceding 10-year period; or

(ii) The period of time under which the hospital is subject to the prospective payment system for capital-related costs.

(f) *Payment adjustment for certain immunotherapy cases.* For discharges occurring on or after October 1, 2020, in determining the payment amount under this section for certain clinical trial or expanded access use immunotherapy cases, or, for discharges occurring on or after October 1, 2025, other cases where the

immunotherapy product is not purchased in the usual manner, such as provided at no cost, as described in § 412.85(b), the DRG weighting factor described in paragraph (b)(1) of this section is adjusted as described in § 412.85(c).

[56 FR 43449, Aug. 30, 1991, as amended at 67 FR 50113, Aug. 1, 2002; 69 FR 49250, Aug. 11, 2004; 69 FR 60252, Oct. 7, 2004; 85 FR 59023, Sept. 18, 2020; 90 FR 37203, Aug. 4, 2025]

§ 412.316 Geographic adjustment factors.

(a) *Local cost variation.* CMS adjusts for local cost variation based on the hospital wage index value that is applicable to the hospital under subpart D of this part. The adjustment factor equals the hospital wage index value applicable to the hospital raised to the .6848 power and is applied to 100 percent of the Federal rate.

(b) *Large urban location.* For discharges occurring on or before September 30, 2007, CMS provides an additional payment to a hospital located in a large urban area equal to 3.0 percent of what would otherwise be payable to the hospital based on the Federal rate.

(1) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location for the purpose of receiving payment under § 412.63(a). The term ''large urban area'' is defined under § 412.63(c)(6).

(2) For discharges occurring on or after October 1, 2004, and before October 1, 2007, the definition of large urban areas under § 412.63(c)(6) continues be in effect for purposes of the payment adjustment under this section, based on the geographic classification under § 412.64, except as provided for in paragraph (b)(3) of this section.

(3) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, and before October 1, 2007, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.

(c) *Cost-of-living adjustment.* CMS provides an additional payment to a hospital located in Alaska and Hawaii equal to [0.3152 × (the cost-of-living adjustment factor used to determine payments under subpart D of this part − 1)] percent.

[56 FR 43449, Aug. 30, 1991, Aug. 11, 2004, as amended at 69 FR 49250, Aug. 11, 2004; 71 FR 48140, Aug. 18, 2006; 72 FR 47412, Aug. 22, 2007]

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.

(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, and before October 1, 2023, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.

(2) The hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor.* (1) If a hospital meets the criteria in paragraph (a)(1) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 × the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), −1], where e is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of hospital

inpatient operating prospective payments, the disproportionate share adjustment factor is the factor that results from deeming the hospital to have the same disproportionate share patient percentage that would yield its operating disproportionate share adjustment.

[56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992, as amended at 58 FR 46339, Sept. 1, 1993; 69 FR 49250, Aug. 11, 2004; 71 FR 48140, Aug. 18, 2006; 88 FR 59334, Aug. 28, 2023]

§ 412.322 Indirect medical education adjustment factor.

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

(1) The hospital's number of full-time equivalent residents as determined under § 412.105(f).

(2) The hospital's average daily census is determined by dividing the total number of inpatient days in the acute inpatient area of the hospital by the number of days in the cost reporting period.

(3) The measurement of teaching activity is the ratio of the hospital's full-time equivalent residents to average daily census. This ratio cannot exceed 1.5.

(b) *Payment adjustment factor.* The indirect teaching adjustment factor equals [e (raised to the power of .2822 × the ratio of residents to average daily census) − 1].

(c)–(d) [Reserved]

[56 FR 43449, Aug. 30, 1991, as amended at 63 FR 26357, May 12, 1998; 63 FR 41004, July 31, 1998; 72 FR 47412, Aug. 22, 2007; 74 FR 43998, Aug. 27, 2009]

Determination of Transition Period Payment Rates for Capital-Related Costs

§ 412.324 General description.

(a) *Hospitals under Medicare in FY 1991.* During the ten-year transition period, payments to a hospital with a hospital-specific rate below the Federal rate are based on the fully prospective payment methodology under § 412.340 or for a hospital with a hospital-specific rate above the Federal rate, the hold-harmless payment methodology under § 412.344.

(b) *New hospitals.* (1) A new hospital, as defined under § 412.300(b), is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its cost reporting period ending at least 2 years after the hospital accepts its first patient.

(2) For the third year through the remainder of the transition period, the hospital is paid based on the fully prospective payment methodology or the hold-harmless payment methodology using the base period determined under § 412.328(a)(2).

(3) If the hospital is paid under the hold-harmless methodology described in § 412.344, the hold-harmless payment for old capital costs described in § 412.344(a)(1) is payable for up to and including 8 years and may continue beyond the first cost reporting period beginning on or after October 1, 2000.

(c) *Hospitals with 52–53 week fiscal years ending September 25 through September 29.* For purposes of this subpart, a hospital with a 52–53 week fiscal year period beginning September 26 through September 30, 1992 is deemed to have the same beginning date for all cost reporting periods beginning before October 1, 2000 (unless the hospital later changes its cost reporting period).

[56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992]

§ 412.328 Determining and updating the hospital-specific rate.

(a) *Base-year cost reporting period*—(1) *Last 12 month cost reporting period ending on or before December 31, 1990.* For each hospital, the intermediary uses the hospital's latest 12-month or longer cost reporting period ending on or before December 31, 1990 as the base period to determine a hospital's hospital-specific rate.

(2) *New hospitals.* The base-year cost reporting period for a new hospital is its 12-month cost reporting period (or a combination of cost reporting periods covering at least 12 months) that begins at least 1 year after the hospital accepts its first patient.

(3) *Other hospitals.* For other than a new hospital as defined in § 412.300(b), if a hospital does not have a 12-month cost reporting period or does not have adequate Medicare utilization to file a cost report in a period ending on or before December 31, 1990, the hospital-specific rate is based on the hospital's

old capital costs (per discharge) in its first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) ending after December 31, 1990.

(b) *Base-year costs per discharge*—(1) *Base period allowable inpatient capital costs per discharge*—(i) *Determination.* The intermediary determines the base period allowable inpatient capital costs per discharge for the hospital by dividing the hospital's total allowable Medicare inpatient hospital capital-related cost in the base period by the number of Medicare discharges in the base period.

(ii) *Disposal of assets in the base year.* When a depreciable asset has been disposed of in the base year, only that portion of the gain or loss that is allocated to the base-year cost reporting period is reflected in the hospital-specific rate.

(iii) *Disposal of assets subsequent to the base year.* If an asset for which the Medicare program had recognized depreciation during the base year is disposed of subsequent to the base year, the hospital-specific rate will not be revised to recognize the portion of the gain or loss allocated to the base year.

(2) *Discharges.* For the purpose of determining a hospital's base period capital costs per discharge, a discharge includes discharges as defined in §412.4(a) and transfers as defined in §412.4(b)(2), adjusted by the transfer adjustment factor that is determined under paragraph (b)(3) of this section.

(3) *Transfer adjustment factor.* (i) For base year cost reporting periods ending on or before December 31, 1990, CMS uses the base year MEDPAR data received as of June 30, 1991 to develop an adjustment to discharges to account for transfers. CMS divides the length of stay for each transfer case by the geometric mean length of stay for the DRG (but in no case using a number greater than 1.0) and assigns each nontransfer case a value of 1.0. To determine the transfer adjustment factor, CMS adds together the adjusted discharges and divides the result by total discharges including transfers.

(ii) For base year cost reporting periods ending after December 31, 1990 but beginning before October 1, 1991, CMS determines a transfer adjustment factor as described in paragraph (b)(3)(i) of this section for a hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least 6 months after the close of the approved base year.

(iii) For base year cost reporting periods beginning on or after October 1, 1991, the intermediary determines the transfer adjustment factor in place of CMS as described in paragraph (b)(3)(i) of this section based on the most recent billing data available as of the date of the final determination of the hospital-specific rate.

(c) *Case-mix adjustment*—(1) *Determining transfer-adjusted case mix value. Step 1:* For base year cost reporting periods ending on or before December 31, 1990, CMS uses the base year MEDPAR data received as of June 30, 1991 to determine the hospital's transfer-adjusted case-mix value. For base year cost reporting periods ending after December 31, 1990 and beginning before October 1, 1991, CMS determines a transfer-adjusted case-mix value for a hospital using the applicable base year MEDPAR data on file as of the December 31 or June 30 occurring at least 6 months after the close of the base year. For base year cost reporting periods beginning on or after October 1, 1991, the intermediary determines the transfer-adjusted case-mix value based on the most recent billing data available as of the date of the final determination of the hospital-specific rate. CMS or the intermediary, as appropriate, multiplies the DRG weight for each case by one of the following factors:

(i) If the case is not a transfer, the factor equals 1.0.

(ii) If the case is a transfer, the factor equals the lesser of 1.0 or the ratio of the length of stay for the case divided by the geometric mean length of stay for the DRG.

Step 2: The products derived for all cases under Step 1 are added together and the result is divided by the adjusted discharges used to calculate the transfer adjustment factor determined under paragraph (b)(3) of this section.

(2) *Adjusting base period capital costs per discharge by the hospital's transfer-adjusted case-mix value.* The intermediary divides the base period capital costs per discharge for each hospital as

determined in paragraph (b) of this section by the hospital's transfer-adjusted case mix value for the cost reporting period determined under paragraph (c)(1) of this section.

(d) *Updating to FY 1992.* The intermediary updates the case-mix adjusted base period costs per discharge to FY 1992 based on the national average increase in Medicare inpatient capital costs per discharge as estimated by CMS, excluding the portion of the increase in capital costs per discharge attributable to changes in case mix.

(e) *Hospital-specific rate.* The intermediary determines the hospital-specific rate each year by adjusting the amount determined under paragraph (d) of this section by the following factors:

(1) *Update factor.* After FY 1992, the intermediary updates the hospital-specific rate in accordance with § 412.308(c)(1).

(2) *Exceptions payment adjustment factor.* For FY 1992 through FY 2001, the intermediary reduces the updated amount determined in paragraph (d) of this section by an adjustment factor equal to the estimated additional payments for capital-related costs for exceptions under § 412.348, determined as a proportion of the total amount of payments under the hospital-specific rate and Federal rate.

(3) *Budget neutrality adjustment factor.* For FY 1992 through FY 1995, the intermediary adjusts the updated amount determined in paragraph (d) of this section by a budget neutrality adjustment factor determined under § 412.352.

(4) *Payment for transfer cases.* Effective FY 1996, the intermediary reduces the updated amount determined in paragraph (d) of this section by 0.28 percent to account for the effect of the revised policy for payment of transfers under § 412.4(d).

(5) *Reduction of rate: FY 1998.* Effective FY 1998, the unadjusted hospital-specific rate as in effect on September 30, 1997 described in paragraph (e)(1) of this section is reduced by 15.68 percent.

(6) *Reduction of rate: FY 1998 through FY 2002.* For discharges occurring on or after October 1, 1997 through September 30, 2002, the unadjusted hospital-specific rate in effect on September 30, 1997, described in paragraph (e)(1) of this section is further reduced by 2.1 percent.

(f) *Redetermination of hospital-specific rate*—(1) *General.* (i) Upon request by a hospital, the intermediary redetermines the hospital-specific rate to reflect an increase in old capital costs as determined in a cost reporting period subsequent to the base year. An increase in Medicare old capital cost per discharge that is related solely to a decline in utilization is not recognized as an increase in old capital costs for purposes of this section. New capital costs are excluded from the redetermination of the hospital-specific rate.

(ii) The hospital may request redetermination for any cost reporting period beginning subsequent to the base period but no later than the later of the hospital's cost reporting period beginning in FY 1994 or the cost reporting period beginning after obligated capital that is recognized as old capital under § 412.302(b) is put in use.

(iii) The hospital must request a redetermination in writing no later than the date the cost report must be filed with the hospital's intermediary for the first cost reporting period beginning on or after October 1, 1991 or the cost reporting period that will serve as the new base period, whichever is later. The hospital's redetermination request must include the cost report for the new base period and an estimate of the revised hospital-specific rate indicating that the new rate exceeds the hospital's current hospital-specific rate.

(2) *Determination of old capital costs.* The intermediary determines the hospital's old capital costs for the subsequent cost reporting period that will serve as the new base period. The intermediary includes the costs of obligated capital that are recognized as old capital costs under § 412.302(b), excludes the costs of assets disposed of subsequent to the initial base year, and reflects changes in allowable old capital costs occurring subsequent to the initial base period.

(3) *Redetermined hospital-specific rate.* The intermediary redetermines the hospital-specific rate based on the old capital costs that are determined under paragraph (f)(2) of this section for the new base period. The intermediary—

(i) Divides the hospital's old capital costs for the new base period by the number of Medicare discharges in that cost reporting period (consistent with paragraph (b) of this section);

(ii) Divides the old capital costs per discharge by the hospital's transfer adjusted case-mix value for the new base period (consistent with paragraph (c) of this section);

(iii) Applies an update factor, if appropriate, to account for inflation occurring subsequent to the new base year, an exceptions payment adjustment factor, and a budget neutrality adjustment factor (consistent with paragraphs (d) and (e) of this section).

(4) *Denial by intermediary.* If the intermediary determines, after audit, that the revised hospital-specific rate is lower than the current hospital-specific rate, it advises the hospital that its request is denied and explains the basis for the denial.

(5) *Implementation date.* The redetermined hospital-specific rate applies to discharges occurring on or after the beginning date of the new base period.

(g) *Review and revision of the hospital-specific rate*—(1) *Interim determination.* The intermediary makes an interim determination of the hospital-specific rate based on the best data available and notifies the hospital at least 30 days before the beginning of the hospital's first cost reporting period beginning on or after October 1, 1991.

(2) *Final determination.* (i) The intermediary makes a final determination of the hospital-specific rate based on the final settlement of the base period cost report.

(ii) The final determination of the hospital-specific rate is effective retroactively to the beginning of the hospital's first cost reporting period beginning on or after October 1, 1991 or, in the case of a redetermination of the hospital-specific rate under §412.328(f), to the beginning of the new base period.

(iii) The final determination of the hospital-specific rate is subject to administrative and judicial review in accordance with subpart R of part 405 of this chapter, governing provider reimbursement determinations and appeals.

(iv) The intermediary adjusts the hospital-specific rate to reflect any revisions that result from administrative or judicial review of the final determination of hospital-specific rate. The revised determination is effective retroactively to the same extent as in paragraph (g)(2)(ii) of this section.

[56 FR 43449, Aug. 30, 1991; 57 FR 3016, 3017, Jan. 27, 1992; 57 FR 39828, Sept. 1, 1992; 60 FR 45849, Sept. 1, 1995; 62 FR 46031, Aug. 29, 1997]

§412.331 Determining hospital-specific rates in cases of hospital merger, consolidation, or dissolution.

(a) *New hospital merger or consolidation.* If, after a new hospital accepts its first patient but before the end of its base year, it merges with one or more existing hospitals, and two or more separately located hospital campuses are maintained, the hospital-specific rate and payment determination for the merged entity are determined as follows—

(1) *Post-merger base year payment methodology.* The new campus is paid based on reasonable costs until the end of its base year. The existing campus remains on its previous payment methodology until the end of the new campus' base year. Effective with the first cost reporting period beginning after the end of the new campus' base year, the intermediary determines a hospital-specific rate applicable to the new campus in accordance with §412.328, and then determines a revised hospital-specific rate for the merged entity in accordance with paragraph (a)(2) of this section.

(2) *Revised hospital-specific rate.* Using each hospital's base period data, the intermediary determines a combined average discharge-weighted hospital-specific rate.

(3) *Post-base year payment determination.* To determine the applicable payment methodology under §412.336 and for payment purposes under §412.340 or §412.344, the discharge-weighted hospital-specific rate determined by the intermediary is compared to the Federal rate. The revised payment methodology is effective on the first day of the cost reporting period beginning after the end of the new campus' base year.

(b) *Hospital merger or consolidation.* If, after the base year, two or more hospitals merge or consolidate into one hospital as provided for under

§ 413.134(k) of this chapter and the provisions of paragraph (a) of this section do not apply, the intermediary determines a revised hospital-specific rate applicable to the combined facility under § 412.328, which is effective beginning with the date of merger or consolidation. The following rules apply to the revised hospital-specific rate and payment determination:

(1) *Revised hospital-specific rate.* Using each hospital's base period data, the intermediary determines a combined average discharge weighted hospital-specific rate.

(2) *Payment determination.* The discharge-weighted hospital-specific rate determined by the intermediary is compared to the Federal rate to establish the appropriate payment methodology under § 412.336 and for payment purposes under §§ 412.340 or 412.344. The revised payment methodology is effective as of the date of merger or consolidation.

(3) *Old capital cost determination.* The capital-related costs related to the assets of each merged or consolidated hospital as of December 31, 1990 are recognized as old capital costs during the transition period. If the hospital is paid under the hold-harmless methodology after merger or consolidation, only that original base year old capital is eligible for hold-harmless payments.

(c) *Hospital dissolution.* If a hospital separates into two or more hospitals that are subject to capital payments under this subpart after the base year, the intermediary determines new hospital-specific rates for each separate hospital under the provisions of § 412.328 effective as of the date of the dissolution. The new hospital-specific rates are determined as follows:

(1) *Hospital-specific rate*—(i) *Adequate base year data.* The intermediary determines whether the base year capital-related cost data and necessary statistical records are adequate to reconstruct the cost and other data required under § 412.328 from the former hospital's financial records to determine the hospital-specific rates for each facility. If the data are adequate, the intermediary uses the former hospital's base period to determine the hospital-specific rate for each separate hospital.

(ii) *Inadequate original base year data.* If the intermediary determines that the base period data for the former hospital is inadequate to establish separate hospital-specific rates, the intermediary establishes a new base period for each hospital. The new base period is each hospital's first 12-month or longer cost reporting period (or combination of cost reporting periods covering at least 12 months) immediately following separation of the hospitals. The intermediary determines the hospital-specific rate for each hospital using the new base period under § 412.328.

(2) *Payment determinations.* The intermediary applies the payment methodology provisions of § 412.336. The revised payment determination is effective as of the date of the hospital's dissolution.

(3) *Old capital cost determination.* In determining the old capital costs for each hospital, the amount recognized as old capital is limited to the allowable capital-related costs attributable to assets that were in use for patient care as of December 31, 1990, and the hospitals are subject to all other transition period rules of this subpart.

[57 FR 39828, Sept. 1, 1992, as amended at 63 FR 41004, July 31, 1998]

§ 412.332 Payment based on the hospital-specific rate.

The payment amount for each discharge (as defined in § 412.4(a)) based on the hospital-specific rate determined under § 412.328 (e) or (f) is determined by multiplying the applicable hospital-specific rate by the DRG weighting factor applicable to the discharge under § 412.60 and the applicable hospital-specific rate percentage for the pertinent cost reporting period under § 412.340.

§ 412.336 Transition period payment methodologies.

(a) *General.* For discharges occurring in cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, a hospital is paid under one of two payment methodologies described in §§ 412.340 and 412.344. Except as provided under paragraph (b) of this section, a hospital is paid under the same methodology throughout the transition period.

(1) *Hospital-specific rate below the Federal rate.* A hospital with a hospital-specific rate below the Federal rate (after taking into account the estimated effect of the payment adjustments and outlier payments) is paid under the fully prospective payment methodology as described in §412.340.

(2) *Hospital-specific rate above the Federal rate.* A hospital with a hospital-specific rate that is above the Federal rate (after taking into account the estimated effect of the payment adjustments and outlier payments) is paid under the hold-harmless payment methodology as described in §412.344.

(b) *Special rule for revised hospital-specific rate.* If a hospital with a hospital-specific rate below the Federal rate requests that its hospital-specific rate be redetermined, the redetermined hospital-specific rate is compared to the Federal rate that is applicable to the new base period (after taking into account the estimated effect of the payment adjustments and outlier payments). If the redetermined hospital-specific rate is higher than the Federal rate, the hospital is paid under the hold-harmless methodology effective with the beginning of the new base period and continuing throughout the remainder of the transition.

(c) *Interim and final determinations of applicable payment methodology*—(1) *Interim determination.* The intermediary makes an interim determination of the applicable payment methodology based on the best data available and notifies the hospital of its determination at least 30 days before the beginning of the hospital's first cost reporting period beginning on or after October 1, 1991.

(2) *Final determination.* (i) The intermediary makes a final determination of the applicable payment methodology based on its final determination of the hospital's hospital-specific rate. The final determination of the applicable payment methodology is effective retroactively to the beginning of the hospital's first cost reporting period beginning on or after October 1, 1991.

(ii) If the hospital-specific rate is redetermined in accordance with §412.328(f), the intermediary makes a new determination of the applicable payment methodology. The new determination is effective retroactively to the beginning of the new base period.

(iii) If the hospital-specific rate is revised under §412.328(g) as a result of administrative or judicial review, the intermediary makes a new determination of the applicable payment methodology. The new determination is effective retroactively to the beginning of the hospital's first cost reporting period beginning on or after October 1, 1991 or to the beginning of the new base period.

(d) *Special Rule for Redetermination of Hospital Payment Methodology.* For cost reporting periods beginning on or after October 1, 1993, the intermediary redetermines the hospital payment methodologies to take into account the reduction to the standard Federal rate provided in §412.308(b)(2):

(1) For a hospital paid under the fully prospective payment methodology in the last hospital cost reporting period beginning before October 1, 1993, the intermediary compares the hospital's FY 1994 hospital-specific rate with the hospital's FY 1994 Federal rate (after taking into account the estimated effect of the payment adjustments and outlier payments).

(i) A hospital with a FY 1994 hospital-specific rate that is above the FY 1994 adjusted Federal rate is paid under the hold-harmless payment methodology described in §412.344.

(ii) Subject to the provisions of §412.328(f), a hospital with a FY 1994 hospital-specific rate that is below the FY 1994 adjusted Federal rate continues to be paid under the fully prospective payment methodology as described in §412.340.

(iii) The intermediary notifies the hospital of the new determination of the hospital's payment methodology within 90 days of the hospital's first cost reporting period beginning on or after October 1, 1993. The new determination is effective to the beginning of the hospital's first cost reporting period beginning on or after October 1, 1993.

(2) A hospital paid under the hold-harmless payment methodology in the last cost reporting period beginning before October 1, 1993, will continue to be

paid in accordance with the provisions of § 412.344.

[56 FR 43449, Aug. 30, 1991; 57 FR 3017, Jan. 27, 1992, as amended at 58 FR 46340, Sept. 1, 1993]

§ 412.340 Fully prospective payment methodology.

A hospital paid under the fully prospective payment methodology receives a payment per discharge based on a proportion of the hospital-specific rate and the Federal rate as follows:

Cost reporting periods beginning on or after:	Federal rate percentage	Hospital-specific rate percentage
October 1, 1991	10	90
October 1, 1992	20	80
October 1, 1993	30	70
October 1, 1994	40	60
October 1, 1995	50	50
October 1, 1996	60	40
October 1, 1997	70	30
October 1, 1998	80	20
October 1, 1999	90	10
October 1, 2000	100	0

§ 412.344 Hold-harmless payment methodology.

(a) *General.* A hospital paid under the hold-harmless payment methodology receives a payment per discharge based on the higher of:

(1) 85 percent of reasonable costs for old capital costs (100 percent for sole community hospitals) plus an amount for new capital costs based on a proportion of the Federal rate. The proportion is equal to the ratio of the hospital's Medicare inpatient costs for new capital to total Medicare inpatient capital costs; or

(2) 100 percent of the Federal rate.

(3) *Exceptions.* (i) A hospital that would receive higher payment under paragraph (a)(1) of this section may elect payment based on 100 percent of the Federal rate under paragraph (a)(2) of this section.

(ii) A hospital that does not maintain records that are adequate to identify its old capital costs is deemed to have elected payment per discharge based on 100 percent of the Federal rate.

(b) *Continued basis of payment.* A hospital paid based on 100 percent of the Federal rate during the later of its cost reporting period beginning in FY 1994 or its first cost reporting period beginning after obligated capital that is recognized as old capital under § 412.302(b) is put in use continues to be paid on that basis in subsequent cost reporting periods during the transition period and does not receive a reasonable cost payment for old capital costs under paragraph (a)(1) of this section.

(c) *Basis of determination.* The determination under paragraph (a) of this section regarding which payment alternative is applicable is made without regard to additional payments under the exceptions process under § 412.348.

(d) *Interim and final payment determinations.* (1) Using the best data available, the intermediary makes an interim payment determination under paragraph (a) of this section concerning the applicable payment alternative, and, in the case of payment under paragraph (a)(1) of this section, the payment amounts for old and new capital. The intermediary notifies the hospital of its determination at least 30 days before the beginning of the hospital's first cost reporting period beginning on or after October 1, 1991. The intermediary may revise its determination based on additional information submitted by the hospital and make appropriate adjustments retroactively.

(2) The final determination of the amount payable under paragraph (a) of this section is based on final settlement of the Medicare cost report for the applicable cost reporting period and is effective retroactively to the beginning of that cost reporting period. This final determination is subject to administrative and judicial review in accordance with subpart R of part 405 of this chapter, governing provider reimbursement determinations and appeals.

[56 FR 43449, Aug. 30, 1991; 57 FR 3017, Jan. 27, 1992]

§ 412.348 Exception payments.

(a) *Definitions.* As used in this section—

Annual operating expenses. Annual operating expenses means the sum of net expenses for all reimbursable cost centers for a 12 month cost reporting period. Annual operating expenses are obtained from the Medicare cost report.

Average age of fixed assets. The average age of fixed assets is the ratio of accumulated depreciation for buildings

and fixed equipment to current depreciation expense for buildings and fixed equipment. The average age of fixed assets is determined from information on the Medicare cost report.

Fixed assets. Fixed assets mean buildings and fixed equipment.

(b) *Criterion for additional payment during the transition period.* An additional payment is made to a hospital paid under either the fully prospective payment methodology or the hold-harmless payment methodology as determined under paragraph (c) of this section for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001.

(c) *Minimum payment level by class of hospital.* (1) CMS establishes a minimum payment level by class of hospital. The minimum payment level for a hospital will equal a fixed percentage of the hospital's capital-related costs. The minimum payment levels may be no greater than the percentages of allowable capital-related costs that follow:

(i) 90 percent for sole community hospitals.

(ii) 80 percent for hospitals located in an urban area for purposes of §412.63(a) with at least 100 beds, as determined under §412.105(b), that have a disproportionate share patient percentage of at least 20.2 percent as determined under §412.106(b), and for hospitals located in an urban area for purposes of §412.63(a) with at least 100 beds that qualify for disproportionate share payments under §412.106(c)(2).

(iii) 70 percent for all other hospitals.

(2) When it is necessary to adjust the minimum payment levels set by class of hospitals specified in paragraphs (c)(1)(i) and (g)(6) of this section, CMS will adjust those levels for each class of hospitals in one percentage point increments as necessary to satisfy the requirement specified in paragraph (h) of this section that total estimated payments under the exception process not exceed 10 percent of the total estimated capital prospective payments (exclusive of hold-harmless payments for old capital) for the same fiscal year.

(d) *Additional payments.* A hospital is entitled to an additional payment if its capital payments for the cost reporting period would otherwise be less than the applicable minimum payment level. The additional payment equals the difference between the applicable minimum payment level and the capital payments that the hospital would otherwise receive minus any offset amount determined under paragraph (e)(2) of this section.

(e) *Determining a hospital's exception payment amount*—(1) *Cumulative comparison.* For each cost reporting period beginning before October 1, 2001, the hospital's exception payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to the prospective payment system.

(2) *Offsetting amounts.* Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment levels is deducted from the additional payment that would otherwise be payable for a cost reporting period.

(f) *Additional payment exception for extraordinary circumstances.* (1) A hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million (net of proceeds from other payment sources such as insurance, litigation decisions and other State, local or Federal government funding programs) due to extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include, but are not limited to, a flood, fire, or earthquake.

(2) A hospital must apply to its CMS Regional Office by the later of October 1, 1992 or 180 days after the extraordinary circumstance causing the unanticipated expenditures for a determination by CMS of whether the hospital is eligible for an additional payment based on the nature of the circumstances and the amount of financial loss documented by the hospital.

(3) Except for sole community hospitals, the additional payment is based on a minimum payment amount of 85 percent for Medicare's share of allowable capital-related costs attributable to the extraordinary circumstances. For sole community hospitals, the

minimum payment amount is 100 percent.

(4) The minimum payment level applicable under paragraph (c)(1) of this section is adjusted to take into account the 85 percent minimum payment level (100 percent for sole community hospitals) under paragraph (f)(3) of this section for the unanticipated capital-related costs. The additional payment for the cost reporting period equals the difference between the adjusted minimum payment level and the capital payments the hospital would otherwise receive less any offset amount determined under paragraph (e)(2) of this section.

(g) *Special exceptions process.* For eligible hospitals that meet a project need requirement, a project size requirement, and, in the case of certain urban hospitals, meet an excess capacity test, an additional payment may be made for up to 10 years beyond the end of the capital prospective payment system transition period.

(1) *Eligible hospitals.* The following classes of hospitals are eligible to receive exceptions payments under this special exceptions provision:

(i) Sole community hospitals.

(ii) Hospitals located in an urban area under § 412.63(a) with at least 100 beds, as determined under § 412.105(b), that either have a disproportionate share of at least 20.2 percent as determined under § 412.106(b) or qualify for disproportionate share payments under § 412.106(c)(2).

(iii) Hospitals with a combined inpatient Medicare and Medicaid utilization of at least 70 percent.

(2) *Project need requirement.* A hospital must show that it has obtained any required approval from a State or local planning authority. If a hospital is not required to obtain approval from a planning authority, it must satisfy the age of asset test specified in paragraph (g)(3) of this section and, in the case of an urban hospital, the excess capacity test under paragraph (g)(4) of this section.

(3) *Age of assets test.* A hospital must show that its average age of fixed assets is at or above the 75th percentile for the hospital's first cost reporting period beginning on or after October 1, 1991.

(4) *Excess capacity test for urban hospitals.* Urban hospitals that are not required to receive approval from a State or local planning authority must demonstrate that either—

(i) The overall average occupancy rate in its metropolitan statistical area is at least 80 percent; or

(ii) After completion of the project, its capacity is no more than 80 percent of its prior capacity (in terms of bed size).

(5) *Project size requirement.* A hospital must complete, during the period from the beginning of its first cost reporting period beginning on or after October 1, 1991 to the end of its last cost reporting period beginning before October 1, 2001, a project whose costs for replacement and/or renovation of fixed assets related to patient care are at least:

(i) $200 million; or

(ii) 100 percent of its operating cost during the first 12 month cost reporting period beginning on or after October 1, 1991.

(6) *Minimum payment level.* (i) The minimum payment level for qualifying hospitals will be 70 percent.

(ii) CMS will adjust the minimum payment level in one percentage point increments as necessary to satisfy the requirement specified in paragraph (h) of this section that total estimated payments under the exceptions process not exceed 10 percent of the total estimated capital prospective payment system payments for the same fiscal year.

(7) *Limitation on the period for exception payments.* A qualifying hospital may receive an exceptions payment for up to 10 years from the year in which it completes a project for replacement or renovation of capital assets that meets project need and project size requirements (and, if applicable, excess capacity test), provided that it completes the project no later than the end of the hospital's last cost reporting period beginning before October 1, 2001. A project is considered to be completed when the assets are put into use for patient care.

(8) *Determining a hospital's exception payment amount*—(i) *Cumulative comparison.* For each cost reporting period, the hospital's exception payment is determined by comparing the cumulative

payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to the prospective payment system.

(ii) *Offsetting amounts.* Offsetting amounts are applied in the following order—(A) Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment levels is deducted from the additional payment that would otherwise be payable for a cost reporting period.

(B) Any amount by which the hospital's current year Medicare inpatient operating and capital prospective payment system payments (excluding, if applicable, 75 percent of the hospital's operating prospective payment system disproportionate share payments) exceed its Medicare inpatient operating and capital costs is deducted from the additional payment that would otherwise be payable for the cost reporting period. For purposes of calculating the offset, the costs and payments for services that are not subject to the hospital inpatient prospective payment system are excluded.

(9) *Notification requirement.* Eligible hospitals must submit documentation to the intermediary indicating the completion date of a project that meets the project need requirement under paragraph (g)(2) of this section, the project size requirement under paragraph (g)(5) of this section, and, in the case of certain urban hospitals, an excess capacity test under paragraph (g)(4) of this section, by the later of October 1, 2001 or within 3 months of the end of the hospital's last cost reporting period beginning before October 1, 2001, during which a qualifying project was completed.

(h) *Limit on exception payments.* Total estimated payments under the exception process may not exceed 10 percent of the total estimated capital prospective payments (exclusive of hold-harmless payments for old capital) for the same fiscal year.

[59 FR 45399, Sept. 1, 1994, as amended at 62 FR 46031, Aug. 29, 1997; 66 FR 39936, Aug. 1, 2001]

§ 412.352 Budget neutrality adjustment.

For FY 1992 through FY 1995, CMS will determine an adjustment to the hospital-specific rate and the Federal rate proportionately so that the estimated aggregate payments under this subpart for inpatient hospital capital costs each fiscal year will equal 90 percent of what CMS estimates would have been paid for capital-related costs on a reasonable cost basis under § 413.130 of this chapter.

Special Rules for Puerto Rico Hospitals

§ 412.370 General provisions for hospitals located in Puerto Rico.

Except as provided in § 412.374, hospitals located in Puerto Rico are subject to the rules in this subpart governing the prospective payment system for inpatient hospital capital-related costs.

§ 412.374 Payments to hospitals located in Puerto Rico.

(a) *FY 1998 through FY 2004.* Payments for capital-related costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of the following:

(1) 50 percent of the Puerto Rico capital rate based on data from Puerto Rico hospitals only, which is determined in accordance with procedures for developing the Federal rate; and

(2) 50 percent of the Federal rate, as determined under § 412.308.

(b) *FY 2005 through FY 2016.* For discharges occurring on or after October 1, 2004 and on or before September 30, 2016, payments for capital-related costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of the following:

(1) 25 percent of the Puerto Rico capital rate based on data from Puerto Rico hospitals only, which is determined in accordance with procedures for developing the Federal rate; and

(2) 75 percent of the Federal rate, as determined under § 412.308.

(c) Effective for fiscal year 1998, the Puerto Rico capital rate described in paragraph (a) of this section in effect

on September 30, 1997, is reduced by 15.68 percent.

(d) For discharges occurring on or after October 1, 1997 through September 30, 2002, the Puerto Rico capital rate described in paragraph (a) of this section in effect on September 30, 1997 is further reduced by 2.1 percent.

(e) *FY 2017 and subsequent fiscal years.* For discharges occurring on or after October 1, 2016, payments for capital-related costs to hospitals located in Puerto Rico that are paid under the prospective payment system are based on 100 percent of the Federal rate, as determined under § 412.308.

[62 FR 46032, Aug. 29, 1997, as amended at 69 FR 49250, Aug. 11, 2004; 81 FR 57268, Aug. 22, 2016]

Subpart N—Prospective Payment System for Inpatient Hospital Services of Inpatient Psychiatric Facilities

SOURCE: 69 FR 66977, Nov. 15, 2004, unless otherwise noted.

§ 412.400 Basis and scope of subpart.

(a) *Basis.* This subpart implements section 124 of Public Law 106–113, which provides for the implementation of a per diem-based prospective payment system for inpatient hospital services of inpatient psychiatric facilities.

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for the inpatient hospital services of inpatient psychiatric facilities, including the methodology used for the development of the Federal per diem rate, payment adjustments, implementation issues, and related rules. Under this system, for cost reporting periods beginning on or after January 1, 2005, payment for the operating and capital-related costs of inpatient hospital services furnished by inpatient psychiatric facilities to Medicare Part A fee-for-service beneficiaries is made on the basis of prospectively determined payment amount applied on a per diem basis.

§ 412.402 Definitions.

As used in this subpart—

Closure of an IPF means closure of a hospital as defined in § 413.79(h)(1)(i) by an IPF meeting the requirements of § 412.404(b) for the purposes of accounting for indirect teaching costs.

Closure of an IPF's residency training program means closure of a hospital residency training program as defined in § 413.79(h)(1)(ii) by an IPF meeting the requirements of § 412.404(b) for the purposes of accounting for indirect teaching costs.

Comorbidity means all specific patient conditions that are secondary to the patient's primary diagnosis and that coexist at the time of admission, develop subsequently, or that affect the treatment received or the length of stay or both. Diagnoses that relate to an earlier episode of care that have no bearing on the current hospital stay are excluded.

Displaced resident means a displaced resident as defined in § 413.79(h)(1)(iii) for the purposes of accounting for indirect teaching costs.

Federal per diem base rate means the payment based on the average routine operating, ancillary, and capital-related cost of 1 day of hospital inpatient services in an inpatient psychiatric facility.

Federal per diem payment amount means the Federal per diem base rate with all applicable adjustments.

Fixed dollar loss threshold amount means a dollar amount which, when added to the Federal payment amount for a case, the estimated costs of a case must exceed in order for the case to qualify for an outlier payment.

Inpatient psychiatric facilities means hospitals that meet the requirements as specified in §§ 412.22, 412.23(a), 482.60, 482.61, and 482.62, and units that meet the requirements as specified in §§ 412.22, 412.25, and 412.27.

Inpatient psychiatric facilities prospective payment system rate year means—

(1) Through June 30, 2011, the 12-month period of July 1 through June 30.

(2) Beginning July 1, 2011, the 15-month period of July 1, 2011 through September 30, 2012.

(3) Beginning October 1, 2012, the 12-month period of October 1 through September 30, referred to as Fiscal Year (FY).

Interrupted stay means a Medicare inpatient is discharged from an inpatient

psychiatric facility and is admitted to any inpatient psychiatric facility within 3 consecutive calendar days following discharge. The 3 consecutive calendar days begins with the day of discharge from the inpatient psychiatric facility and ends on midnight of the third day.

New graduate medical education program means a medical education program that receives initial accreditation by the appropriate accrediting body or begins training residents on or after November 15, 2004.

Outlier payment means an additional payment beyond the Federal per diem payment amount for cases with unusually high costs.

Principal diagnosis means the condition established after study to be chiefly responsible for occasioning the admission of the patient to the inpatient psychiatric facility. Principal diagnosis is also referred to as the primary diagnosis.

Qualifying emergency department means an emergency department that is staffed and equipped to furnish a comprehensive array of emergency services and meeting the definitions of a dedicated emergency department as specified in §489.24(b) of this chapter and the definition of ''provider-based status'' as specified in §413.65 of this chapter.

Rural area means for cost reporting periods beginning January 1, 2005, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2006, an area as defined in §412.62(f)(1)(iii). For discharges occurring on or after July 1, 2006, rural area means an area as defined in §412.64(b)(1)(ii)(C).

Urban area means for cost reporting periods beginning on or after January 1, 2005, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2006, an area as defined in §412.62(f)(1)(ii). For discharges occurring on or after July 1, 2006, urban area means an area as defined in §412.64(b)(1)(ii)(A) and §412.64(b)(1)(ii)(B).

[69 FR 66977, Nov. 15, 2004; 70 FR 19728, Apr. 1, 2005, as amended at 71 FR 27086, May 9, 2006; 76 FR 26465, May 6, 2011; 83 FR 38619, Aug. 6, 2018; 86 FR 42678, Aug. 4, 2021]

§ 412.404 Conditions for payment under the prospective payment system for inpatient hospital services of psychiatric facilities.

(a) *General requirements.* (1) Effective for cost reporting periods beginning on or after January 1, 2005, an inpatient psychiatric facility must meet the conditions of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare Part A fee-for-service beneficiaries.

(2) If an inpatient psychiatric facility fails to comply fully with these conditions, CMS may, as appropriate—

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient psychiatric facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient psychiatric facility as an inpatient hospital that is subject to the conditions of subpart C of this part and is paid under the prospective payment system as specified in §412.1(a)(1).

(b) *Inpatient psychiatric facilities subject to the prospective payment system.* Subject to the special payment provisions of §412.22(c), an inpatient psychiatric facility must meet the general criteria set forth in §412.22. In order to be excluded from the hospital inpatient prospective payment system as specified in §412.1(a)(1), a psychiatric hospital must meet the criteria set forth in §§412.23(a), 482.60, 482.61, and 482.62 and psychiatric units must meet the criteria set forth in §412.25 and §412.27.

(c) *Limitations on charges to beneficiaries*—(1) *Prohibited charges.* Except as permitted in paragraph (c)(2) of this section, an inpatient psychiatric facility may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's cost of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) *Permitted charges.* An inpatient psychiatric facility receiving payment under this subpart for a covered hospital stay (that is, a stay that included at least one covered day) may charge the Medicare beneficiary or other person only the applicable deductible and

coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this chapter and for items or services as specified under § 489.20(a) of this chapter.

(d) *Furnishing of inpatient hospital services directly or under arrangement.* (1) Subject to the provisions of § 412.422, the applicable payments made under this subpart are payment in full for all inpatient hospital services, as specified in § 409.10 of this chapter. Hospital inpatient services do not include the following:

(i) Physicians' services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(ii) Physician assistant services, as specified in section 1861(s)(2)(K)(i) of the Act.

(iii) Nurse practitioners and clinical nurse specialist services, as specified in section 1861(s)(2)(K)(ii) of the Act.

(iv) Certified nurse midwife services, as specified in section 1861(gg) of the Act.

(v) Qualified psychologist services, as specified in section 1861(ii) of the Act.

(vi) Services of a certified registered nurse anesthetist, as specified in section 1861(bb) of the Act and defined in § 410.69 of this subchapter.

(2) CMS does not pay providers or suppliers other than inpatient psychiatric facilities for services furnished to a Medicare beneficiary who is an inpatient of the inpatient psychiatric facility, except for services described in paragraphs (d)(1)(i) through (d)(1)(vi) of this section

(3) The inpatient psychiatric facility must furnish all necessary covered services to a Medicare beneficiary who is an inpatient of the inpatient psychiatric facility, either directly or under arrangements (as specified in § 409.3 of this chapter).

(e) *Reporting and recordkeeping requirements.* All inpatient psychiatric facilities participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements as specified in §§ 412.27(c), 413.20, 413.24, and 482.61 of this chapter.

[69 FR 66977, Nov. 15, 2004, as amended at 76 FR 26465, May 6, 2011]

§ 412.405 Preadmission services as inpatient operating costs under the inpatient psychiatric facility prospective payment system.

The prospective payment system includes payment for inpatient operating costs of preadmission services if the inpatient operating costs are for—

(a) Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary on the date of the beneficiary's inpatient admission, and during the calendar day immediately preceding the date of the beneficiary's inpatient admission, to the inpatient psychiatric facility that meet the following conditions:

(1) The services are furnished by the inpatient psychiatric facility or by an entity wholly owned or wholly operated by the inpatient psychiatric facility. An entity is wholly owned by the inpatient psychiatric facility if the inpatient psychiatric facility is the sole owner of the entity. An entity is wholly operated by an inpatient psychiatric facility if the inpatient psychiatric facility has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the inpatient psychiatric facility also has policymaking authority over the entity.

(2) The services are diagnostic (including clinical diagnostic laboratory tests).

(3) The services are nondiagnostic when furnished on the date of the beneficiary's inpatient admission, the services are nondiagnostic when furnished on the calendar day preceding the date of the beneficiary's inpatient admission and the hospital does not demonstrate that such services are unrelated to the beneficiary's inpatient admission, and are not one of the following:

(i) Ambulance services.

(ii) Maintenance renal dialysis services.

(b) The preadmission services are furnished on or after June 25, 2010.

[75 FR 50415, Aug. 16, 2010]

§ 412.422 Basis of payment.

(a) *Method of Payment.* (1) Under the inpatient psychiatric facility prospective payment system, inpatient psychiatric facilities receive a predetermined Federal per diem base rate for inpatient hospital services furnished to Medicare Part A fee-for-service beneficiaries.

(2) The Federal per diem payment amount is based on the Federal per diem base rate plus applicable adjustments as specified in § 412.424.

(3) During the transition period, payment is based on a blend of the Federal per diem payment amount as specified in § 412.424, and the facility-specific payment rate as specified in § 412.426.

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as specified in subpart G of part 409 of this chapter) for inpatient operating and capital-related costs associated with furnishing Medicare covered services in an inpatient psychiatric facility, but not the cost of an approved medical education program as specified in § 413.75 through § 413.85 of this chapter.

(2) In addition to the Federal per diem payment amounts, inpatient psychiatric facilities receive payment for bad debts of Medicare beneficiaries, as specified in § 413.89 of this chapter.

[69 FR 66977, Nov. 15, 2004; 70 FR 19728, Apr. 1, 2005, as amended at 76 FR 26465, May 6, 2011]

§ 412.424 Methodology for calculating the Federal per diem payment amount.

(a) *Data sources.* (1) To calculate the Federal per diem base rate (as specified in paragraph (b) of this section for inpatient psychiatric facilities, as specified in paragraph (b) of this section, CMS uses the following data sources:

(2) The best Medicare data available to estimate the average inpatient operating and capital-related costs per day made as specified in part 413 of this chapter.

(i) Patient and facility cost report data capturing routine and ancillary costs.

(ii) An appropriate wage index to adjust for wage differences.

(iii) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services provided by inpatient psychiatric facilities.

(b) *Determining the average per diem cost of inpatient psychiatric facilities for FY 2002.* CMS determines the average inpatient operating, ancillary, and capital-related per diem cost for which payment is made to each inpatient psychiatric facility, using the available data described in paragraph (a) of this section.

(c) *Determining the Federal per diem base rate for cost reporting periods beginning on or after January 1, 2005 through June 30, 2006*—(1) *General.* Payment under the inpatient psychiatric facility prospective payment system is based on a standardized per diem payment referred to as the Federal per diem base rate. The Federal per diem base rate is the adjusted cost for 1 day of inpatient hospital services in an inpatient psychiatric facility in a base year as described in paragraph (b) of this section. The adjusted cost per day is adjusted in accordance with paragraphs (c)(2) through (c)(5) of this section.

(2) *Update of the average per diem cost.* CMS applies the increase factor described in paragraph (a)(2)(iii) of this section to the updated average per diem cost to the midpoint of the January 1, 2005 through June 30, 2006, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act.

(3) *Budget neutrality.* (i) CMS adjusts the updated average per diem cost so that the aggregate payments in the first 18 months (for January 1, 2005 through June 30, 2006) under the inpatient psychiatric facility prospective payment system are estimated to equal the amount that would have been made to the inpatient psychiatric facilities under part 413 of this chapter if the inpatient psychiatric facility prospective payment system described in this subpart were not implemented.

(ii) CMS evaluates the accuracy of the budget-neutrality adjustment within the first 5 years after implementation of the inpatient psychiatric facility prospective payment system. CMS may make a one-time prospective adjustment to the Federal per diem base

rate to account for significant differences between the historical data on cost-based TEFRA payments (the basis of the budget-neutrality adjustment at the time of implementation) and estimates of TEFRA payments based on actual data from the first year of the prospective payment system.

(4) *Outlier payments.* CMS determines a reduction factor equal to the estimated proportion of outlier payments described in paragraph (d)(3)(i) of this section.

(5) *Standardization.* CMS determines a reduction factor to reflect estimated increases in the Federal per diem base rate as defined in §412.402 resulting from the facility-level and patient-level adjustments described in paragraph (d) of this section.

(6) *Computation of the Federal per diem base rate.* The Federal per diem base rate is computed as follows:

(i) For cost reporting periods beginning on or after January 1, 2005 and on or before June 30, 2006, the Federal per diem base rate is computed in accordance with paragraph (c) of this section.

(ii) For inpatient psychiatric facilities beginning on or after July 1, 2006, the Federal per diem base rate will be the Federal per diem base rate for the previous year, updated by an increase factor described in paragraph (a)(2)(iii) of this section.

(d) *Determining the Federal per diem payment amount.* The Federal per diem payment amount is the product of the Federal per diem base rate established under paragraph (c) of this section, the facility-level adjustments applicable to the inpatient psychiatric facility, patient-level adjustments and other policy adjustments applicable to the case.

(1) *Facility-level adjustments—* (i) *Adjustment for wages.* CMS adjusts the labor portion of the Federal per diem base rate to account for geographic differences in the area wage levels using an appropriate wage index.

(A) The application of the wage index is made on the basis of the location of the inpatient psychiatric facility in an urban or rural area as defined in §412.402.

(B) Beginning October 1, 2022, CMS applies a cap on decreases to the wage index, such that the wage index applied to an inpatient psychiatric facility is not less than 95 percent of the wage index applied to that inpatient psychiatric facility in the prior fiscal year.

(ii) *Rural location.* CMS adjusts the Federal per diem base rate for inpatient psychiatric facilities located in a rural area as defined in §412.402.

(iii) *Teaching adjustment.* CMS adjusts the Federal per diem base rate by a factor to account for indirect teaching costs.

(A) An inpatient psychiatric facility's teaching adjustment is based on the ratio of the number of full-time equivalent residents training in the inpatient psychiatric facility divided by the facility's average daily census.

(B) Residents with less than full-time status and residents rotating through the inpatient psychiatric facility for less than a full year will be counted in proportion to the time they spend in the inpatient psychiatric facility.

(C) Except as described in paragraph (d)(1)(iii)(D) of this section, the actual number of current year full-time equivalent residents used in calculating the teaching adjustment is limited to the number of full-time equivalent residents in the inpatient psychiatric facility's most recently filed cost report filed with its fiscal intermediary before November 15, 2004 (base year).

(D) If the inpatient psychiatric facility first begins training residents in a new approved graduate medical education program after November 15, 2004, the number of full-time equivalent residents determined under paragraph (d)(1)(iii)(C) of this section may be adjusted using the method described in §413.79(e)(1)(i) and (ii) of this chapter.

(E) The teaching adjustment is made on a claim basis as an interim payment, and the final payment in full for the claim is made during the final settlement of the cost report.

(F) *Closure of an IPF or IPF residency training program—(1) Closure of an IPF.* For cost reporting periods beginning on or after July 1, 2011, an IPF may receive a temporary adjustment to its FTE cap to reflect displaced residents added because of another IPF's closure if the IPF meets the following criteria:

(*i*) The IPF is training additional displaced residents from an IPF that closed on or after July 1, 2011.

(*ii*) No later than 60 days after the IPF begins to train the displaced residents, the IPF submits a request to its Medicare contractor for a temporary adjustment to its cap, documents that the IPF is eligible for this temporary adjustment by identifying the displaced residents who have come from the closed IPF and have caused the IPF to exceed its cap, and specifies the length of time the adjustment is needed.

(*2*) *Closure of an IPF's residency training program.* If an IPF that closes its residency training program on or after July 1, 2011, agrees to temporarily reduce its FTE cap according to the criteria specified in paragraph (d)(1)(iii)(F)(*2*)(*ii*) of this section, another IPF(s) may receive a temporary adjustment to its FTE cap to reflect displaced residents added because of the closure of the residency training program if the criteria specified in paragraph (d)(1)(iii)(F)(*2*)(*i*) of this section are met.

(*i*) *Receiving IPF(s).* For cost reporting periods beginning on or after July 1, 2011, an IPF may receive a temporary adjustment to its FTE cap to reflect displaced residents added because of the closure of another IPF's residency training program if the IPF is training additional displaced residents from the residency training program of an IPF that closed a program; and if no later than 60 days after the IPF begins to train the displaced residents, the IPF submits to its Medicare Contractor a request for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the displaced residents who have come from another IPF's closed program and have caused the IPF to exceed its cap, specifies the length of time the adjustment is needed, and submits to its Medicare contractor a copy of the FTE reduction statement by the hospital that closed its program, as specified in paragraph (d)(1)(iii)(F)(*2*)(*ii*) of this section.

(*ii*) *IPF that closed its program.* An IPF that agrees to train displaced residents who have been displaced by the closure of another IPF's program may receive a temporary FTE cap adjustment only if the hospital with the closed program temporarily reduces its FTE cap based on the FTE of displaced residents in each program year training in the program at the time of the program's closure. This yearly reduction in the FTE cap will be determined based on the number of those displaced residents who would have been training in the program during that year had the program not closed. No later than 60 days after the displaced residents who were in the closed program begin training at another hospital, the hospital with the closed program must submit to its Medicare contractor a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the IPF training the displaced residents to obtain a temporary adjustment to its cap; identifies the displaced residents who were in training at the time of the program's closure; identifies the IPFs to which the displaced residents are transferring once the program closes; and specifies the reduction for the applicable program years.

(iv) *Inpatient psychiatric facilities located in Alaska and Hawaii.* CMS adjusts the non-labor portion of the Federal per diem base rate to reflect the higher cost of living of inpatient psychiatric facilities located in Alaska and Hawaii.

(v) *Adjustment for IPF with qualifying emergency departments.* (A) CMS adjusts the Federal per diem base rate to account for the costs associated with maintaining a qualifying emergency department. A qualifying emergency department is staffed and equipped to furnish a comprehensive array of emergency services (medical and psychiatric) and meets the requirements of §§489.24(b) and 413.65 of this chapter.

(B) Where the inpatient psychiatric facility is part of an acute care hospital that has a qualifying emergency department as described in paragraph (d)(1)(v)(A) of this section and an individual patient is discharged to the inpatient psychiatric facility from that acute care hospital, CMS would not apply the emergency adjustment.

(vi) *Applicable percentage change for fiscal year 2014 payment determination and for subsequent years.* (A) In the case

of an inpatient psychiatric facility that is paid under the prospective payment system in §412.1(a)(2) that does not submit quality data to CMS, in the form and manner and at a time specified by CMS, the applicable annual update to a Federal standard rate is reduced by 2.0 percentage points.

(B) Any reduction in the applicable annual update to a Federal standard rate will apply only to the fiscal year involved and will not be taken into account in computing the annual payment update for a subsequent year.

(2) *Patient-level adjustments.* The inpatient psychiatric facility must identify a principal psychiatric diagnosis as specified in §412.27(a) for each patient. CMS adjusts the Federal per diem base rate by a factor to account for the diagnosis-related group assignment associated with the principal diagnosis, as specified by CMS.

(i) *Age.* CMS adjusts the Federal per diem base rate to account for patient age based on age groupings specified by CMS.

(ii) *Diagnosis-related group assignment.* The inpatient psychiatric facility must identify a principal diagnosis as specified in §412.27(a) for each patient. CMS adjusts the Federal per diem base rate by a factor to account for the CMS inpatient psychiatric facility prospective payment system recognized diagnosis-related group assignment associated with each patient's principal diagnosis.

(iii) [Reserved]

(iv) *Comorbidities.* CMS adjusts the Federal per diem base rate by a factor to account for certain comorbidities as specified by CMS.

(v) *Variable per diem adjustments.* CMS adjusts the Federal per diem base rate by factors as specified by CMS to account for the cost of each day of inpatient psychiatric care relative to the cost of the median length of stay.

(3) *Other adjustments.* (i) *Outlier payments.* CMS provides an outlier payment if an inpatient psychiatric facility's estimated total cost for a case exceeds a fixed dollar loss threshold amount for an inpatient psychiatric facility as defined in §412.402 plus the Federal payment amount for the case.

(A) The fixed dollar loss threshold amount is adjusted for the inpatient psychiatric facility's adjustments for wage area, teaching, rural locations, and cost of living adjustment for facilities located in Alaska and Hawaii.

(B) The outlier payment equals a percentage of the difference between the IPF's estimated cost for the case and the adjusted threshold amount specified by CMS for each day of the inpatient stay.

(C) For discharges occurring in cost reporting periods beginning on or after January 1, 2005, outlier payments are subject to the adjustments specified at §§412.84(i) and 412.84(m) of this part, except that national urban and rural median cost-to-charge ratios would be used instead of statewide average cost-to-charge ratios.

(ii) *Stop-loss payments.* CMS will provide additional payments during the transition period, specified in §412.426(a)(1) through (3), to an inpatient psychiatric facility to ensure that aggregate payments under the prospective payment system are at least 70 percent of the amount the inpatient psychiatric facility would have received under reasonable cost reimbursement had the prospective payment system not been implemented.

(iii) *Special payment provision for interrupted stays.* If a patient is discharged from an inpatient psychiatric facility and is admitted to the same or another inpatient psychiatric facility within 3 consecutive calendar days following the discharge, the case is considered to be continuous for the purposes listed below. The 3 consecutive calendar days begins with the day of discharge from the inpatient psychiatric facility and ends on midnight of day 3.

(A) Determining the appropriate variable per diem adjustment, as specified in paragraph (d)(2)(v) of this section, applicable to the case.

(B) Determining whether the total cost for a case meets the criteria for outlier payments, as specified in paragraph (d)(3)(i)(C) of this section.

(iv) Payment for electroconvulsive therapy treatments. CMS provides an additional payment to reflect the cost of electroconvulsive therapy treatments received by a patient during an

inpatient psychiatric facility stay in a manner specified by CMS.

[69 FR 66977, Nov. 15, 2004; 70 FR 16729, Apr. 1, 2005, as amended at 71 FR 27086, May 9, 2006; 76 FR 26465, May 6, 2011; 77 FR 53678, Aug. 31, 2012; 86 FR 42678, Aug. 4, 2021; 87 FR 46878, July 29, 2022]

§412.426 Transition period.

(a) *Duration of transition period and composition of the blended transition payment.* Except as provided in paragraph (c) of this section, for cost reporting periods beginning on or after January 1, 2005 through December 31, 2007, an inpatient psychiatric facility receives a payment comprised of a blend of the estimated Federal per diem payment amount, as specified in §412.424(d) of this subpart and a facility-specific payment as specified under paragraph (b) of this section.

(1) For cost reporting periods beginning on or after January 1, 2005 and before January 1, 2006, payment is based on 75 percent of the facility-specific payment and 25 percent is based on the Federal per diem payment amount.

(2) For cost reporting periods beginning on or after January 1, 2006 and before January 1, 2007, payment is based on 50 percent of the facility-specific payment and 50 percent is based on the Federal per diem payment amount.

(3) For cost reporting periods beginning on or after January 1, 2007 and before January 1, 2008, payment is based on 25 percent of the facility-specific payment and 75 percent is based on the Federal per diem payment amount.

(4) For cost reporting periods beginning on or after January 1, 2008, payment is based entirely on the Federal per diem payment amount.

(b) *Calculation of the facility-specific payment.* The facility-specific payment is equal to the estimated payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility's Medicare fiscal intermediary calculates the facility-specific payment for inpatient operating costs and capital costs in accordance with part 413 of this chapter.

(c) *Treatment of new inpatient psychiatric facilities.* New inpatient psychiatric facilities, are facilities that under present or previous ownership or both have their first cost reporting period as an IPF beginning on or after January 1, 2005. New IPFs are paid based on 100 percent of the Federal per diem payment amount.

[69 FR 66977, Nov. 15, 2004; 70 FR 16729, Apr. 1, 2005, as amended at 71 FR 27087, May 9, 2006; 76 FR 26466, May 6, 2011]

§412.428 Publication of changes to the inpatient psychiatric facility prospective payment system.

CMS will issue annually in the FEDERAL REGISTER information pertaining to changes to the inpatient psychiatric facility prospective payment system. This information includes:

(a) A description of the methodology and data used to calculate the federal per diem base payment amount for the subsequent fiscal year.

(b)(1) For discharges occurring on or after January 1, 2005 but before July 1, 2006, the update, described in §412.424(a)(2)(iii), for the federal portion of the inpatient psychiatric facility's payments is based on the 1997-based excluded hospital with capital market basket under the applicable percentage increase methodology described in section 1886(b)(3)(B)(ii) of the Act for each year.

(2)(i) For discharges occurring on or after July 1, 2006 but before October 1, 2015, the update for the federal portion of the inpatient psychiatric facility's payment is based on the rehabilitation, psychiatric, and long-term care market basket.

(ii) For discharges occurring on or after October 1, 2015, the update of the inpatient psychiatric facility's payment is based on the inpatient psychiatric facility market basket.

(3) For discharges occurring on or after January 1, 2005 but before October 1, 2005, the update, described in §412.424(a)(2)(iii), for the reasonable cost portion of the inpatient psychiatric facility's payment is based on the 1997-based excluded hospital with capital market basket under the updated methodology described in section 1886(b)(3)(B)(ii) of the Act for each year.

(4) For discharges occurring on or after October 1, 2005 but before July 1, 2008, the update for the reasonable cost

portion of the inpatient psychiatric facility's payment is based on the 2002-based excluded hospital market basket.

(c) The best available hospital wage index and information regarding whether an adjustment to the Federal per diem base rate is needed to maintain budget neutrality.

(d) Updates to the fixed dollar loss threshold amount in order to maintain the appropriate outlier percentage.

(e) Describe the ICD–10–CM coding changes and DRG classification changes discussed in the annual update to the hospital inpatient prospective payment system regulations.

(f) Update the electroconvulsive therapy adjustment by a factor specified by CMS.

(g) Update the national urban and rural cost to charge ratio median and ceilings. CMS will apply the national cost to charge ratio to—

(1) New inpatient psychiatric facilities that have not submitted their first Medicare cost report.

(2) Inpatient psychiatric facilities whose operating or capital cost to charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean.

(3) Other inpatient psychiatric facilities for which the fiscal intermediary obtains inaccurate or incomplete data with which to calculate either an operating or capital cost to charge ratio or both.

(h) Update the cost of living adjustment factor if appropriate.

[69 FR 66977, Nov. 15, 2004, as amended at 71 FR 27087, May 9, 2006; 80 FR 46726, Aug. 5, 2015; 83 FR 38619, Aug. 6, 2018]

§ 412.432 Method of payment under the inpatient psychiatric facility prospective payment system.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, an inpatient psychiatric facility receives payment under this subpart for inpatient operating cost and capital-related costs for each inpatient stay following submission of a bill.

(b) *Periodic interim payments (PIP).* (1) Criteria for receiving PIP.

(i) An inpatient psychiatric facility receiving payment under this subpart may receive PIP for Part A services under the PIP method subject to the provisions of § 413.64(h) of this chapter.

(ii) To be approved for PIP, the inpatient psychiatric facility must meet the qualifying requirements in § 413.64(h)(3) of this chapter.

(iii) A hospital that is receiving periodic interim payments also receives payment under this subpart for applicable services furnished by its excluded psychiatric unit.

(iv) As provided in § 413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of resulting in an overpayment to the provider.

(2) *Frequency of payment.* For facilities approved for PIP, the intermediary estimates the annual inpatient psychiatric facility's Federal per diem prospective payments, net of estimated beneficiary deductibles and coinsurance, and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If the inpatient psychiatric facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as specified in § 413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient psychiatric facility receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the inpatient psychiatric facility.* Subject to the provisions of paragraph (b)(1)(iii) of this section, an inpatient psychiatric facility receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the inpatient psychiatric facility no longer meets the requirements of § 413.64(h) of this chapter.

(c) *Interim payments for Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system.* For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of the biweekly period of service as specified in §413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient psychiatric facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Outlier payments.* Additional payments for outliers are not made on an interim basis. Outlier payments are made based on the submission of a discharge bill and represents final payment subject to the cost report settlement specified in §412.84(i) and §412.84(m) of this part.

(e) *Accelerated payments*—(1) *General rule.* Upon request, an accelerated payment may be made to an inpatient psychiatric facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient psychiatric facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient psychiatric facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient psychiatric facility's preparation and submittal of bills to the intermediary beyond the normal billing cycle.

(2) *Approval of accelerated payment.* An inpatient psychiatric facility's request for an accelerated payment must be approved by the intermediary and CMS.

(3) *Amount of accelerated payment.* The amount of the accelerated payment is computed as a percent of the net payment for unbilled or unpaid covered services.

(4) *Recovery of accelerated payment.* Recovery of the accelerated payment is made by recoupment as inpatient psychiatric facility bills are processed or by direct payment by the inpatient psychiatric facility.

[69 FR 66977, Nov. 15, 2004, as amended at 76 FR 26465, May 6, 2011]

§412.433 Procedural requirements under the IPFQR Program.

(a) *Statutory authority.* Section 1886(s)(4) of the Act requires the Secretary to implement a quality reporting program for inpatient psychiatric hospitals and psychiatric units. Under section 1886(s)(4) of the Act, for an IPF paid under the IPF PPS that fails to submit data required for the quality measures selected by the Secretary in a form and manner and at a time specified by the Secretary, we reduce the otherwise applicable annual update to the standard Federal rate by 2.0 percentage points with respect to the applicable fiscal year.

(b) *Participation in the IPFQR Program.* To participate in the IPFQR Program, an IPF (as defined under §412.402) that is paid under the IPF PPS must:

(1) Register and maintain an account on the CMS-designated information system before beginning to report data, identification of a security official is necessary to complete such registration; and

(2) Submit a notice of participation (NOP).

(c) *Withdrawal from the IPFQR Program.* An IPF may withdraw from the IPFQR Program by changing the NOP status in the secure portion of the CMS-designated information system. The IPF may withdraw at any time up to and including August 15 before the beginning of each respective payment determination year. A withdrawn IPF is subject to a reduced annual payment update as specified under paragraph (a) of this section and is mandatory to renew participation as specified in paragraph (b) of this section in order to

participate in any future year of the IPFQR Program.

(d) *Submission of IPFQR Program data.* In general, except as provided in paragraph (f) of this section, IPFs that participate in the IPFQR Program must submit to CMS data on measures selected under section 1886(s)(4)(D) of the Act and specified non-measure data in a form and manner, and at a time specified by CMS.

(e) *Quality measure updates, retention, and removal*—(1) *General rule for updates to quality measures.* CMS uses rulemaking to make substantive updates to the specifications of measures used in the IPFQR Program

(2) *General rule for the retention of quality measures.* Quality measures adopted for the IPFQR Program measure set for a previous payment determination year are retained for use in subsequent payment determination years, except when they are removed, suspended, or modified as set forth in paragraph (3) of this section.

(3) *Measure removal, suspension, or modification through the rulemaking process.* CMS will use the regular rulemaking process to remove, suspend, or modify quality measures in the IPFQR Program to allow for public comment.

(i) *Factors for consideration in removal or replacement of quality measures.* CMS will weigh whether to remove or modify measures based on the following factors:

(A) Factor 1: Measure performance among IPFs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made;

(B) Factor 2: Measure does not align with current clinical guidelines or practice;

(C) Factor 3: Measure can be replaced by a more broadly applicable measure (across settings or populations) or a measure that is more proximal in time to desired patient outcomes for the particular topic;

(D) Factor 4: Measure performance or improvement does not result in better patient outcomes;

(E) Factor 5: Measure can be replaced by a measure that is more strongly associated with desired patient outcomes for the particular topic;

(F) Factor 6: Measure collection or public reporting leads to negative unintended consequences other than patient harm;

(G) Factor 7: Measure is not feasible to implement as specified; and

(H) Factor 8: The costs associated with a measure outweigh the benefit of its continued use in the program.

(ii) *Retention.* CMS may retain a quality measure that meets one or more of the measure removal factors described in paragraph (i) of this subsection if the continued collection of data on the quality measure would align with other CMS and HHS policy goals, align with other CMS programs, or support efforts to move IPFs toward reporting electronic measures.

(f) *Extraordinary Circumstance Exception (ECE)*—(1) *General rule.* CMS may grant an extraordinary circumstance exception (ECE) with respect to the reporting requirements under this section in the event of extraordinary circumstances beyond the control of the IPF. For purposes of this paragraph (f), an extraordinary circumstance is an event beyond the control of an IPF (for example, a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing) that affected the ability of the IPF to comply with one or more applicable reporting requirements with respect to a fiscal year.

(2) *Process for requesting an ECE.* (i) An IPF may request an ECE within 60 calendar days of the date that the extraordinary circumstance occurred by submitting the information specified by CMS at *QualityNet* or a successor website.

(ii) CMS notifies the IPF of its decision on the request, in writing, via email. In the event that CMS grants an ECE to the IPF, the written decision will specify whether the IPF is exempted from one or more reporting requirements or whether CMS has granted the IPF an extension of time to comply with one or more reporting requirements.

(3) *Authority to grant an ECE.* CMS may grant an ECE to one or more IPFs that have not requested an ECE if CMS determines that—

(i) A systemic problem with a CMS data collection system directly impacted the ability of the IPF to comply with a quality data reporting requirement, or

(ii) An extraordinary circumstance has affected an entire region or locale. Any ECE granted under this paragraph (f)(3) will specify whether the affected IPFs are exempted from one or more reporting requirements or whether CMS has granted the IPF an extension of time to comply with one or more reporting requirements.

(g) *Public reporting of IPFQR Program data.* Data that an IPF submits to CMS for the IPFQR Program will be made publicly available on a CMS website after providing the IPF an opportunity to review the data to be made public. IPFs will have a period of 30 days to review and submit corrections to errors resulting from CMS calculations prior to the data being made public.

[88 FR 51161, Aug. 2, 2023, as amended at 90 FR 37676, Aug. 5, 2025]

§ 412.434 Reconsideration and appeals procedures of Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program decisions.

(a) An inpatient psychiatric facility may request reconsideration of a decision by CMS that the inpatient psychiatric facility has not met the requirements of the IPFQR Program for a particular fiscal year. An inpatient psychiatric facility must submit a reconsideration request to CMS no later than 30 days from the date identified on the IPFQR Program Annual Payment Update Notification Letter provided to the inpatient psychiatric facility.

(b) A reconsideration request must contain the following information:

(1) The inpatient psychiatric facility's CMS Certification Number (CCN);

(2) The name of the inpatient psychiatric facility;

(3) Contact information for the inpatient psychiatric facility's chief executive officer and QualityNet security official, including each individual's name, email address, telephone number, and physical mailing address;

(4) A summary of the reason(s), as set forth in the IPFQR Program Annual Payment Update Notification Letter, that CMS concluded the inpatient psychiatric facility did not meet the requirements of the IPFQR Program;

(5) A detailed explanation of why the inpatient psychiatric facility believes that it complied with the requirements of the IPFQR Program for the applicable fiscal year; and

(6) Any evidence that supports the inpatient psychiatric facility's reconsideration request, such as emails and other documents.

(c) An inpatient psychiatric facility that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R of this chapter.

[77 FR 53678, Aug. 31, 2012, as amended at 86 FR 42678, Aug. 4, 2021]

Subpart O—Prospective Payment System for Long-Term Care Hospitals

SOURCE: 67 FR 56049, Aug. 30, 2002, unless otherwise noted.

§ 412.500 Basis and scope of subpart.

(a) *Basis.* This subpart implements the following:

(1) Section 123 of Public Law 106–113, which provides for the implementation of a prospective payment system for long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Act.

(2) Section 307 of Public Law 106–554, which states that the Secretary shall examine and may provide for appropriate adjustments to that system, including adjustments to DRG weights, area wage adjustments, geographic reclassification, outliers, updates, and disproportionate share adjustments consistent with section 1886(d)(5)(F) of the Act.

(3) Section 114 of Public Law 110–173, which contains several provisions regarding long-term care hospitals, including the—

(i) Amendment of section 1886 of the Act to add a new subsection (m) that references section 123 of Public Law 106–113 and section 307(b) of Public Law 106–554 for the establishment and implementation of a prospective payment system for payments under title XVIII

for inpatient hospital services furnished by a long-term care hospital described in section 1886(d)(1)(B)(iv) of the Act; and

(ii) Revision of the standard Federal rate for RY 2008.

(4) Section 4302(a) of Public Law 111–5, which amended sections 114(c) and (d) of Public Law 110–173 relating to several moratoria on the establishment of new long-term care hospitals and satellite facilities and on the increase in the number of beds in existing long-term care hospitals and satellite facilities under the long-term care hospital prospective payment system.

(5) Sections 3106(a) and 10312(a) of Public Law 111–148, which extended certain payment rules and moratoria under the long-term care hospital prospective payment system by further amending sections 114(c) and (d) of Public Law 110–173.

(6) Section 1206 of Public Law 113–67, which further extended certain payment rules and moratoria under the long-term care hospital prospective payment system by amending sections 114(c) and (d) of Public Law 110–173, and which:

(i) Added a new section 1886(m)(6) to the Act to establish a site neutral payment amount for long-term care hospital discharges that fail to meet the applicable criteria in cost reporting periods beginning on or after October 1, 2015; and

(ii) Requires the Secretary's review of the payment rates and regulations governing long-term care hospitals established under section 1886(d)(1)(B)(iv)(II) of the Act and application of payment adjustments based on that review.

(7) Section 411 of Public Law 114–10 which revises the annual update to the LTCH PPS standard Federal payment rate in FY 2018.

(8) Public Law 114–255 which at—

(i) Section 15004 amended the moratorium on increasing beds in existing LTCHs and LTCH satellite facilities and amended high cost outlier payment requirements;

(ii) Section 15006 amended moratoria on certain payment policies;

(iii) Section 15007 amended the average length of stay requirements;

(iv) Section 15009 temporally excepted certain spinal cord specialty hospitals from the site neutral payment rate; and

(v) Section 15010 temporally excepted certain wound care discharges from certain LTCHs from the site neutral payment rate.

(9) Section 51005(a) of Public Law 115–123 which extended the blended payment rate for the site neutral payment rate cases to apply to discharges occurring in cost reporting periods beginning in FYs 2018 and 2019.

(10) Section 51005(b) of Public Law which reduces the IPPS comparable amount for the site neutral payment rate cases by 4.6 percent for FYs 2018 through 2026.

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for long-term care hospitals, including the methodology used for the development of payment rates and associated adjustments and related rules. Under this system, for cost reporting periods beginning on or after October 1, 2002, payment for the operating and capital-related costs of inpatient hospital services furnished by long-term care hospitals is made on the basis of prospectively determined rates and applied on a per discharge basis.

[67 FR 56049, Aug. 30, 2002, as amended at 73 FR 24879, May 6, 2008; 79 FR 50355, Aug. 22, 2014; 82 FR 38512, Aug. 14, 2017; 83 FR 41704, Aug. 17, 2018]

§ 412.503 Definitions.

As used in this subpart—

CMS stands for the Centers for Medicare & Medicaid Services.

Discharge. A Medicare patient in a long-term care hospital is considered discharged when—

(1) For purposes of the long-term care hospital qualification calculation, as described in § 412.23(e)(3), the patient is formally released;

(2) For purposes of payment, as described in § 412.521(b), the patient stops receiving Medicare-covered long-term care services; or

(3) The patient dies in the long-term care facility.

Long-term care hospital prospective payment system fiscal year means, beginning October 1, 2010, the 12-month period of October 1 through September 30.

Long-term care hospital prospective payment system payment year means the general term that encompasses both the definition of ''long-term care hospital prospective payment system rate year'' and ''long-term care hospital prospective payment system fiscal year'' specified in this section.

Long-term care hospital prospective payment system rate year means—

(1) From July 1, 2003 and ending on or before June 30, 2008, the 12-month period of July 1 through June 30.

(2) From July 1, 2008 and ending on September 30, 2009, the 15-month period of July 1, 2008 through September 30, 2009.

(3) From October 1, 2009 through September 30, 2010, the 12-month period of October 1 through September 30.

LTC–DRG stands for the diagnosis-related group used to classify patient discharges from a long-term care hospital based on clinical characteristics and average resource use, for prospective payment purposes. Effective October 1, 2007, long-term care hospital patient discharges occurring on or after October 1, 2007, are classified by a severity-adjusted patient classification system, the MS–LTC–DRGs. Any reference to the term ''LTC–DRG'' shall be considered a reference to the term ''MS–LTC–DRG'' when applying the provisions of this subpart for policy descriptions and payment calculations for discharges from a long-term care hospital occurring on or after October 1, 2007.

MSA means a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget.

MSA-dominant area means an MSA in which an MSA-dominant hospital is located.

MSA-dominant hospital means a hospital that has discharged more than 25 percent of the total subsection (d) hospital Medicare discharges in the MSA (not including discharges paid by a Medicare Advantage plan) in which the hospital is located.

MS–LTC–DRG stands for the severity-adjusted diagnosis-related group used to classify patient discharges from a long-term care hospital based on clinical characteristics and average resource use, for prospective payment purposes for discharges from a long-term care hospital occurring on or after October 1, 2007.

Outlier payment means an additional payment beyond the long-term care hospital standard Federal payment rate or the site neutral payment rate (including, when applicable, the blended payment rate), as applicable, for cases with unusually high costs.

QIO (formerly PRO or Peer Review Organization) stands for the Quality Improvement Organization.

Rural area means—(1) For cost reporting periods beginning on or after October 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2005, an area defined in §412.62(f)(1)(iii);

(2) For discharges occurring on or after July 1, 2005, and before July 1, 2008, an area as defined in §412.64(b)(1)(ii)(C); and

(3) For discharges occurring on or after July 1, 2008, any area outside an urban area.

Subsection (d) hospital means, for purposes of §412.522, a hospital defined in section 1886(d)(1)(B) of the Social Security Act and includes any hospital that is located in Puerto Rico and that would be a subsection (d) hospital as defined in section 1886(d)(1)(B) of the Social Security Act if it were located in one of the 50 States.

Urban area means—(1) For cost reporting periods beginning on or after October 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before July 1, 2005, an area defined in §412.62(f)(1)(ii);

(2) For discharges occurring on or after July 1, 2005, and before July 1, 2008, an urban area means an area as defined in §412.64(b)(1)(ii)(A) and (B); and

(3) For discharges occurring on or after July 1, 2008, a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget.

[67 FR 56049, Aug. 30, 2002, as amended at 72 FR 47412, Aug. 22, 2007; 73 FR 26838, May 9, 2008; 75 FR 50416, Aug. 16, 2010; 80 FR 49767, Aug. 17, 2015; 81 FR 57268, Aug. 22, 2016]

§ 412.505 Conditions for payment under the prospective payment system for long-term care hospitals.

(a) *Long-term care hospitals subject to the prospective payment system.* To be eligible to receive payment under the prospective payment system specified in this subpart, a long-term care hospital must meet the criteria to be classified as a long-term care hospital set forth in § 412.23(e) for exclusion from the acute care hospital inpatient prospective payment systems specified in § 412.1(a)(1). This condition is subject to the special payment provisions of § 412.22(c), the provisions on change in hospital status of § 412.22(d), the provisions related to hospitals-within-hospitals under § 412.22(e), and the provisions related to satellite facilities under § 412.22(h).

(b) *General requirements.* (1) Effective for cost reporting periods beginning on or after October 1, 2002, a long-term care hospital must meet the conditions for payment of this section, § 412.22(e)(3) and (h)(6), if applicable, and § 412.507 through § 412.511 to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare beneficiaries.

(2) If a long-term care hospital fails to comply fully with these conditions for payment with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, CMS may withhold (in full or in part) or reduce Medicare payment to the hospital.

[67 FR 56049, Aug. 30, 2002, as amended at 71 FR 48140, Aug. 19, 2006]

§ 412.507 Limitation on charges to beneficiaries.

(a) *Prohibited charges.* Except as provided in paragraph (b) of this section, a long-term care hospital may not charge a beneficiary for any covered services for which payment is made by Medicare, even if the hospital's costs of furnishing services to that beneficiary are greater than the amount the hospital is paid under the prospective payment system.

(1) If Medicare has paid at the full LTCH prospective payment system standard Federal payment rate, that payment applies to the hospital's costs for services furnished until the high-cost outlier threshold is met.

(2) If Medicare pays less than the full LTCH prospective payment system standard Federal payment rate and payment was not made at the site neutral payment rate (including, when applicable, the blended payment rate), that payment only applies to the hospital's costs for those costs or days used to calculate the Medicare payment.

(3) For cost reporting periods beginning on or after October 1, 2016, for Medicare payments to a long-term care hospital described in § 412.23(e)(2)(ii), that payment only applies to the hospital's costs for those costs or days used to calculate the Medicare payment.

(4) If Medicare has paid at the full site neutral payment rate, that payment applies to the hospital's costs for services furnished until the high-cost outlier is met.

(b) *Permitted charges.* (1) A long-term care hospital that receives a payment at the full LTCH prospective payment system standard Federal payment rate or the site neutral payment rate may only charge the Medicare beneficiary for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this chapter, and for items and services as specified under § 489.20(a) of this chapter.

(2) A long-term care hospital that receives a payment at less than the full LTCH prospective payment system standard Federal payment rate for a short-stay outlier case, in accordance with § 412.529 (which would not include any discharge paid at the site neutral payment rate), may only charge the Medicare beneficiary for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this chapter, for items and services as specified under § 489.20(a) of this chapter, and for services provided during the stay that were not the basis for the short-stay adjusted payment.

(3) For cost reporting periods beginning on or after October 1, 2016, a long-term care hospital described in § 412.23(e)(2)(ii) may only charge the Medicare beneficiary for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this

chapter, for items and services as specified under § 489.20(a) of this chapter, and for services provided during the stay for which benefit days were not available and that were not the basis for adjusted LTCH prospective payment system payment amount under § 412.526.

[80 FR 49767, Aug. 17, 2015, as amended at 81 FR 57268, Aug. 22, 2016]

§ 412.508 Medical review requirements.

(a) *Admission and quality review.* A long-term care hospital must have an agreement with a QIO to have the QIO review, on an ongoing basis, the following:

(1) The medical necessity, reasonableness, and appropriateness of hospital admissions and discharges.

(2) The medical necessity, reasonableness, and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of §§ 412.523(d)(1) and 412.525(a).

(3) The validity of the hospital's diagnostic and procedural information.

(4) The completeness, adequacy, and quality of the services furnished in the hospital.

(5) Other medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries.

(b) *Physician acknowledgement.* Payment under the long-term care hospital prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's medical record. The hospital must assure that physicians complete an acknowledgement statement to this effect in accordance with paragraphs (b)(1) and (b)(2) of this section.

(1) *Content of physician acknowledgement statement.* When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice:

NOTICE TO PHYSICIANS: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

(2) *Completion of acknowledgement.* The acknowledgement must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient. Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

(c) *Denial of payment as a result of admissions and quality review.* (1) If CMS determines, on the basis of information supplied by a QIO, that a hospital has misrepresented admissions, discharges, or billing information, or has taken an action that results in the unnecessary admission or unnecessary multiple admissions of an individual entitled to benefits under Part A, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, CMS may, as appropriate—

(i) Deny payment (in whole or in part) under Part A with respect to inpatient hospital services provided for an unnecessary admission or subsequent readmission of an individual; or

(ii) Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

(2) When payment with respect to admission of an individual patient is denied by a QIO under paragraph (c)(1) of this section, and liability is not waived in accordance with §§ 411.400 through 411.402 of this chapter, notice and appeals are provided under procedures established by CMS to implement the provisions of section 1155 of the Act, Right to Hearing and Judicial Review.

(3) A determination under paragraph (c)(1) of this section, if it is related to a pattern of inappropriate admissions and billing practices that has the effect of circumventing the prospective payment system, is referred to the Department's Office of Inspector General for

handling in accordance with § 1001.201 of this title.

[67 FR 56049, Aug. 30, 2002, as amended at 71 FR 48140, Aug. 19, 2006]

§ 412.509 Furnishing of inpatient hospital services directly or under arrangement.

(a) Subject to the provisions of § 412.521(b), the applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in § 409.10 of this chapter. Inpatient hospital services do not include the following:

(1) Physicians' services that meet the requirements of § 415.102(a) of this subchapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioners and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse midwife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69 of this subchapter.

(b) Medicare does not pay any provider or supplier other than the long-term care hospital for services furnished to a Medicare beneficiary who is an inpatient of the hospital except for services described in paragraphs (a)(1) through (a)(6) of this section.

(c) The long-term care hospital must furnish all necessary covered services to the Medicare beneficiary who is an inpatient of the hospital either directly or under arrangements (as defined in § 409.3 of this subchapter).

§ 412.511 Reporting and recordkeeping requirements.

A long-term care hospital participating in the prospective payment system under this subpart must meet the requirement of §§ 412.22(e)(3) and 412.22(h)(6) to report co-located status, if applicable, and the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this subchapter.

[71 FR 48140, Aug. 18, 2006]

§ 412.513 Patient classification system.

(a) *Classification methodology.* CMS classifies specific inpatient hospital discharges from long-term care hospitals by long-term care diagnosis-related groups (LTC-DRGs) to ensure that each hospital discharge is appropriately assigned based on essential data abstracted from the inpatient bill for that discharge.

(b) *Assignment of discharges to LTC-DRGs.* (1) The classification of a particular discharge is based, as appropriate, on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and the patient's discharge status.

(2) Each discharge from a long-term care hospital is assigned to only one LTC-DRG (related, except as provided in paragraph (b)(3) of this section, to the patient's principal diagnosis), regardless of the number of conditions treated or services furnished during the patient's stay.

(3) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill is returned to the hospital for validation and reverification. The LTC-DRG classification system provides a LTC-DRG, and an appropriate weighting factor, for those cases for which none of the surgical procedures performed are related to the principal diagnosis.

(c) *Review of LTC-DRG assignment.* (1) A hospital has 60 days after the date of the notice of the initial assignment of a discharge to a LTC-DRG to request a review of that assignment. The hospital may submit additional information as a part of its request.

(2) The intermediary reviews that hospital's request and any additional information and decides whether a change in the LTC-DRG assignment is appropriate. If the intermediary decides that a different LTC-DRG should be assigned, the case will be reviewed by the appropriate QIO as specified in § 476.71(c)(2) of this chapter.

(3) Following the 60-day period described in paragraph (c)(1) of this section, the hospital may not submit additional information with respect to the

DRG assignment or otherwise revise its claim.

§ 412.515 LTC–DRG weighting factors.

(a) For each LTC–DRG, CMS assigns an appropriate weight that reflects the estimated relative cost of hospital resources used within that group compared to discharges classified within other groups.

(b)(1) Beginning FY 2023, each LTC–DRG weight is subject to a maximum 10 percent reduction as compared to the weight for the same LTC–DRG for the prior fiscal year, except as provided in paragraph (b)(2) of this section.

(2) The limitation described in paragraph (b)(1) of this section does not apply to LTC–DRGs with less than 25 applicable LTCH cases in the data used to determine the relative weights for the fiscal year.

[87 FR 49405, Aug. 10, 2022]

§ 412.517 Revision of LTC-DRG group classifications and weighting factors.

(a) CMS adjusts the classifications and weighting factors annually to reflect changes in—

(1) Treatment patterns;

(2) Technology;

(3) Number of discharges; and

(4) Other factors affecting the relative use of hospital resources.

(b) Beginning in FY 2008, the annual changes to the LTC–DRG classifications and recalibration of the weighting factors described in paragraph (a) of this section are made in a budget neutral manner such that estimated aggregate LTCH PPS payments are not affected.

(c) Beginning in FY 2016, the annual recalibration of the weighting factors described in paragraph (a) of this section is determined using long-term care hospital discharges described in § 412.522(a)(2) (or that would have been described in such section had the application of the site neutral payment rate been in effect at the time of the discharge).

[67 FR 56049, Aug. 30, 2002, as amended at 72 FR 26991, May 11, 2007; 80 FR 49768, Aug. 17, 2015]

§ 412.521 Basis of payment.

(a) *Method of payment.* (1) Under the prospective payment system, long-term care hospitals receive a predetermined payment amount per discharge for inpatient services furnished to Medicare beneficiaries.

(2) Except as provided for in § 412.526, the amount of payment under the prospective payment system is based on either the long-term care hospital prospective payment system standard Federal payment rate established in accordance with § 412.523, including adjustments described in § 412.525, or the site neutral payment rate established in accordance with § 412.522(c), or, if applicable during a transition period, the blend of the LTCH PPS standard Federal payment rate and the applicable site neutral payment rate described in § 412.522(c)(3).

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance described in subpart G of part 409 of this subchapter) for covered inpatient operating costs as described in §§ 412.2(c)(1) through (c)(4) of this part and § 412.540 and capital-related costs described in subpart G of part 413 of this subchapter associated with furnishing Medicare covered services in long-term care hospitals.

(2) In addition to payment based on prospective payment rates, long-term care hospitals may receive payments separate from payments under the prospective payment system for the following:

(i) The costs of approved medical education programs described in §§ 413.75 through 413.83, 413.85, and 413.87 of this subchapter.

(ii) Bad debts of Medicare beneficiaries, as provided in § 413.89 of this subchapter.

(iii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

(iv) Anesthesia services furnished by hospital employed nonphysician anesthetists or obtained under arrangements, as specified in § 412.113(c)(2).

(v) The costs of photocopying and mailing medical records requested by a QIO, in accordance with § 476.78(c) of this chapter.

(c) *Payment by workers' compensation, automobile medical, no-fault or liability insurance or an employer group health plan primary to Medicare.* If workers' compensation, automobile medical, no-fault, or liability insurance or an employer group health plan that is primary to Medicare pays in full or in part, payment is determined in accordance with the guidelines specified in § 412.120(b).

(d) *Effect of change of ownership on payments under the prospective payment system.* When a hospital's ownership changes, as described in § 489.18 of this chapter, the following rules apply:

(1) Payment for the operating and capital-related costs of inpatient hospital services for each patient, including outlier payments as provided in § 412.525 and payments for hemophilia clotting factor costs as provided in paragraph (b)(2)(iii) of this section, are made to the entity that is the legal owner on the date of discharge. Payments are not prorated between the buyer and seller.

(i) The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a beneficiary regardless of when the beneficiary's coverage began or ended during a stay, or of how long the stay lasted.

(ii) Each bill submitted must include all information necessary for the intermediary to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.

(2) Other payments for the direct costs of approved medical education programs, bad debts, anesthesia services furnished by hospital employed nonphysician anesthetists, and costs of photocopying and mailing medical records to the QIO as provided for under paragraphs (b)(2)(i), (ii), (iv), and (v) of this section are made to each owner or operator of the hospital (buyer and seller) in accordance with the principles of reasonable cost reimbursement.

(e) *Special payment provisions for patients in acute care hospitals that change classification status to LTCH status during a patient stay.* (1) If a patient is admitted to an acute care hospital and then the acute care hospital meets the criteria at § 412.23(e) to be paid as a LTCH during the course of the patient's hospitalization, Medicare considers all the days of the patient stay in the facility (days prior to and after the designation of LTCH status) to be a single episode of LTCH care. Payment for the entire patient stay (days prior to and after the designation of LTCH status) will include the day and cost data for that patient at both the acute care hospital and the LTCH in determining the payment to the LTCH under this subpart. The requirements of this paragraph (e)(1) apply only to a patient stay in which a patient is in an acute care hospital and that hospital is designated as a LTCH on or after October 1, 2004.

(2) The days of the patient's stay prior to and after the hospital's designation as a LTCH as specified in paragraph (e)(1) of this section are included for purposes of determining the beneficiary's length of stay.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34162, June 6, 2003; 69 FR 49250, Aug. 11, 2004; 70 FR 47487, Aug. 12, 2005; 75 FR 50416, Aug. 16, 2010; 79 FR 50355, Aug. 22, 2014; 80 FR 49768, Aug. 17, 2015]

§ 412.522 Application of site neutral payment rate.

(a) *General.* For discharges in cost reporting periods beginning on or after October 1, 2015—

(1) Except as provided for in paragraph (b) of this section, all discharges are paid based on the site neutral payment rate as determined under the provisions of paragraph (c) of this section.

(2) Discharges that meet the criteria for exclusion from site neutral payment rate specified in paragraph (b) of this section are paid based on the standard Federal prospective payment rate established under § 412.523.

(b) *Criteria for exclusion from the site neutral payment rate*—(1) *General criteria*—(i) *Basis and scope.* A discharge that meets the following criteria is excluded from the site neutral payment rate specified under this section.

(A) The discharge from the long-term care hospital does not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation based on

the LTC–DRG assignment of the discharge under § 412.513; and

(B) The admission to the long-term care hospital was immediately preceded by a discharge from a subsection (d) hospital and meets either the intensive care unit criterion specified in paragraph (b)(1)(ii) of this section or the ventilator criterion specified in paragraph (b)(1)(iii) of this section. In order for an admission to a long-term care hospital to be considered immediately preceded for purposes of this section, the patient discharged from the subsection (d) hospital must be directly admitted to the long-term care hospital.

(ii) *Intensive care unit criterion.* In addition to meeting the requirements of paragraph (b)(1)(i) of this section, the discharge from the subsection (d) hospital that immediately preceded the admission to the long-term care hospital includes at least 3 days in an intensive care unit (as defined in § 413.53(d) of this chapter), as evidenced by at least one of the revenue center codes on the claim for the discharge that indicate such services were provided for the requisite number of days during the stay.

(iii) *Ventilator criterion.* In addition to meeting the requirements of paragraph (b)(1)(i) of this section, the discharge from the long-term care hospital is assigned to a LTC–DRG based on the patient's receipt of ventilator services of at least 96 hours, as evidenced by the procedure code on the discharge bill indicating such services were provided during the stay.

(2) *Special criteria*—(i) *Definitions.* For purposes of this paragraph (b)(2) the following definitions are applicable:

Severe wound means a wound which is a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, infected wound, fistula, osteomyelitis or wound with morbid obesity as identified by the applicable code on the claim from the long-term care hospital.

Wound means an injury, usually involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment.

(ii) *Discharges for severe wounds.* A discharge that occurs on or after April 21, 2016 and before January 1, 2017 for a patient that was treated for a severe wound that meets the all of following criteria is excluded from the site neutral payment rate specified under this section:

(A) The severe wound meets the definition specified in paragraph (b)(2)(i) of this section.

(B) The discharge is from a long term care hospital that is—

(*1*) Described in § 412.23(e)(2)(i) and meets the criteria of § 412.22(f); and

(*2*) Located in a rural area (as defined at § 412.503) or reclassified as rural by meeting the requirements set forth in § 412.103.

(3) *Temporary exception for certain severe wound discharges.*—(i) *Definitions.* For purposes of this paragraph (b)(3) the following definitions are applicable:

Severe wound means a wound which is a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, fistula, as identified by the applicable code on the claim from the long-term care hospital.

Wound means an injury, usually involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment.

(ii) *Discharges for severe wounds.* A discharge that occurs in a cost reporting period beginning during fiscal year 2018 for a patient who was treated for a severe wound that meets all of the following criteria is excluded from the site neutral payment rate specified under this section:

(A) The severe wound meets the definition specified in paragraph (b)(3)(i) of this section.

(B) The discharge is from a long-term care hospital that is described in § 412.23(e)(2)(i) and meets the criteria of § 412.22(f); and

(C) The discharge is classified under MS–LTC–DRG 539, 540, 602, or 603.

(4) *Temporary exception for certain spinal cord specialty hospitals.* For discharges in cost reporting periods beginning in fiscal years 2018 and 2019, the site neutral payment rate specified under this section does not apply if such discharge is from a long-term care hospital that meets each of the following requirements:

(i) The hospital was a not-for-profit long-term care hospital on June 1, 2014, as determined by cost report data;

(ii) Of the discharges in calendar year 2013 from the long-term care hospital for which payment was made under subpart O, at least 50 percent were classified under MS–LTC–DRGs 28, 29, 52, 57, 551, 573, and 963; and

(iii) The long-term care hospital discharged inpatients (including both individuals entitled to, or enrolled for, benefits under Medicare Part A and individuals not so entitled or enrolled) during fiscal year 2014 who had been admitted from at least 20 of the 50 States determined by the States of residency of such inpatients.

(c) *Site neutral payment rate*—(1) *General.* Subject to the provisions of paragraph (c)(2) of this section, the site neutral payment rate is the lower of—

(i) The inpatient hospital prospective payment system comparable per diem amount determined under § 412.529(d)(4), including any applicable outlier payments specified in § 412.525(a); or

(ii) 100 percent of the estimated cost of the case determined under the provisions of § 412.529(d)(2). The provisions for cost-to-charge ratios at § 412.529(f)(4)(i) through (iii) apply to the calculation of the estimated cost of the case under this paragraph.

(iii) For discharges occurring in fiscal years 2018 through 2026, the amount in paragraph (c)(1)(i) of this section is reduced by 4.6 percent.

(2) *Adjustments.* CMS adjusts the payment rate determined under paragraph (c)(1) of this section to account for—

(i) Outlier payments, by applying a reduction factor equal to the estimated proportion of outlier payments under § 412.525(a) payable for discharges from a long-term care hospital described in paragraph (a)(1) of this section to total estimated payments under the long-term care hospital prospective payment system to discharges from a long-term care hospital described in paragraph (a)(1) of this section. The adjustment under this paragraph (c)(2)(i) does not include the portion of the blended payment rate described in paragraph (c)(3)(ii) of this section.

(ii) A 3-day or less interruption of a stay and a greater than 3-day interruption of a stay, as provided for in § 412.531. For purposes of the application of the provisions of § 412.531 to discharges from a long-term care hospital described under paragraph (a)(1) of this section, the long-term care hospital prospective payment system standard Federal payment-related terms, such as ''LTC–DRG payment,'' ''full Federal LTC–DRG prospective payment,'' and ''Federal prospective payment,'' mean the site neutral payment rate calculated under paragraph (c) of this section.

(iii) The special payment provisions for long-term care hospitals-within-hospitals and satellite facilities of long-term care hospitals specified in § 412.534.

(iv) The special payment provisions for long-term care hospitals and satellite facilities of long-term care hospitals that discharged Medicare patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or satellite facility of the long-term care hospital, as provided in § 412.536.

(3) *Transition.* For discharges occurring in cost reporting periods beginning on or after October 1, 2015 and on or before September 30, 2019, payment for discharges under paragraph (c)(1) of this section are made using a blended payment rate, which is determined as—

(i) 50 percent of the site neutral payment rate amount for the discharge as determined under paragraph (c)(1) of this section; and

(ii) 50 percent of the standard Federal prospective payment rate amount for the discharge as determined under § 412.523.

(d) *Discharge payment percentage.* (1) For purposes of this section, the discharge payment percentage is a ratio, expressed as a percentage, of Medicare discharges that meet the criteria for exclusion from the site neutral payment rate as described under paragraph (a)(2) of this section to total Medicare discharges paid under this subpart during the cost reporting period.

(2) CMS will inform each long-term care hospital of its discharge payment percentage, as determined under paragraph (d)(1) of this section, for each

cost reporting period beginning on or after October 1, 2015.

(3) For cost reporting periods beginning on or after October 1, 2019, if a long-term care hospital's discharge payment percentage for the cost reporting period is not at least 50 percent, discharges in all cost reporting periods beginning after the notification described under paragraph (d)(2) of this section will be paid under the payment adjustment described in paragraph (d)(4) of this section until reinstated under paragraph (d)(5) or (6) of this section.

(4) For cost reporting periods subject to the payment adjustment under paragraph (d)(3) of this section, the payment for all discharges consists of—

(i) An amount equivalent to the hospital inpatient prospective payment system amount as determined under § 412.529(d)(4)(i)(A) and (d)(4)(ii) and (iii); and

(ii) If applicable, an additional payment for high cost outlier cases based on the fixed-loss amount established for the hospital inpatient prospective payment system in effect at the time of the LTCH discharge.

(5) For full reinstatement—

(i) When the discharge payment percentage for a cost reporting period is calculated to be at least 50 percent, any payment adjustment described in paragraph (d)(4) of this section will be discontinued for cost reporting periods beginning on or after the notification described under paragraph (d)(2) of this section.

(ii) A long-term care hospital reinstated under paragraph (d)(5)(i) of this section will be subject to the payment adjustment under paragraph (d)(4) of this section if, after being reinstated, it again meets the criteria in paragraph (d)(3) of this section.

(6) For special probationary reinstatement—

(i) A hospital that would be subject to the payment adjustment under paragraph (d)(4) of this section for a cost reporting period will have application of the payment adjustment delayed for that period if, for the period of at least 5 consecutive months of the 6 months immediately preceding the cost reporting period, the discharge payment percentage is calculated to be at least 50 percent.

(ii) For any cost reporting period to which the payment adjustment under paragraph (d)(4) of this section would have applied but for a delay under paragraph (d)(6)(i) of this section, the payment adjustment under paragraph (d)(4) of this section will be applied to all discharges in the cost reporting period if the discharge payment percentage for the cost reporting period is not calculated to be at least 50 percent.

[80 FR 49768, Sept. 1, 2015, as amended at 81 FR 23438, Apr. 21, 2016; 81 FR 57269, Aug. 22, 2016; 82 FR 38512, Aug. 14, 2017; 83 FR 41704, Aug. 17, 2018; 84 FR 42614, Aug. 16, 2019]

§ 412.523 Methodology for calculating the Federal prospective payment rates.

(a) *Data used.* To calculate the initial prospective payment rates for inpatient hospital services furnished by long-term care hospitals, CMS uses—

(1) The best Medicare data available; and

(2) A rate of increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient long-term care hospital services.

(b) *Determining the average costs per discharge for FY 2003.* CMS determines the average inpatient operating and capital-related costs per discharge for which payment is made to each inpatient long-term care hospital using the available data under paragraph (a)(1) of this section. The cost per discharge is adjusted to FY 2003 by a rate of increase factor, described in paragraph (a)(2) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year.

(c) *Determining the Federal prospective payment rates*—(1) *General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the standard Federal rate. The standard Federal rate is a standardized payment amount based on average costs from a base year that reflects the combined aggregate effects of the weighting factors and other adjustments.

(2) *Update the cost per discharge.* CMS applies the increase factor described in paragraph (a)(2) of this section to each hospital's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for FY 2003. Based on the updated cost per discharge, CMS estimates the payments that would have been made to each hospital for FY 2003 under Part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Computation of the standard Federal rate.* Subject to the provisions of paragraph (c)(4) of this section, the standard Federal rate is computed as follows:

(i) *For FY 2003.* Based on the updated costs per discharge and estimated payments for FY 2003 determined in paragraph (c)(2) of this section, CMS computes a standard Federal rate for FY 2003 that reflects, as appropriate, the adjustments described in paragraph (d) of this section. The FY 2003 standard Federal rate is effective for discharges occurring in cost reporting periods beginning on or after October 1, 2002 through June 30, 2003.

(ii) *For long-term care hospital prospective payment system rate years beginning on or after July 1, 2003 and ending on or before June 30, 2006.* The standard Federal rate for long-term care hospital prospective payment system rate years beginning on or after July 1, 2003 and ending on or before June 30, 2006 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year, updated by the increase factor described in paragraph (a)(2) of this section, and adjusted, as appropriate, as described in paragraph (d) of this section. For the rate year from July 1, 2003 through June 30, 2004, the updated and adjusted standard Federal rate is offset by a budget neutrality factor to account for updating the FY 2003 standard Federal rate on July 1 rather than October 1.

(iii) *For long-term care hospital prospective payment system rate year beginning July 1, 2006 and ending June 30, 2007.* The standard Federal rate for long-term care hospital prospective payment system rate year beginning July 1, 2006 and ending June 30, 2007 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by zero percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(iv) *For long-term care hospital prospective payment system rate year beginning July 1, 2007 and ending June 30, 2008.* (A) The standard Federal rate for long-term care hospital prospective payment system rate year beginning July 1, 2007 and ending June 30, 2008 is the same as the standard Federal rate for the previous long-term care hospital prospective payment system rate year. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(B) With respect to discharges occurring on or after July 1, 2007 and before April 1, 2008, payments are based on the standard Federal rate in paragraph (c)(3)(iii) of this section updated by 0.71 percent.

(v) *For long-term care hospital prospective payment system rate year beginning July 1, 2008 and ending September 30, 2009.* The standard Federal rate for long-term care hospital prospective payment system rate year beginning July 1, 2008 and ending September 30, 2009 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by 2.7 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(vi) *For long-term care hospital prospective payment system rate year beginning October 1, 2009 and ending September 30, 2010.* (A) The standard Federal rate for long-term care hospital prospective payment system rate year beginning October 1, 2009 and ending September 30, 2010 is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by 1.74 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(B) With respect to discharges occurring on or after October 1, 2009 and before April 1, 2010, payments are based on the standard Federal rate in paragraph (c)(3)(v) of this section updated by 2.0 percent.

(vii) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2010, and ending September 30, 2011.* The standard Federal rate for the long-term care hospital prospective payment system fiscal year beginning October 1, 2010, and ending September 30, 2011, is the standard Federal rate for the previous long-term care hospital prospective payment system rate year updated by −0.49 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(viii) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2011, and ending September 30, 2012.* The standard Federal rate for the long-term care hospital prospective payment system beginning October 1, 2011, and ending September 30, 2012, is the standard Federal rate for the previous long-term care hospital prospective payment system fiscal year updated by 1.8 percent. The standard Federal rate is adjusted, as appropriate, as described in paragraph (d) of this section.

(ix) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2012, and ending September 30, 2013.* (A) The standard Federal rate for the long-term care hospital prospective payment system beginning October 1, 2012, and ending September 30, 2013, is the standard Federal rate for the previous long-term care hospital prospective payment system fiscal year updated by 1.8 percent, and further adjusted, as appropriate, as described in paragraph (d) of this section.

(B) With respect to discharges occurring on or after October 1, 2012 and before December 29, 2012, payments are based on the standard Federal rate in paragraph (c)(3)(ix)(A) of this section without regard to the adjustment provided for under paragraph (d)(3)(ii) of this section.

(x) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2013, and ending September 30, 2014.* The standard Federal rate for the long-term care hospital prospective payment system beginning October 1, 2013, and ending September 30, 2014, is the standard Federal rate for the previous long-term care hospital prospective payment system fiscal year updated by 1.7 percent, and further adjusted, as appropriate, as described in paragraph (d) of this section.

(xi) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2014, and ending September 30, 2015.* The standard Federal rate for the long-term care hospital prospective payment system beginning October 1, 2014, and ending September 30, 2015, is the standard Federal rate for the previous long-term care hospital prospective payment system fiscal year updated by 2.2 percent, and further adjusted, as appropriate, as described in paragraph (d) of this section.

(xii) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2015, and ending September 30, 2016.* The LTCH PPS standard Federal payment rate for the long-term care hospital prospective payment system beginning October 1, 2015, and ending September 30, 2016, is the standard Federal payment rate for the previous long-term care hospital prospective payment system fiscal year updated by 1.7 percent, and further adjusted, as appropriate, as described in paragraph (d) of this section.

(xiii) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2016, and ending September 30, 2017.* The LTCH PPS standard Federal payment rate for the long-term care hospital prospective payment system beginning October 1, 2016, and ending September 30, 2017, is the standard Federal payment rate for the previous long-term care hospital prospective payment system fiscal year updated by 1.75 percent and further adjusted, as appropriate, as described in paragraph (d) of this section.

(xiv) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2017, and ending September 30, 2018.* The LTCH PPS standard Federal payment rate for the long-term care hospital prospective payment system beginning October 1, 2017, and ending September 30, 2018, is the standard Federal payment rate for the previous long-term care hospital prospective payment system fiscal year updated by 1.0 percent and further adjusted, as appropriate, as described in paragraph (d) of this section.

(xv) *For long-term care hospital prospective payment system fiscal year beginning October 1, 2018, and ending September 30, 2019.* The LTCH PPS standard Federal payment rate for the long-term care hospital prospective payment system beginning October 1, 2018, and ending September 30, 2019, is the standard Federal payment rate for the previous long-term care hospital prospective payment system fiscal year updated by 1.35 percent and further adjusted, as appropriate, as described in paragraph (d) of this section.

(xvi) *For long-term care prospective payment system fiscal year beginning October 1, 2019, and ending September 30, 2020.* The long-term care hospital prospective payment system standard Federal payment rate for the long-term care hospital prospective payment system beginning October 1, 2019 and ending September 30, 2020 is the standard Federal payment rate for the previous long-term care prospective payment system fiscal year updated by 2.5 percent and further adjusted, as appropriate, as described in paragraph (d) of this section.

(xvii) *For long-term care prospective payment system fiscal year 2021 and subsequent fiscal years.* The long-term care hospital prospective payment system standard Federal payment rate for a long-term care hospital prospective payment system fiscal year is the standard Federal payment rate for the previous long-term care prospective payment system fiscal year updated by the percentage increase in the market basket index (as determined by CMS) less a multifactor productivity adjustment (as determined by CMS), and further adjusted, as appropriate, as described in paragraph (d) of this section.

(4) *For fiscal year 2014 and subsequent fiscal years—*

(i) In the case of a long-term care hospital that does not submit quality reporting data to CMS in the form and manner and at a time specified by the Secretary, the annual update to the standard Federal rate specified in paragraph (c)(3) of this section is further reduced by 2.0 percentage points.

(ii) Any reduction of the annual update to the standard Federal rate under paragraph (c)(4)(i) of this section will apply only to the fiscal year involved and will not be taken into account in computing the annual update to the standard Federal rate for a subsequent fiscal year.

(5) *Determining the Federal prospective payment rate for each LTC-DRG.* The Federal prospective payment rate for each LTC-DRG is the product of the weighting factors described in § 412.515 and the standard Federal rate described in paragraph (c)(3) of this section.

(d) *Adjustments to the standard Federal rate.* The standard Federal rate described in paragraph (c)(3) of this section will be adjusted for—

(1) *Outlier payments.* CMS adjusts the LTCH PPS standard Federal payment rate by a reduction factor of 8 percent, the estimated proportion of outlier payments under § 412.525(a) payable for discharges described in § 412.522(a)(2) (notwithstanding the provisions of § 412.525(a)(2)(ii) for FY 2018 and subsequent years.

(2) *Budget neutrality.* CMS adjusts the Federal prospective payment rates for FY 2003 so that aggregate payments under the prospective payment system are estimated to equal the amount that would have been paid to long-term care hospitals under part 413 of this subchapter without regard to the prospective payment system implemented under this subpart, excluding the effects of section 1886(b)(2)(E) and (b)(3)(J) of the Act.

(3)(i) *General.* The Secretary reviews payments under this prospective payment system and may make a one-time prospective adjustment to the long-term care hospital prospective payment system rates no earlier than December 29, 2012, so that the effect of any significant difference between the data used in the original computations of budget neutrality for FY 2003 and more recent data to determine budget neutrality for FY 2003 is not perpetuated in the prospective payment rates for future years.

(ii) *Adjustment to the standard Federal rate.* The standard Federal rate determined in paragraph (c)(3) of this section is permanently adjusted by 3.75 percent to account for the estimated difference between projected aggregate payments in FY 2003 made under the

prospective payment system implemented under this subpart and the projected aggregate payments that would have been made in FY 2003 under Part 413 of this chapter without regard to the implementation of the prospective payment system implemented under this subpart, excluding the effects of sections 1886(b)(2)(E) and (b)(3)(J) of the Act. This adjustment is transitioned over 3 years beginning in FY 2013.

(iii) *Special rule for certain discharges occurring during FY 2013.* The adjustment applied under paragraph (d)(3)(ii) of this section is not applicable when making payments under this subpart for discharges occurring on or after October 1, 2012, and on or before December 28, 2012.

(4) *Changes to the adjustment for area wage levels.* Beginning in FY 2012, CMS adjusts the standard Federal rate by a factor that accounts for the estimated effect of any adjustments or updates to the area wage level adjustment under § 412.525(c)(1) on estimated aggregate LTCH PPS payments.

(5) *Adjustment for changes to the short-stay outlier policy.* The standard Federal rate determined under paragraph (c)(3) of this section is permanently adjusted by a one-time factor so that estimated aggregate payments to LTCH PPS standard Federal rate cases in FY 2018 are projected to equal estimated aggregate payments that would have been paid for such cases without regard to the change in the short-stay outlier policy for FY 2018 under § 412.529(c)(4).

(6) *Adjustment for the elimination of the limitation on long-term care hospital admissions from referring hospitals.* The standard Federal payment rate determined in paragraph (c)(3) of this section is adjusted as follows:

(i) For discharges occurring on or after October 1, 2018 and before October 1, 2019, by a one-time factor so that estimated aggregate payments to LTCH PPS standard Federal rate cases in FY 2019, and the portion of estimated aggregate payments to site neutral cases that are paid based on the LTCH PPS standard Federal rate in FY 2019, are projected to equal estimated aggregate payments that would have been paid for such cases without regard to the elimination of the limitation on long-term care hospital admissions from referring hospitals. This adjustment only applies to the fiscal year involved and will not be taken into account in computing the standard Federal payment rate for a subsequent fiscal year.

(ii) For discharges occurring on or after October 1, 2019 and before October 1, 2020, by a one-time factor so that estimated aggregate payments to LTCH PPS standard Federal rate cases in FY 2020, and the portion of estimated aggregate payments to site neutral payment rate cases that are paid based on the LTCH PPS standard Federal rate in FY 2020, are projected to equal estimated aggregate payments that would have been paid for such cases without regard to the elimination of the limitation on long-term care hospital admissions from referring hospitals. This adjustment only applies to the fiscal year involved and will not be taken into account in computing the standard Federal payment rate for a subsequent fiscal year.

(iii) For discharges occurring on or after October 1, 2020, by a permanent, one-time factor so that estimated aggregate payments to LTCH PPS standard Federal rate cases in FY 2021 are projected to equal estimated aggregate payments that would have been paid for such cases without regard to the elimination of the limitation on long-term care hospital admissions from referring hospitals.

(e) *Calculation of the adjusted Federal prospective payment.* For each discharge, a long-term care hospital's Federal prospective payment is computed on the basis of the Federal prospective payment rate multiplied by the relative weight of the LTC-DRG assigned for that discharge. A hospital's Federal prospective payment rate will be adjusted, as appropriate, to account for outliers and other factors as specified in § 412.525.

[67 FR 56049, Aug. 30, 2002]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.523, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

§ 412.525 Adjustments to the Federal prospective payment.

(a) *Adjustments for high-cost outliers.* (1) CMS provides for an additional payment to a long-term care hospital if its estimated costs for a patient exceed the applicable long-term care hospital prospective payment system payment plus an applicable fixed-loss amount. For each long-term care hospital prospective payment system payment year, CMS annually establishes a fixed-loss amount that is the maximum loss that a long-term care hospital would incur under the long-term care hospital prospective payment system for a case with unusually high costs before receiving an additional payment.

(2)(i) The fixed loss-amount for discharges from a long-term care hospital described under § 412.522(a)(2) is determined for the long-term care hospital prospective payment system payment year, using the LTC–DRG relative weights that are in effect at the start of the applicable long-term care hospital prospective payment system payment year.

(ii) For FY 2018 and subsequent years, the fixed-loss amount for long-term care hospital discharges described under § 412.522(a)(2) is determined such that the estimated proportion of outlier payments under paragraph (a) of this section payable for such discharges is projected to be equal to 99.6875 of 8 percent.

(3) The additional payment equals 80 percent of the difference between the estimated cost of the patient's care (determined by multiplying the hospital-specific cost-to-charge ratio by the Medicare allowable covered charge) and the sum of the applicable long-term care hospital prospective payment system payment and the applicable fixed-loss amount.

(4)(i) For discharges occurring on or after October 1, 2002 and before August 8, 2003, no reconciliations will be made to outlier payments upon cost report settlement to account for differences between the estimated cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(ii) For discharges occurring on or after August 8, 2003, and before October 1, 2006, high-cost outlier payments are subject to the provisions of § 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(iii) For discharges occurring on or after October 1, 2003, and before October 1, 2006, high-cost outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

(iv) For discharges occurring on or after October 1, 2006, high-cost outlier payments are subject to the following provisions:

(A) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (a)(4)(iv)(B) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. A request must be approved by the CMS Regional Office.

(B) The cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period.

(C) The fiscal intermediary may use a statewide average cost-to-charge ratio, which CMS establishes annually, if it is unable to determine an accurate cost-to-charge ratio for a hospital in one of the following circumstances:

(*1*) A new hospital that has not yet submitted its first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(*2*) A hospital whose cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean cost-to-charge ratio. CMS establishes and publishes this mean annually.

(*3*) Any other hospital for which data to calculate a cost-to-charge ratio are not available.

(D) Any reconciliation of outlier payments is based on the cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(E) At the time of any reconciliation under paragraph (a)(4)(iv)(D) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

(5) For purposes of this paragraph (a)—

(i) *Applicable long-term care hospital prospective payment system payment* means—

(A) The site neutral payment rate established under § 412.522(c) for long-term care hospital discharges described under § 412.522(a)(1);

(B) The standard Federal prospective payment rates established under § 412.523 for long-term care hospital discharges described under § 412.522(a)(2); or

(C) The standard Federal prospective payment rates established under § 412.523 for discharges occurring on or after October 1, 2015, in a long-term care hospital cost reporting period that begins before October 1, 2015.

(ii) *Applicable fixed-loss amount* means—

(A) For long-term care hospital discharges described under § 412.522(a)(1), the fixed-loss amount established for such cases as provided at § 412.522(c)(2)(i);

(B) For long-term care hospital discharges described under § 412.522(a)(2), the fixed-loss amount established for such cases as provided at § 412.523(e); or

(C) For discharges occurring on or after October 1, 2015 in a long-term care hospital cost reporting period that begins before October 1, 2015, the fixed-loss amount payable to discharges described under § 412.522(a)(2) as set forth in paragraph (a)(5)(ii)(B) of this section.

(b) *Adjustments for Alaska and Hawaii.* CMS adjusts the Federal prospective payment for the effects of a higher cost of living for hospitals located in Alaska and Hawaii.

(c) *Adjustments for area wage levels.* (1) The labor portion of a long-term care hospital's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index (established by CMS), which reflects the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined in accordance with the definitions set forth in § 412.503) of the hospital compared to the national average level of hospital wages and wage-related costs.

(i)(A) The appropriate wage index that is established by CMS is updated annually.

(B) Beginning in fiscal year 2023, if CMS determines that an LTCH's wage index value for a fiscal year would decrease by more than 5 percent as compared to the LTCH's wage index value for the prior fiscal year, CMS limits the decrease to 5 percent for the fiscal year.

(ii) The labor portion of a long-term care hospital's Federal prospective payment is established by CMS and is updated annually.

(2) Beginning in FY 2012, any adjustments or updates to the area wage level adjustment under this paragraph (c) will be made in a budget neutral manner such that estimated aggregate LTCH PPS payments are not affected.

(d) *Special payment provisions.* CMS adjusts the Federal prospective payment to account for—

(1) Short-stay outliers, as provided for in § 412.529.

(2) A 3-day or less interruption of a stay and a greater than 3-day interruption of a stay, as provided for in § 412.531.

(3) [Reserved]

(4) Long-term care hospitals-within-hospitals and satellites of long-term care hospitals as provided in § 412.534.

(5) Long-term care hospitals and satellites of long-term care hospitals that discharged Medicare patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or satellite of

the long-term care hospital, as provided in § 412.536.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34163, June 6, 2003; 68 FR 34515, June 9, 2003; 69 FR 25721, May 7, 2004; 70 FR 24222, May 6, 2005; 71 FR 48140, Aug. 18, 2006; 73 FR 26839, May 9, 2008; 74 FR 43998, Aug. 27, 2009; 75 FR 50416, Aug. 16, 2010; 76 FR 51783, Aug. 18, 2011; 79 FR 50356, Aug. 22, 2014; 80 FR 49769, Aug. 17, 2015; 81 FR 57269, Aug. 22, 2016; 82 FR 38513, Aug. 14, 2017; 83 FR 41705, Aug. 17, 2018; 87 FR 49405, Aug. 10, 2022]

§ 412.526 Payment provisions for a "subclause (II)" long-term care hospital.

(a) *Definition.* A ''subclause (II)'' long-term care hospital is a hospital that qualifies as an LTCH under section 1886(d)(1)(B)(iv)(II) of the Act.

(b) *Method of payment.* (1) For cost reporting periods beginning on or after October 1, 2003 and before September 30, 2014, payment to a ''subclause (II)'' long-term care hospital is made under the prospective payment system specified in § 412.1(a)(4) and Subpart O of this part.

(2) For cost reporting periods beginning on or after October 1, 2014, payment to a ''subclause (II)'' long-term care hospital is made under the prospective payment system specified in § 412.1(a)(4) and under Subpart O of this part, as adjusted. The adjusted payment amount is determined based on reasonable cost, as described at § 412.526(c).

(c) *Determining the adjusted payment for Medicare inpatient operating and capital-related costs under the reasonable cost-based reimbursement rules.* Medicare inpatient operating costs are paid based on reasonable cost, subject to a ceiling. The ceiling is the aggregate upper limit on the amount of a hospital's net Medicare inpatient operating costs that the program will recognize for payment purposes, as determined under paragraph (c)(1) of this section.

(1) *Ceiling.* For each cost reporting period, the ceiling is determined by multiplying the updated target amount, as defined in paragraph (c)(2) of this section, for that period by the number of Medicare discharges paid under this subpart during that period.

(2) *Target amounts.* (i) For cost reporting periods beginning during Federal fiscal year 2015, the target amount equals the hospital's target amount determined under § 413.40(c)(4) for its cost reporting period beginning during Federal fiscal year 2000, updated by the applicable annual rate-of-increase percentages specified in § 413.40(c)(3) to the subject period.

(ii) For subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period updated by the applicable annual rate-of-increase percentage specified in § 413.40(c)(3) for the subject cost reporting period.

(3) *Payment for inpatient operating costs.* For cost reporting periods subject to this section, the hospital's Medicare allowable net inpatient operating costs for that period (as defined at § 413.40(a)(3)) are paid on a reasonable cost basis, subject to that hospital's ceiling (as determined under paragraph (c)(1) of this section) for that period.

(4) *Payment for inpatient capital-related costs.* Medicare allowable net inpatient capital costs are paid on a reasonable cost basis, in accordance with the regulations under Part 413 of this chapter.

(5) *Adjustments for extraordinary circumstances*—(i) *General rules.* (A) CMS may adjust the ceiling determined under paragraph (c)(1) of this section for one or more cost reporting periods when unusual inpatient operating costs have resulted in the hospital exceeding its ceiling imposed under this section due to extraordinary circumstances beyond the hospital's control. These circumstances include, but are not limited to, strikes, fire, earthquakes, floods, or similar unusual occurrences with substantial cost effects.

(B) When the hospital requests an adjustment, CMS makes an adjustment only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified separately, identified by the hospital, and verified by the Medicare administrative contractor.

(ii) *Process for adjustment requests.* The provisions of §§ 413.40(e)(1) through (e)(5) of this subchapter are applicable to extraordinary circumstances adjustment requests under this section.

[79 FR 50356, Aug. 22, 2014]

§412.529 Special payment provision for short-stay outliers.

(a) *Short-stay outlier defined.* ''Short-stay outlier'' means a discharge with a covered length of stay in a long-term care hospital that is up to and including five-sixths of the geometric average length of stay for each LTC–DRG.

(b) *Adjustment to payment.* CMS adjusts the hospital's Federal prospective payment to account for any case that is determined to be a short-stay outlier, as defined in paragraph (a) of this section, under the methodology specified in paragraph (c) of this section.

(c) *Method for determining the payment amount*—(1) *Discharges occurring before July 1, 2006.* For discharges from long-term care hospitals described under §412.23(e)(2)(i), occurring before July 1, 2006, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) One hundred and twenty (120) percent of the LTC–DRG specific per diem amount determined under paragraph (d)(1) of this section.

(ii) One hundred and twenty (120) percent of the estimated cost of the case determined under paragraph (d)(2) of this section.

(iii) The Federal prospective payment for the LTC–DRG determined under paragraph (d)(3) of this section.

(2) *Discharges occurring on or after July 1, 2006 and before July 1, 2007 and discharges occurring on or after December 29, 2007 and before December 29, 2012.* For discharges from long-term care hospitals described under §412.23(e)(2)(i) occurring on or after July 1, 2006 and before July 1, 2007 and discharges occurring on or after December 29, 2007 and before December 29, 2012, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) One hundred and twenty (120) percent of the LTC–DRG specific per diem amount determined under paragraph (d)(1) of this section.

(ii) One hundred (100) percent of the estimated cost of the case determined under paragraph (d)(2) of this section.

(iii) The Federal prospective payment for the LTC–DRG as determined under paragraph (d)(3) of this section.

(iv) An amount payable under subpart O computed as a blend of an amount comparable to the hospital inpatient prospective payment system per diem amount determined under paragraph (d)(4)(i) of this section and the 120 percent of the LTC–DRG specific per diem payment amount determined under paragraph (d)(1) of this section.

(A) The blend percentage applicable to the 120 percent of the LTC–DRG specific per diem payment amount determined under paragraph (d)(1) of this section is determined by dividing the covered length-of-stay of the case by the lesser of five-sixths of the geometric average length of stay of the LTC–DRG or 25 days, not to exceed 100 percent.

(B) The blend percentage of the amount determined under paragraph (d)(4)(i) of this section is determined by subtracting the percentage determined in paragraph (A) from 100 percent.

(3) *Discharges occurring on or after July 1, 2007 and before December 29, 2007 and discharges occurring on or after December 29, 2012 and on or before September 30, 2017.* For discharges from long-term care hospitals described under §412.23(e)(2)(i) occurring on or after July 1, 2007, and on or before December 29, 2007 and discharges occurring on or after December 29, 2012, and on or before September 30, 2017, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is adjusted by either of the following:

(i) If the covered length of stay of the case assigned to a particular LTC–DRG is less than or equal to one standard deviation from the geometric ALOS of the same DRG under the inpatient prospective payment system (the IPPS-comparable threshold), the LTCH prospective payment system adjusted payment amount for such a case is the least of the following amounts:

(A) One hundred and twenty (120) percent of the LTC–DRG specific per diem amount determined under paragraph (d)(1) of this section.

(B) One hundred (100) percent of the estimated cost of the case determined under paragraph (d)(2) of this section.

(C) The Federal prospective payment for the LTC–DRG as determined under paragraph (d)(3) of this section.

(D) An amount payable under subpart O of this part comparable to the hospital inpatient prospective payment system per diem amount determined under paragraph (d)(4) of this section.

(ii) If the covered length of stay of the case assigned to a particular LTC–DRG is greater than one standard deviation from the geometric ALOS of the same DRG under the inpatient prospective payment system (the IPPS-comparable threshold), the LTCH prospective payment system adjusted payment amount for such a case is determined under paragraph (c)(2) of this section.

(4) *Discharges occurring on or after October 1, 2017.* For discharges occurring on or after October 1, 2017, short-stay outlier payments are determined according to paragraph (c)(2)(iv) of this section.

(d) *Calculation of alternative payment amounts*—(1) *Determining the LTC–DRG per diem amount.* CMS calculates the LTC–DRG per diem amount for short-stay outliers for each LTC–DRG by dividing the product of the standard Federal payment rate and the LTC–DRG relative weight by the geometric average length of stay of the specific LTC–DRG multiplied by the covered days of the stay.

(2) *Determining the estimated cost of a case.* To determine the estimated cost of a case, CMS multiplies the hospital-specific cost-to-charge ratio by the Medicare allowable charges for the case.

(3) *Determining the Federal prospective payment for the LTC–DRG.* CMS calculates the Federal prospective payment for the LTC–DRG by multiplying the adjusted standard Federal payment rate by the LTC–DRG relative weight.

(4) *Determining the amount comparable to the hospital inpatient prospective payment system per diem amount*—(i) *General.* Under subpart O, CMS calculates—

(A) An amount comparable to what would otherwise be paid under the hospital inpatient prospective payment system based on the sum of the applicable operating inpatient prospective payment system standardized amount and the capital inpatient prospective payment system Federal rate in effect at the time of the LTCH discharge.

(B) An amount comparable to the hospital inpatient prospective payment system per diem amount for each DRG that is determined by dividing the amount that would otherwise be paid under the hospital inpatient prospective payment system computed under paragraph (A) of this section by the hospital inpatient prospective payment system geometric average length of stay of the specific DRG multiplied by the covered days of the stay.

(C) The payment amount specified under paragraph (d)(4)(i)(B) of this section may not exceed the full amount comparable to what would otherwise be paid under the hospital inpatient prospective payment system determined under paragraph (d)(4)(i)(A) of this section.

(ii) *Hospital inpatient prospective payment system operating standardized amount.* The hospital inpatient prospective payment system operating standardized amount—

(A) Is adjusted for the applicable hospital inpatient prospective payment system DRG weighting factors.

(B)(*1*) Is adjusted for different area wage levels based on the geographic classifications set forth at § 412.503 and the applicable hospital inpatient prospective payment system (IPPS) labor-related share, using the applicable hospital inpatient prospective payment system wage index value for non-reclassified hospitals (an LTCH's applicable IPPS wage index).

(*2*) Beginning in fiscal year 2023, if CMS determines that an LTCH's applicable IPPS wage index value for a fiscal year would decrease by more than 5 percent as compared to the LTCH's applicable IPPS wage index value for the prior fiscal year, CMS limits the decrease to 5 percent for the fiscal year.

(*3*) For LTCHs located in Alaska and Hawaii, the amount specified in paragraph (d)(4)(ii) of this section is also adjusted by the applicable hospital inpatient prospective payment system cost of living adjustment factors.

(C) Includes, where applicable, adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(iii) *Hospital inpatient prospective payment system capital Federal rate.* The hospital inpatient prospective payment system capital Federal rate—

(A) Is adjusted for the applicable inpatient prospective payment system DRG weighting factors.

(B)(*1*) Is adjusted for the applicable geographic adjustment factors, including local cost variation based on the geographic classifications set forth at §412.503 and the applicable full hospital inpatient prospective payment system (IPPS) wage index value for nonreclassified hospitals (an LTCH's applicable IPPS wage index) and applicable cost of living adjustment factors for LTCHs in Alaska and Hawaii.

(*2*) Beginning in fiscal year 2023, if CMS determines that an LTCH's applicable IPPS wage index value for a fiscal year would decrease by more than 5 percent as compared to the LTCH's applicable IPPS wage index value for the prior fiscal year, CMS limits the decrease to 5 percent for the fiscal year.

(C) Includes, where applicable, adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(e) Short-stay outlier payments to long-term care hospitals described under §412.23(e)(2)(ii).

(1) For discharges occurring on or after October 1, 2002, through June 30, 2003, the LTCH prospective payment system adjusted payment amount for a short-stay outlier case is the least of the following amounts:

(i) 120 percent of the LTC–DRG specific per diem amount determined under paragraph (d)(1) of this section;

(ii) 120 percent of the estimated cost of the case determined under paragraph (d)(2) of this section; or

(iii) The Federal prospective payment for the LTC–DRG determined under paragraph (d)(3) of this section.

(2) For discharges occurring on or after July 1, 2003, subject to the provisions of paragraph (e)(2)(v) of this section, the adjusted payment amount for a short-stay outlier is determined under the formulas set forth in paragraphs (e)(1)(i) through (iv) of this section with the following substitutions:

(i) For the first year of the transition period, as specified at §412.533(a)(1), the 120 percent specified for the LTC–DRG specific per diem amount and the 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(1)(ii) of this section are substituted with 195 percent.

(ii) For the second year of the transition period, as specified at §412.533(a)(2), the 120 percent specified for the LTC–DRG specific per diem amount and the 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(1)(ii) of this section are substituted with 193 percent.

(iii) For the third year of the transition period, as specified at §412.533(a)(3), the 120 percent specified for the LTC–DRG specific per diem amount and the 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(1)(ii) of this section are substituted with 165 percent.

(iv) For the fourth year of the transition period, as specified at §412.533(a)(4), the 120 percent specified for the LTC–DRG specific per diem amount and 120 percent of the cost of the case in the formula under paragraphs (e)(1)(i) and (e)(1)(ii) of this section are substituted with 136 percent.

(v) For discharges occurring in cost reporting periods beginning on or after October 1, 2006 (beginning with the fifth year of the transition period), as specified at §412.533(a)(5), short-stay outlier payments are made based on the least of the following amounts:

(A) 120 percent of the LTC–DRG specific per diem amount determined under paragraph (d)(1) of this section;

(B) 120 percent of the estimated cost of the case determined under paragraph (d)(2) of this section; or

(C) The Federal prospective payment for the LTC–DRG determined under paragraph (d)(3) of this section.

(f) *Reconciliation of short-stay payments.* Payments for discharges occurring before October 1, 2017 are reconciled in accordance with one of the following:

(1) *Discharges occurring on or after October 1, 2002, and before August 8, 2003.* For discharges occurring on or after

October 1, 2002, and before August 8, 2003, no reconciliations are made to short-stay outlier payments upon cost report settlement to account for differences between cost-to-charge ratio and the actual cost-to-charge ratio of the case.

(2) *Discharges occurring on or after August 8, 2003, and before October 1, 2006.* For discharges occurring on or after August 8, 2003, and before October 1, 2006, short-stay outlier payments are subject to the provisions of § 412.84(i)(1), (i)(3), and (i)(4) and (m) for adjustments of cost-to-charge ratios.

(3) *Discharges occurring on or after October 1, 2003, and before October 1, 2006.* For discharges occurring on or after October 1, 2003, and before October 1, 2006, short-stay outlier payments are subject to the provisions of § 412.84(i)(2) for adjustments to cost-to-charge ratios.

(4) *Discharges occurring on or after October 1, 2006.* For discharges occurring on or after October 1, 2006, short-stay outlier payments are subject to the following provisions:

(i) CMS may specify an alternative to the cost-to-charge ratio otherwise applicable under paragraph (f)(4)(ii) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. This request must be approved by the appropriate CMS Regional Office.

(ii) The cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period.

(iii) The fiscal intermediary may use a statewide average cost-to-charge ratio, which CMS establishes annually, if it is unable to determine an accurate cost-to-charge ratio for a hospital in one of the following circumstances:

(A) A new hospital that has not yet submitted its first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with § 489.18 of this chapter.)

(B) A hospital whose cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. CMS establishes and publishes this mean annually.

(C) Any other hospital for which data to calculate a cost-to-charge ratio are not available.

(iv) Any reconciliation of outlier payments is based on the cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

(v) At the time of any reconciliation under paragraph (f)(4)(iv) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment is based upon a widely available index to be established in advance by the Secretary, and is applied from the midpoint of the cost reporting period to the date of reconciliation.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 34163, June 6, 2003; 68 FR 34515, June 9, 2003; 71 FR 27899, May 12, 2006; 71 FR 48141, Aug. 18, 2006; 72 FR 26991, May 11, 2007; 73 FR 24880, May 6, 2008; 73 FR 26839, May 9, 2008; 75 FR 50416, Aug. 16, 2010; 77 FR 53679, Aug. 31, 2012; 82 FR 38513, Aug. 14, 2017; 87 FR 49405, Aug. 10, 2022]

§ 412.531 Special payment provisions when an interruption of a stay occurs in a long-term care hospital.

(a) *Definitions*—(1) *A 3-day or less interruption of stay defined.* ''A 3-day or less interruption of stay'' means a stay at a long-term care hospital during which a Medicare inpatient is discharged from the long-term care hospital to an acute care hospital, IRF, SNF, or the patient's home and readmitted to the same long-term care hospital within 3 days of the discharge from the long-term care hospital. The 3-day or less period begins with the date of discharge from the long-term care hospital and ends not later than midnight of the third day.

(2) *A greater than 3-day interruption of stay defined.* ''A greater than 3-day or less interruption of stay'' means A stay in a long-term care hospital during which a Medicare inpatient is discharged from the long-term care hospital to an acute care hospital, an IRF, or a SNF for a period of greater than 3

days but within the applicable fixed-day period specified in paragraphs (a)(2)(i) through (a)(2)(iii) of this section before being readmitted to the same long-term care hospital.

(i) For a discharge to an acute care hospital, the applicable fixed day period is between 4 and 9 consecutive days. The counting of the days begins on the date of discharge from the long-term care hospital and ends on the 9th date after the discharge.

(ii) For a discharge to an IRF, the applicable fixed day period is between 4 and 27 consecutive days. The counting of the days begins on the day of discharge from the long-term care hospital and ends on the 27th day after discharge.

(iii) For a discharge to a SNF, the applicable fixed day period is between 4 and 45 consecutive days. The counting of the days begins on the day of discharge from the long-term care hospital and ends on the 45th day after the discharge.

(b) *Methods of determining payments.* (1) For purposes of determining a Federal prospective payment—

(i) *Determining the length of stay.* In determining the length of stay of a patient at a long-term care hospital for payment purposes under this paragraph (b)—

(A) Except as specified in paragraphs (b)(1)(i)(B) and (b)(1)(i)(C) of this section, the number of days that a beneficiary spends away from the long-term care hospital during a 3-day or less interruption of stay under paragraph (a)(1) of this section is not included in determining the length of stay of the patient at the long-term care hospital when there is no outpatient or inpatient medical treatment or care provided at an acute care hospital or an IRF, or SNF services during the interruption that is considered a covered service delivered to the beneficiary.

(B) The number of days that a beneficiary spends away from a long-term care hospital during a 3-day or less interruption of stay under paragraph (a)(1) of this section are counted in determining the length of stay of the patient at the long-term care hospital if the beneficiary receives inpatient or outpatient medical care or treatment provided by an acute care hospital or IRF, or SNF services during the interruption. In the case where these services are provided during some, but not all days of a 3-day or less interruption, Medicare will include all days of the interruption in the long-term care hospitals day-count.

(C) Surgical DRG exception to the 3-day or less interruption of stay policy.

(*1*) The number of days that a beneficiary spends away from a long-term care hospital during a 3-day or less interruption of stay under paragraph (a)(1) of this section during which the beneficiary receives a procedure grouped to a surgical DRG under the hospital inpatient prospective payment system in an acute care hospital during the 2005 and 2006 LTCH prospective payment system rate years are not included in determining the length of stay of the patient at the long-term care hospital.

(*2*) For discharges occurring on or after July 1 2006, the number of days that a beneficiary spends away from a long-term care hospital during a 3-day or less interruption of stay under paragraph (a)(1) of this section during which the beneficiary receives a procedure grouped to a surgical DRG under the hospital inpatient prospective payment system in an acute care hospital are included in determining the length of stay of the patient at the long-term care hospital.

(D) The number of days that a beneficiary spends away from a LTCH during a greater than 3-day interruption of stay, as defined in paragraph (a)(2) of this section, is not included in determining the length of stay at the LTCH.

(ii) *Determining how payment is made.* (A) Subject to the provisions of paragraphs (b)(1)(ii)(A)(*1*) and (b)(1)(ii)(A)(*2*) of this section, for a 3-day or less interruption of stay under paragraph (a)(1) of this section, the entire stay is paid as a single discharge from the long-term care hospital. CMS makes only one LTC-DRG payment for all portions of a long-term care stay.

(*1*) For a 3-day or less interruption of stay under paragraph (a)(1) of this section in which a long-term care hospital discharges a patient to an acute care hospital and the patient's treatment during the interruption is grouped into a surgical DRG under the acute care

inpatient hospital prospective payment system, for the LTCH 2005 and 2006 rate years, CMS also makes a separate payment to the acute care hospital for the surgical DRG discharge in accordance with paragraph (b)(1)(i)(C) of this section.

(*2*) For discharges occurring on or after July 1, 2006, for a 3-day or less interruption of stay under paragraph (a)(1) of this section in which a long-term care hospital discharges a patient to an acute care hospital and the patient's treatment during the interruption is grouped into a surgical DRG under the acute care hospital inpatient prospective payment system, the services must be provided under arrangements in accordance with §412.509(c). CMS does not make a separate payment to the acute care hospital for the surgical treatment. The LTC–DRG payment made to the long-term care hospital is considered payment in full as specified in §412.521(b).

(*3*) For a 3-day or less interruption of stay under paragraph (a)(1) of this section during which the patient receives inpatient or outpatient treatment or services at an acute care hospital or IRF, or SNF services, that are not otherwise excluded under §412.509(a), the services must be provided under arrangements in accordance with §412.509(c). CMS does not make a separate payment to the acute care hospital, IRF, or SNF for these services. The LTC-DRG payment made to the long-term care hospital is considered payment in full as specified in §412.521(b).

(B) For a greater than 3-day interruption of stay under paragraph (a)(2) of this section, CMS will make only one LTC-DRG payment for all portions of a long-term care stay. CMS also separately pays the acute care hospital, the IRF, or the SNF in accordance with their respective payment systems, as specified in paragraph (c) of this section.

(iii) *Basis for the prospective payment.* Payment to the long-term care hospital is based on the patient's LTC-DRG that is determined in accordance with §412.513(b).

(2) If the total number of days of a patient's length of stay in a long-term care hospital prior to and following a 3-day or less interruption of stay under paragraphs (b)(1)(i)(A), (B), or (C) of this section or a greater than 3-day interruption of stay under paragraph (b)(1)(i)(D) of this section is up to and including five-sixths of the geometric average length of stay of the LTC-DRG, CMS will make a Federal prospective payment for a short-stay outlier in accordance with §412.529(c).

(3) If the total number of days of a patient's length of stay in a long-term care hospital prior to and following a 3-day or less interruption of stay under paragraphs (b)(1)(i)(A), (B), or (C) of this section or a greater than 3-day interruption of stay under paragraph (b)(1)(i)(D) of this section exceeds five-sixths of the geometric average length of stay for the LTC-DRG, CMS will make one full Federal LTC-DRG prospective payment for the case. An additional payment will be made if the patient's stay qualifies as a high-cost outlier, as set forth in §412.525(a).

(4) Notwithstanding the provisions of paragraph (a) of this section, if a patient who has been discharged from a long-term care hospital to another facility and is readmitted to the long-term care hospital for additional treatment or services in the long-term care hospital following the stay at the other facility, the subsequent admission to the long-term care hospital is considered a new stay, even if the case is determined to fall into the same LTC-DRG, and the long-term care hospital will receive two separate Federal prospective payments if one of the following conditions are met:

(i) The patient has a length of stay in the acute care hospital that exceeds 9 days from the day of discharge from the long-term care hospital;

(ii) The patient has a length of stay in the IRF that exceeds 27 days from the day of discharge from the long-term care hospital; or

(iii) The patient has a length of stay in the SNF that exceeds 45 days from the day of discharge from the long-term care hospital.

(c) *Payments to an acute care hospital, an IRF, or a SNF during an interruption of a stay.* (1) Payment to the acute care hospital for the acute care hospital stay following discharge from the long-

term care hospital will be paid in accordance with the acute care hospital inpatient prospective payment systems specified in §412.1(a)(1).

(2) Payment to an IRF for the IRF stay following a discharge from the long-term care hospital will be paid in accordance with the IRF prospective payment system specified in §412.624 of subpart P of this part.

(3) Payment to a SNF for the SNF stay following a discharge from the long-term care hospital will be paid in accordance with the SNF prospective payment system specified in subpart J of part 413 of this subchapter.

[67 FR 56049, Aug. 30, 2002, as amended at 69 FR 25721, May 7, 2004; 70 FR 24222, May 6, 2005; 71 FR 27900, May 12, 2006]

§412.533 Transition payments.

(a) *Duration of transition periods.* Except for a long-term care hospital that makes an election under paragraph (c) of this section or for a long-term care hospital that is defined as new under §412.23(e)(4), for cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, a long-term care hospital receives a payment comprised of a blend of the adjusted Federal prospective payment as determined under §412.523, and the payment determined under the cost-based reimbursement rules under Part 413 of this subchapter.

(1) For cost reporting periods beginning on or after October 1, 2002 and before October 1, 2003, payment is based on 20 percent of the Federal prospective payment rate and 80 percent of the cost-based reimbursement rate.

(2) For cost reporting periods beginning on or after October 1, 2003 and before October 1, 2004, payment is based on 40 percent of the Federal prospective payment rate and 60 percent of the cost-based reimbursement rate.

(3) For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005, payment is based on 60 percent of the Federal prospective payment rate and 40 percent of the cost-based reimbursement rate.

(4) For cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006, payment is based on 80 percent of the Federal prospective payment rate and 20 percent of the cost-based reimbursement rate.

(5) For cost reporting periods beginning on or after October 1, 2006, payment is based entirely on the adjusted Federal prospective payment rate.

(b) *Adjustments based on reconciliation of cost reports.* The cost-based percentage of the provider's total Medicare payment under paragraphs (a)(1) through (a)(4) of this section are subject to adjustments based on reconciliation of cost reports.

(c) *Election not to be paid under the transition period methodology.* A long-term care hospital may elect to be paid based on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition periods specified in paragraph (a) of this section. Once a long-term care hospital elects to be paid based on 100 percent of the Federal prospective payment rate, it may not revert to the transition blend.

(1) *General requirement.* A long-term care hospital must notify its fiscal intermediary of its intent to elect to be paid based on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition period specified in paragraph (a) of this section.

(2) *Notification requirement to make election.* (i) The request by the long-term care hospital to make the election under paragraph (c)(1) of this section must be made in writing to the Medicare fiscal intermediary.

(ii) For cost reporting periods that begin on or after October 1, 2002 through November 30, 2002, the fiscal intermediary must receive the notification of the election before November 1, 2002.

(iii) For cost reporting periods that begin on or after December 1, 2002 through September 30, 2006, the fiscal intermediary must receive the notification of the election on or before the 30th day before the applicable cost reporting period begins.

(iv) The fiscal intermediary must receive the notification by the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the

dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section will not be accepted. If the date specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section falls on a day that the postal service or other delivery sources are not open for business, the long-term care hospital is responsible for allowing sufficient time for the delivery of the notification before the deadline.

(v) If a long-term care hospital's notification is not received by the dates specified in paragraphs (c)(2)(ii) and (c)(2)(iii) of this section, payment will be based on the transition period rates specified in paragraphs (a)(1) through (a)(5) of this section.

(d) *Payments to new long-term care hospitals.* A new long-term care hospital, as defined in § 412.23(e)(4), will be paid based on 100 percent of the standard Federal rate, as described in § 412.523, with no transition payments, as described in § 412.533(a)(1) through (a)(5).

§ 412.534 Special payment provisions for long-term care hospitals-within-hospitals and satellites of long-term care hospitals, effective for discharges occurring in cost reporting periods beginning on or before September 30, 2016.

(a) *Scope.* Except as provided in paragraph (h), the policies set forth in this section apply to discharges occurring in cost reporting periods beginning on or after October 1, 2004 from long-term care hospitals as described in § 412.23(e)(2)(i) meeting the criteria in § 412.22(e)(2), or satellite facilities of long-term care hospitals that meet the criteria in § 412.22(h).

(b) *Patients admitted from hospitals not located in the same building or on the same campus as the long-term care hospital or long-term care hospital satellite—* (1) *For cost reporting periods beginning on or after October 1, 2004 and before July 1, 2007.* Payments to the long-term care hospital as described in § 412.23(e)(2)(i) meeting the criteria in § 412.22(e)(2) for patients admitted to the long-term care hospital or to a long-term care hospital satellite facility as described in § 412.23(e)(2)(i) that meets the criteria of § 412.22(h) from another hospital that is not the co-located hospital are made under the rules in this subpart with no adjustment under this section.

(2) *For cost reporting periods beginning on or after July 1, 2007.* For cost reporting periods beginning on or after July 1, 2007, payments to one of the following long-term care hospitals or long-term care hospital satellites are subject to the provisions of § 412.536 of this subpart:

(i) A long-term care hospital as described in § 412.23(e)(2)(i) of this part that meets the criteria of § 412.22(e) of this part.

(ii) Except as provided in paragraph (h) of this section, a long-term care hospital as described in § 412.23(e)(2)(i) of this part that meets the criteria of § 412.22(f) of this part.

(iii) A long-term care hospital satellite facility as described in § 412.23(e)(2)(i) of this part that meets the criteria in § 412.22(h) or § 412.22(h)(3)(i) of this part.

(c) *Patients admitted from the hospital located in the same building or on the same campus as the long-term care hospital or satellite facility.* Except for a long-term care hospital or a long-term care hospital satellite facility that meets the requirements of paragraphs (d) or (e) of this section, payments to the long-term care hospital for patients admitted to it or to its long-term care hospital satellite facility from the co-located hospital are made under either of the following:

(1) *For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2007 and for cost reporting periods beginning on or after October 1, 2016.* (i) Except as provided in paragraphs (c)(3), (g), and (h) of this section, for any cost reporting period beginning on or after October 1, 2004 and before October 1, 2007, and for cost reporting periods beginning on or after October 1, 2016 in which the long-term care hospital or its satellite facility has a discharged Medicare inpatient population of whom no more than 25 percent were admitted to the hospital or its satellite facility from the co-located hospital, payments are made under the rules at §§ 412.500 through 412.541 with no adjustment under this section.

(ii) Except as provided in paragraph (g) or (h) of this section, for any cost reporting period beginning on or after October 1, 2004 and before October 1,

2007 and for cost reporting periods beginning on or after October 1, 2013 in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than 25 percent were admitted to the hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 25 percent threshold for discharged patients who have been admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that would be determined under the rules at §412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart at §§412.500 through 412.541 with no adjustment under this section.

(iii) In determining the percentage of patients admitted to the long-term care hospital or its satellite from the co-located hospital under paragraphs (c)(1)(i) and (c)(1)(ii) of this section, patients on whose behalf an outlier payment was made to the co-located hospital are not counted towards the 25 percent threshold.

(2) *For cost reporting periods beginning on or after October 1, 2007 and before October 1, 2016.* (i) Except for a long-term care hospital or a long-term care hospital satellite facility subject to paragraph (g) or (h) of this section, payments are determined using the methodology specified in paragraph (c)(1) of this section.

(ii) Payments for a long-term care hospital or long-term care hospital satellite facility subject to paragraph (g) of this section are determined using the methodology specified in paragraph (c)(1) of this section except that 25 percent is substituted with 50 percent.

(3) For a long-term care hospital satellite facility described in §412.22(h)(3)(i), for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2016, payments will be determined using the methodology specified in paragraph (c)(1) of this section, except that the applicable percentage threshold for Medicare discharges is 50 percent.

(d) *Special treatment of rural hospitals*—(1) *For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2007 and for cost reporting periods beginning on or after October 1, 2016.* (i) Subject to paragraphs (g) and (h) of this section, in the case of a long-term care hospital or satellite facility that is located in a rural area as defined in §412.503 and is co-located with another hospital for any cost reporting period beginning on or after October 1, 2004 and before October 1, 2007 and for any cost reporting period beginning on or after October 1, 2016 in which the long-term care hospital or long-term care satellite facility has a discharged Medicare inpatient population of whom more than 50 percent were admitted to the long-term care hospital or satellite facility from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital or satellite facility to exceed the 50 percent threshold for discharged patients who were admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that were otherwise payable under §412.1(a). Payments for the remainder of the long-term care hospital's or long-term care hospital satellite facility's patients are made under the rules in this subpart at §§412.500 through 412.541 with no adjustment under this section.

(ii) In determining the percentage of patients admitted from the co-located hospital under paragraph (d)(1)(i) of this section, patients on whose behalf outlier payment was made at the co-located hospital are not counted toward the 50 percent threshold.

(2) *For cost reporting periods beginning on or after October 1, 2007, and before October 1, 2016.* (i) Except for a long-term care hospital or a long-term care hospital satellite facility subject to paragraph (g) or (h) of this section, payments are determined using the methodology specified in paragraph (d)(1) of this section.

(ii) Payments for long-term care hospitals and long-term care hospital satellite facilities subject to paragraph (g) of this section are determined using the methodology specified in paragraph (d)(1) of this section except that 50 percent is substituted with 75 percent.

(3) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2016, payment for a long-term care hospital satellite facility described in § 412.22(h)(3)(i) will be determined using the methodology specified in paragraph (c)(1) of this section, except that the applicable percentage threshold for Medicare discharges is 75 percent.

(e) *Special treatment of urban single or MSA-dominant hospitals*—(1) *For cost reporting periods beginning on or after October 1, 2004 and before October 1, 2007 and for cost reporting periods beginning on or after October 1, 2016.* (i) Subject to paragraphs (g) and (h) of this section, in the case of a long-term care hospital or a long-term care hospital satellite facility that is co-located with the only other hospital in the MSA or with a MSA-dominant hospital as defined in paragraph (e)(1)(iv) of this section, for any cost reporting period beginning on or after October 1, 2004, and before October 1, 2007 and for any cost reporting periods beginning on or after October 1, 2016, in which the long-term care hospital or long-term care hospital satellite facility has a discharged Medicare inpatient population of whom more than the percentage calculated under paragraph (e)(1)(ii) of this section were admitted to the hospital from the co-located hospital, payments for the patients who are admitted from the co-located hospital and who cause the long-term care hospital to exceed the applicable threshold for discharged patients who have been admitted from the co-located hospital are the lesser of the amount otherwise payable under this subpart or the amount under this subpart that is equivalent, as set forth in paragraph (f) of this section, to the amount that otherwise would be determined under § 412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients are made under the rules in this subpart with no adjustment under this section.

(ii) For purposes of paragraph (e)(1)(i) of this section, the percentage used is the percentage of total Medicare discharges in the Metropolitan Statistical Area in which the hospital is located that are from the co-located hospital for the cost reporting period for which the adjustment was made, but in no case is less than 25 percent or more than 50 percent.

(iii) In determining the percentage of patients admitted from the co-located hospital under paragraph (e)(1)(i) of this section, patients on whose behalf outlier payment was made at the co-located hospital are not counted toward the applicable threshold.

(iv) For purposes of this paragraph, an ''MSA-dominant hospital'' is a hospital that has discharged more than 25 percent of the total hospital Medicare discharges in the MSA in which the hospital is located.

(2) *For cost reporting periods beginning on or after October 1, 2007 and before October 1, 2016.* (i) Except for a long-term care hospital or a long-term care hospital satellite facility subject to paragraph (g) or (h) of this section, payments are determined using the methodology specified in paragraph (e)(1) of this section.

(ii) Payments for a long-term care hospital or long-term care hospital satellite facilities subject to paragraph (g) of this section are determined using the methodology specified in paragraph (e)(1) of this section except that the percentage of Medicare discharges that may be admitted from the co-located hospital without being subject to the payment adjustment at paragraph (e)(1) of this section is 75 percent.

(3) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2016, payments for a long-term care hospital satellite facility described in § 412.22(h)(3)(i) will be determined using the methodology specified in paragraph (c)(1) of this section, except that the applicable percentage threshold for Medicare discharges is 75 percent.

(f) *Calculation of rates*—(1) *Calculation of LTCH prospective payment system amount.* CMS calculates an amount payable under subpart O equivalent to an amount that would otherwise be

paid under the hospital inpatient prospective payment system based on the sum of the applicable hospital inpatient prospective payment system operating standardized amount and capital Federal rate in effect at the time of the LTCH discharge.

(2) *Operating inpatient prospective payment system standardized amount.* The hospital inpatient prospective payment system operating standardized amount—

(i) Is adjusted for the applicable hospital inpatient prospective payment system DRG weighting factors;

(ii) Is adjusted for different area wage levels based on the geographic classifications set forth at §412.503 and the applicable hospital inpatient prospective payment system labor-related share, using the applicable hospital inpatient prospective payment system wage index value for non-reclassified hospitals. For LTCHs located in Alaska and Hawaii, this amount is also adjusted by the applicable hospital inpatient prospective payment system cost of living adjustment factors;

(iii) Includes, where applicable, adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(3) *Hospital inpatient prospective payment system capital Federal rate.* The hospital inpatient prospective payment system capital Federal rate—

(i) Is adjusted for the applicable hospital inpatient prospective payment system DRG weighting factors;

(ii) Is adjusted by the applicable geographic adjustment factors, including local cost variation based on the applicable geographic classifications set forth at §412.503 and the applicable full hospital inpatient prospective payment system wage index value for non-reclassified hospitals, applicable large urban location and cost of living adjustment factors for LTCHs for Alaska and Hawaii, if applicable;

(iii) Includes, where applicable, capital inpatient prospective payment system adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(4) *High cost outlier.* An additional payment for high cost outlier cases is based on the fixed loss amount established for the hospital inpatient prospective payment system.

(g) *Transition period for long-term care hospitals and satellite facilities paid under this subpart.* Except as specified in paragraph (h)(2), in the case of a long-term care hospital or a satellite facility that is paid under the provisions of this subpart on October 1, 2004 or of a hospital that is paid under the provisions of this subpart and whose qualifying period under §412.23(e) began on or before October 1, 2004, the amount paid is calculated as specified below:

(1) For each discharge during the first cost reporting period beginning on or after October 1, 2004, and before October 1, 2005, the amount paid is the amount payable under this subpart with no adjustment under this section but the hospital may not exceed the percentage of patients admitted from the host during its FY 2004 cost reporting period.

(2) For each discharge during the cost reporting period beginning on or after October 1, 2005, and before October 1, 2006, the percentage that may be admitted from the host with no payment adjustment may not exceed the lesser of the percentage of patients admitted from the host during its FY 2004 cost reporting period or 75 percent.

(3) For each discharge during the cost reporting period beginning on or after October 1, 2006, and before October 1, 2007, the percentage that may be admitted from the host with no payment adjustment may not exceed the lesser of the percentage of patients admitted from the host during its FY 2004 cost reporting period or 50 percent.

(4) For each discharge during cost reporting periods beginning on or after October 1, 2007, the percentage that may be admitted from the host with no payment adjustment may not exceed 25 percent or the applicable percentage determined under paragraph (d) or (e) of this section.

(h) *Effective date of policies in this section for certain co-located long-term care hospitals and satellite facilities of long-term care hospitals.* Except as specified in paragraph (h)(4) of this section, the policies set forth in this paragraph (h) apply to Medicare patient discharges

that were admitted from a hospital located in the same building or on the same campus as a long-term care hospital described in § 412.23(e)(2)(i) that meets the criteria in § 412.22(f) and a satellite facility of a long-term care hospital as described under § 412.22(h)(3)(i) for discharges occurring in cost reporting periods beginning on or after July 1, 2007.

(1) Except as specified in paragraph (h)(4) of this section, in the case of a long-term care hospital or long-term care hospital satellite facility that is described under this paragraph (h), the thresholds applied at paragraphs (c), (d), and (e) of this section are not less than the following percentages:

(i) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008, the lesser of 75 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or long-term care hospital satellite facility from its co-located hospital during the cost reporting period or the percentage of Medicare discharges that had been admitted to the long-term care hospital or satellite from that co-located hospital during the long-term care hospital's or satellite's RY 2005 cost reporting period.

(ii) For cost reporting periods beginning on or after July 1, 2008 and before July 1, 2009, the lesser of 50 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or the long-term care hospital satellite facility from its co-located hospital or the percentage of Medicare discharges that had been admitted from that co-located hospital during the long-term care hospital's or satellite's RY 2005 cost reporting period.

(iii) For cost reporting periods beginning on or after July 1, 2009, 25 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or satellite from its co-located hospital during the cost reporting period.

(2) In determining the percentage of Medicare discharges admitted from the co-located hospital under this paragraph, patients on whose behalf a Medicare high cost outlier payment was made at the co-located referring hospital are not counted toward this threshold.

(3) Except as specified in paragraph (h)(4) of this section, for cost reporting periods beginning on or after July 1, 2007, payments to long term care hospitals described in § 412.23(e)(2)(i) that meet the criteria in § 412.22(f) and satellite facilities of long-term care hospitals described at § 412.22(h)(3)(i) are subject to the provisions of § 412.536 for discharges of Medicare patients who are admitted from a hospital not located in the same building or on the same campus as the LTCH or LTCH satellite facility.

(4) For a long-term care hospital described in § 412.23(e)(2)(i) that meets the criteria in § 412.22(f), the policies set forth in this paragraph (h) and in § 412.536 do not apply for discharges occurring in cost reporting periods beginning on or after July 1, 2007.

(5) For a long-term care hospital or a satellite facility that, as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Act at the off-campus location, the policies set forth in this paragraph (h) and in § 412.536 do not apply for discharges occurring in cost reporting periods beginning on or after July 1, 2007 and before July 1, 2016.

[69 FR 49251, Aug. 11, 2004, as amended at 69 FR 78529, Dec. 30, 2004; 71 FR 27900, May 12, 2006; 72 FR 26992, May 11, 2007; 73 FR 26839, May 9, 2008; 73 FR 29709, May 22, 2008; 74 FR 43998, Aug. 27, 2009; 75 FR 50416, Aug. 16, 2010; 77 FR 53679, Aug. 31, 2012; 77 FR 63752, Oct. 17, 2012; 79 FR 50356, Aug. 22, 2014]

§ 412.535 Publication of the Federal prospective payment rates.

Except as specified in paragraph (b), CMS publishes information pertaining to the long-term care hospital prospective payment system effective for each annual update in the FEDERAL REGISTER.

(a) For the period beginning on or after July 1, 2003 and ending on June 30, 2008, information on the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates are published on or before May 1 prior to the

start of each long-term care hospital prospective payment system rate year which begins July 1, unless for good cause it is published after May 1, but before June 1.

(b) For the period beginning on July 1, 2008 and ending on September 30, 2009, information of the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates are published on or before May 1 prior to the start of the long-term care hospital prospective payment system rate year which begins July 1, unless for good cause it is published after May 1, but before June 1.

(c) For the period beginning on or after October 1, 2009, information on the unadjusted Federal payment rates and a description of the methodology and data used to calculate the payment rates are published on or before August 1 prior to the start of the Federal fiscal year which begins October 1, unless for good cause it is published after August 1, but before September 1.

(d) Information on the LTC-DRG classification and associated weighting factors is published on or before August 1 prior to the beginning of each Federal fiscal year.

[68 FR 34163, June 6, 2003, as amended at 73 FR 26839, May 9, 2008]

§ 412.536 Special payment provisions for long-term care hospitals and satellites of long-term care hospitals that discharge Medicare patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or satellite of the long-term care hospital, effective for discharges occurring on or before September 30, 2016 or in cost reporting periods beginning on or before June 30, 2016.

(a) *Scope.* (1) Except as specified in paragraph (a)(2) of this section, for cost reporting periods beginning on or after July 1, 2007, the policies set forth in this section apply to discharges from the following:

(i) Long-term care hospitals as described in § 412.23(e)(2)(i) that meet the criteria in § 412.22(e).

(ii) Long-term care hospitals as described in § 412.23(e)(2)(i) and that meet the criteria in § 412.22(f).

(iii) [Reserved]

(iv) Long-term care hospitals as described in § 412.23(e)(5).

(2) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2016, the policies set forth in this section are not applicable to discharges from:

(i) A long-term care hospital described in § 412.23(e)(5) of this part; or

(ii) [Reserved]

(iii) A long-term care hospital or satellite facility, that as of December 29, 2007, was co-located with an entity that is a provider-based, off-campus location of a subsection (d) hospital which did not provide services payable under section 1886(d) of the Act at the off-campus location.

(b) For cost reporting periods beginning on or after July 1, 2007, payments for discharges of Medicare patients admitted from a hospital not located in the same building or on the same campus as the long-term care hospital or long-term care hospital satellite facility will be made under either paragraph (b)(1) or paragraph (b)(2) of this section.

(1) Except as provided in paragraphs (c), (d) and subject to paragraph (f) of this section, for any cost reporting period beginning on or after July 1, 2007 in which a long-term care hospital or a long-term care hospital satellite facility has a discharged Medicare inpatient population of whom no more than 25 percent were admitted to the long-term care hospital or the satellite facility from any individual hospital not co-located with the long-term care hospital or with the satellite of a long-term care hospital, payments for the Medicare discharges admitted from that hospital are made under the rules at § 412.500 through § 412.541 in this subpart with no adjustment under this section.

(2) Except as provided in paragraph (c) and (d) and subject to paragraph (f) of this section, for any cost reporting period beginning on or after July 1, 2007 in which a long-term care hospital or long-term care hospital satellite facility has a discharged Medicare inpatient population of whom more than 25 percent were admitted to the long-term care hospital or satellite facility from any individual hospital not co-located with the long-term care hospital or

with the satellite of a long-term care hospital, payment for the Medicare discharges who cause the long-term care hospital or satellite facility to exceed the 25 percent threshold for discharged patients who have been admitted from that referring hospital is the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (e) of this section, to the amount that would be determined under the rules at subpart A, §412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's patients admitted from that referring hospital are made under the rules in this subpart at §§412.500 through 412.541 with no adjustment under this section.

(3) In determining the percentage of Medicare discharges admitted to the long-term care hospital or long-term care hospital satellite facility from any referring hospital not co-located with the long-term care hospital or with the satellite of a long-term care hospital, under paragraphs (b)(1) and (b)(2) of this section, patients on whose behalf a Medicare high cost outlier payment was made to the referring hospital are not counted towards the 25 percent threshold from that referring hospital.

(c) *Special treatment of rural hospitals.* (1) Subject to paragraph (f) of this section, in the case of a long-term care hospital or long-term care hospital satellite facility that is located in a rural area as defined in §412.503 that has a discharged Medicare inpatient population of whom more than 50 percent were admitted to the long-term care hospital or long-term care hospital satellite facility from a hospital not co-located with the long-term care hospital or with the satellite of a long-term care hospital, payment for the Medicare discharges who are admitted from that hospital and who cause the long-term care hospital or satellite facility to exceed the 50 percent threshold for Medicare discharges is determined at the lesser of the amount otherwise payable under this subpart or the amount payable under this subpart that is equivalent, as set forth in paragraph (e) of this section, to the amount that is otherwise payable under subpart A, §412.1(a). Payments for the remainder of the long-term care hospital's or long-term care hospital satellite facility's Medicare discharges admitted from that referring hospital are made under the rules in this subpart at §§412.500 through 412.541 with no adjustment under this section.

(2) In determining the percentage of Medicare discharges admitted from the referring hospital under paragraph (c)(1) of this section, patients on whose behalf a Medicare high cost outlier payment was made at the referring hospital are not counted toward the 50 percent threshold.

(d) *Special treatment of urban single or MSA dominant hospitals.* (1) Subject to paragraph (f) of this section, in the case of a long-term care hospital or long-term care hospital satellite facility that admits Medicare patients from the only other hospital in the MSA or from a referring MSA dominant hospital as defined in paragraph (d)(4) of this section, that are not co-located with the long-term care hospital or with the satellite of a long-term care hospital for any cost reporting period beginning on or after July 1, 2007, in which the long-term care hospital or satellite facility has a discharged Medicare inpatient population of whom more than the percentage calculated under paragraph (d)(2) of this section were admitted to the hospital from the single or MSA-dominant referring hospital, payment for the Medicare discharges who are admitted from the referring hospital and who cause the long-term care hospital or long-term care hospital satellite facility to exceed the applicable threshold for Medicare discharges who have been admitted from the referring hospital is the lesser of the amount otherwise payable under this subpart or the amount under this subpart that is equivalent, as set forth in paragraph (e) of this section, to the amount that otherwise would be determined under subpart A, §412.1(a). Payments for the remainder of the long-term care hospital's or satellite facility's Medicare discharges admitted from that referring hospital are made under the rules in this subpart at §§412.500 through 412.541 with no adjustment under this section.

(2) For purposes of paragraph (d)(1) of this section, the percentage threshold is equal to the percentage of total Medicare discharges in the Metropolitan Statistical Area (MSA) in which the hospital is located that are from the referring hospital, but in no case is less than 25 percent or more than 50 percent.

(3) In determining the percentage of patients admitted from the referring hospital under paragraph (d)(1) of this section, patients on whose behalf a Medicare outlier payment was made at the referring hospital are not counted toward the applicable threshold.

(4) For purposes of this paragraph, an ''MSA-dominant hospital'' is a hospital that has discharged more than 25 percent of the total hospital Medicare discharges in the MSA in which the hospital is located.

(e) *Calculation of adjusted payment*—(1) *Calculation of adjusted long-term care hospital prospective payment system amount.* CMS calculates an amount payable under subpart O equivalent to an amount that would otherwise be paid under the hospital inpatient prospective payment system at subpart A, §412.1(a). The amount is based on the sum of the applicable hospital inpatient prospective payment system operating standardized amount and capital Federal rate in effect at the time of the long-term care hospital discharge.

(2) *Operating inpatient prospective payment system standardized amount.* The hospital inpatient prospective payment system operating standardized amount—

(i) Is adjusted for the applicable hospital inpatient prospective payment system DRG weighting factors;

(ii) Is adjusted for different area wage levels based on the geographic classifications defined at §412.503 and the applicable hospital inpatient prospective payment system labor-related share, using the applicable hospital inpatient prospective payment system wage index value for nonreclassified hospitals. For long-term care hospitals located in Alaska and Hawaii, this amount is also adjusted by the applicable hospital inpatient prospective payment system cost of living adjustment factors;

(iii) Includes, where applicable, adjustments for indirect medical education costs and for the costs of serving a disproportionate share of low-income patients.

(3) *Hospital inpatient prospective payment system capital Federal rate.* The hospital inpatient prospective payment system capital Federal rate—

(i) Is adjusted for the applicable hospital inpatient prospective payment system DRG weighting factors;

(ii) Is adjusted by the applicable geographic adjustment factors, including local cost variation based on the applicable geographic classifications set forth at §412.503 and the applicable full hospital inpatient prospective payment system wage index value for non-reclassified hospitals, applicable large urban location and cost of living adjustment factors for long-term care hospitals for Alaska and Hawaii, if applicable;

(iii) Includes, where applicable, capital inpatient prospective payment system adjustments for indirect medical education costs and the costs of serving a disproportionate share of low-income patients.

(4) *High cost outlier.* An additional payment for high cost outlier cases is based on the applicable fixed loss amount established for the hospital inpatient prospective payment system.

(f) *Transition period for long-term care hospitals and satellites paid under this section.* In the case of a long-term care hospital or satellite of a long-term care hospital that is paid under the provisions of this section, the thresholds applied under paragraphs (b), (c) and (d) of this section will not be less than the percentages specified below:

(1) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008, the lesser of 75 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or satellite facility of a long-term care hospital from all referring hospitals not co-located with the long-term care hospital or with the satellite facility of a long-term care hospital during the cost reporting period or the percentage of Medicare discharges that had been admitted to the long-term care hospital or satellite of a long-term care hospital

from that referring hospital during the long-term care hospital's or satellite's RY 2005 cost reporting period.

(2) For cost reporting periods beginning on or after July 1, 2008 and before July 1, 2009, the lesser of 50 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or to the satellite facility of a long-term care hospital from all referring hospitals not co-located with the long-term care hospital or with the satellite facility of a long-term care hospital during the cost reporting period or the percentage of Medicare discharges that had been admitted from that referring hospital during the long-term care hospital's or satellite's RY 2005 cost reporting period.

(3) For cost reporting periods beginning on or after July 1, 2009, 25 percent of the total number of Medicare discharges that were admitted to the long-term care hospital or to the satellite facility of a long-term care hospital from all referring hospitals not co-located with the long-term care hospital or with the satellite facility of a long-term care hospital to the long-term care hospital during the cost reporting period.

(4) In determining the percentage of Medicare discharges admitted from the referring hospital under this paragraph, patients on whose behalf a Medicare high cost outlier payment was made at the referring hospital are not counted toward this threshold.

[72 FR 26993, May 11, 2007, as amended at 73 FR 26840, May 9, 2008; 73 FR 29711, May 22, 2008; 74 FR 44000, Aug. 27, 2009; 75 FR 50416, Aug. 16, 2010; 77 FR 53680, Aug. 31, 2012; 77 FR 63752, Oct. 17, 2012; 79 FR 50357, Aug. 22, 2014]

§ 412.538 [Reserved]

§ 412.540 Method of payment for preadmission services under the long-term care hospital prospective payment system.

The prospective payment system includes payment for inpatient operating costs of preadmission services that are—

(a) Otherwise payable under Medicare Part B;

(b) Furnished to a beneficiary on the date of the beneficiary's inpatient admission, and during the calendar day immediately preceding the date of the beneficiary's inpatient admission, to the long-term care hospital, or to an entity wholly owned or wholly operated by the long-term care hospital; and

(1) An entity is wholly owned by the long-term care hospital if the long-term care hospital is the sole owner of the entity.

(2) An entity is wholly operated by a long-term care hospital if the long-term care hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the long-term care hospital also has policymaking authority over the entity.

(c) Related to the inpatient stay. A preadmission service is related if—

(1) It is diagnostic (including clinical diagnostic laboratory tests); or

(2) It is nondiagnostic when furnished on the date of the beneficiary's inpatient admission; or

(3) On or after June 25, 2010, it is nondiagnostic when furnished on the calendar day preceding the date of the beneficiary's inpatient admission and the hospital does not attest that such service is unrelated to the beneficiary's inpatient admission.

(d) Not one of the following—

(1) Ambulance services.

(2) Maintenance renal dialysis services.

[75 FR 50416, Aug. 16, 2010]

§ 412.541 Method of payment under the long-term care hospital prospective payment system.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, long-term care hospitals receive payment under this subpart for inpatient operating costs and capital-related costs for each discharge only following submission of a discharge bill.

(b) *Periodic interim payments*—(1) *Criteria for receiving periodic interim payments.* (i) A long-term care hospital receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of § 413.64(h) of this subchapter.

(ii) To be approved for PIP, the long-term care hospital must meet the

qualifying requirements in §413.64(h)(3) of this subchapter.

(iii) As provided in §413.64(h)(5) of this subchapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of the PIP resulting in an overpayment to the provider.

(2) *Frequency of payment.* (i) For long-term care hospitals approved for PIP and paid solely under Federal prospective payment system rates under §§412.533(a)(5) and 412.533(c), the intermediary estimates the long-term care hospital's Federal prospective payments net after estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year.

(ii) For long-term care hospitals approved for PIP and paid using the blended payment schedule specified in §412.533(a) for cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, the intermediary estimates the hospital's portion of the Federal prospective payments net and the hospital's portion of the reasonable cost-based reimbursement payments net, after beneficiary deductibles and coinsurance, in accordance with the blended transition percentages specified in §412.533(a), and makes biweekly payments equal to 1/26 of the total estimated amount of both portions of payments for the year.

(iii) If the long-term care hospital has payment experience under the long-term care hospital prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year.

(iv) Each payment is made 2 weeks after the end of a biweekly period of service as described in §413.64(h)(6) of this subchapter.

(v) The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a hospital receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the hospital.* Subject to paragraph (b)(1)(iii) of this section, a long-term care hospital receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the long-term care hospital no longer meets the requirements of §413.64(h) of this subchapter.

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for the costs of an approved education program, blood clotting factors, anesthesia services furnished by hospital-employed nonphysician anesthetists or obtained under arrangement, and photocopying and mailing medical records to a QIO, which are costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of the biweekly period of service as described in §413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if a long-term care hospital receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Special interim payment for unusually long lengths of stay*—(1) *First interim payment.* A hospital that is not receiving periodic interim payments under paragraph (b) of this section may request an interim payment 60 days after a Medicare beneficiary has been admitted to the hospital. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.

(2) *Additional interim payments.* A hospital may request additional interim payments at intervals of at least 60

days after the date of the first interim bill submitted under paragraph (d)(1) of this section. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of this paragraph.

(e) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(f) *Accelerated payments*—(1) *General rule.* Upon request, an accelerated payment may be made to a long-term care hospital that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the hospital is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the long-term care hospital.

(ii) Due to an exceptional situation, there is a temporary delay in the hospital's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* A request by a long-term care hospital for an accelerated payment must be approved by the intermediary and by CMS.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as long-term care hospital bills are processed or by direct payment by the long-term care hospital.

[67 FR 56049, Aug. 30, 2002, as amended at 68 FR 10988, Mar. 7, 2003; 71 FR 48141, Aug. 18, 2006]

§ 412.560 Requirements under the Long-Term Care Hospital Quality Reporting Program (LTCH QRP).

(a) *Participation in the LTCH QRP.* A long-term-care hospital must begin submitting data on measures specified under sections 1886(m)(5)(D), 1899B(c)(1), and 1899B(d)(1) of the Act, and standardized patient assessment data required under section 1899B(b)(1) of the Act, under the LTCH QRP by no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter.

(b) *Data submission requirements and payment impact.* (1) Except as provided in paragraph (c) of this section, a long-term care hospital must submit to CMS data on measures specified under sections 1886(m)(5)(D), 1899B(c)(1) and 1899B(d)(1) of the Act, and standardized patient assessment data required under section 1899B(b)(1) of the Act. Such data must be submitted in a form and manner, and at a time, specified by CMS.

(2) A long-term care hospital that does not submit data in accordance with sections 1886(m)(5)(C) and 1886(m)(5)(F) of the Act with respect to a given fiscal year will have its annual update to the standard Federal rate for discharges for the long-term care hospital during the fiscal year reduced by 2 percentage points.

(3) CMS may remove a quality measure from the LTCH QRP based on one or more of the following factors:

(i) Measure performance among long-term care hospitals is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

(ii) Performance or improvement on a measure does not result in better patient outcomes.

(iii) A measure does not align with current clinical guidelines or practice.

(iv) The availability of a more broadly applicable (across settings, populations, or conditions) measure for the particular topic.

(v) The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic.

(vi) The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic.

(vii) Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

(viii) The costs associated with a measure outweigh the benefit of its continued use in the program.

(c) *Exception and extension request requirements.* Upon request by a long-term care hospital, CMS may grant an

exception or extension with respect to the measures data and standardized patient assessment data reporting requirements, for one or more quarters, in the event of certain extraordinary circumstances beyond the control of the long-term care hospital, subject to the following:

(1) A long-term care hospital that wishes to request an exception or extension with respect to measures data and standardized patient assessment data reporting requirements must submit its request to CMS within 90 days of the date that the extraordinary circumstances occurred.

(2) A long-term care hospital must submit its request for an exception or extension to CMS via email. Email is the only form that may be used to submit to CMS a request for an exception or an extension.

(3) The email request for an exception or extension must contain the following information:

(i) The CCN for the long-term care hospital.

(ii) The business name of the long-term care hospital.

(iii) The business address of the long-term care hospital.

(iv) Contact information for the long-term care hospital's chief executive officer or designated personnel, including the name, telephone number, title, email address, and physical mailing address. (The mailing address may not be a post office box.)

(v) A statement of the reason for the request for the exception or extension.

(vi) Evidence of the impact of the extraordinary circumstances, including, but not limited to, photographs, newspaper articles, and other media.

(vii) The date on which the long-term care hospital will be able to again submit measures data and standardized patient assessment data under the LTCH QRP and a justification for the proposed date.

(4) CMS may grant an exception or extension to a long-term care hospital that has not been requested by the long-term care hospital if CMS determines that—

(i) An extraordinary circumstance affects an entire region or locale; or

(ii) A systemic problem with one of CMS' data collection systems directly affected the ability of the long-term care hospital to submit measures data and standardized patient assessment data.

(d) *Reconsiderations of noncompliance decisions*— (1) *Written letter of non-compliance decision*. Long-term care hospitals that do not meet the requirement in paragraph (b) of this section for a program year will receive a notification of non-compliance sent through at least one of the following methods: The CMS designated data submission system, the United States Postal Service, or via an email from the MAC.

(2) *Request for reconsideration of noncompliance decision*. A long-term care hospital may request a reconsideration of CMS' decision of noncompliance no later than 30 calendar days from the date of the written notification of noncompliance. The reconsideration request by the long-term care hospital must be submitted to CMS via email and must contain the following information:

(i) The CCN for the long-term care hospital.

(ii) The business name of the long-term care hospital.

(iii) The business address of the long-term care hospital.

(iv) Contact information for the long-term care hospital's chief executive officer or designated personnel, including each individual's name, title, email address, telephone number, and physical mailing address. (The physical address may not be a post office box.)

(v) CMS's identified reason(s) for the noncompliance decision from the written notification of noncompliance.

(vi) The reason for requesting reconsideration of CMS' noncompliance decision.

(vii) Accompanying documentation that demonstrates compliance of the long-term care hospital with the LTCH QRP requirements. This documentation must be submitted electronically at the same time as the reconsideration request as an attachment to the email.

(3) *CMS decision on reconsideration request*. (i) CMS notifies the LTCH, in writing, of its final decision regarding any reconsideration request through at least one of the following methods:

(A) CMS designated data submission system.

(B) The United States Postal Service.

(C) Via email from the CMS Medicare Administrative Contractor (MAC).

(ii) CMS grants a timely request for reconsideration, and reverses an initial finding of non-compliance, only if CMS determines that the long-term care hospital was in full compliance with the LTCH QRP requirements for the applicable program year.

(4) *Request for an extension to file a reconsideration of noncompliance request.* A long-term care hospital may request, and CMS may grant, an extension to file a reconsideration request if, during the period to request a reconsideration as set forth in paragraph (d)(2) of this section, the long-term care hospital was affected by an extraordinary circumstance beyond the control of the LTCH (for example, a natural or man-made disaster).

(i) The long-term care hospital must submit its request for an extension to file a reconsideration request no later than 30 calendar days from the date of the written notification of noncompliance.

(ii) The long-term care hospital must submit its request for an extension to CMS via email to *LTCHQRPReconsiderations@cms.hhs.gov*, and it must contain the following information:

(A) The CCN for the long-term care hospital.

(B) The business name of the long-term care hospital.

(C) The business address of the long-term care hospital.

(D) Contact information for the long-term care hospital's chief executive officer or designated personnel, including the name, telephone number, title, email address, and physical mailing address, which may not be a post office box.

(E) A statement of the reason for the request for the extension.

(F) Evidence of the impact of the extraordinary circumstances, including, for example, photographs, newspaper articles, and other media.

(5) *CMS decision on extension to file a reconsideration of noncompliance request.* CMS notifies the long-term care hospital in writing of its final decision regarding its request for an extension to file a reconsideration of noncompliance request via an email from CMS.

(e) *Appeals of reconsideration requests.* A long-term care hospital that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R, of this chapter.

(f) *Data completion thresholds.* (1) Long-term care hospitals must meet or exceed the following data completeness thresholds with respect to a fiscal year:

(i)(A) The threshold set at 100 percent completion of measures data and standardized patient assessment data collected using the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) on at least 80 percent of the assessments LTCHs submit through the CMS designated data submission system for the FY 2014 through the FY 2025 LTCH QRP.

(B) The threshold set at 100 percent completion of measures data and standardized patient assessment data collected using the LCDS on at least 85 percent of the assessments LTCHs submit through the CMS designated data submission system beginning with the FY 2026 LTCH QRP.

(ii) The threshold set at 100 percent for measures data collected and submitted using the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) for FY 2014 and all subsequent payment updates.

(2) The thresholds in paragraph (f)(1) of this section apply to all data that must be submitted under paragraph (b) of this section.

(3) A long-term care hospital must meet or exceed both thresholds in paragraph (f)(1) of this section to avoid receiving a 2 percentage point reduction to its annual payment update for a given fiscal year, beginning with the FY 2019 LTCH QRP.

[80 FR 49769, Aug. 17, 2015, as amended at 81 FR 57270, Aug. 22, 2016; 82 FR 38513, Aug. 14, 2017; 83 FR 41705, Aug. 17, 2018; 84 FR 42615, Aug. 16, 2019; 88 FR 59334, Aug. 28, 2023; 90 FR 37203, Aug. 4, 2025]

Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

SOURCE: 66 FR 41388, Aug. 7, 2001, unless otherwise noted.

§ 412.600 Basis and scope of subpart.

(a) *Basis.* This subpart implements section 1886(j) of the Act, which provides for the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units (in this subpart referred to as ''inpatient rehabilitation facilities'').

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for inpatient rehabilitation facilities, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules. Under this system, for cost reporting periods beginning on or after January 1, 2002, payment for the operating and capital costs of inpatient hospital services furnished by inpatient rehabilitation facilities to Medicare Part A fee-for-service beneficiaries is made on the basis of prospectively determined rates and applied on a per discharge basis.

§ 412.602 Definitions.

As used in this subpart—

Assessment reference date means the specific calendar day in the patient assessment process that sets the designated endpoint of the common patient observation period, with most patient assessment items usually referring back in time from this endpoint.

Closure of an IRF has the same meaning as ''closure of a hospital'' as defined in § 413.79(h)(1)(i) as applied to an IRF meeting the requirements of § 412.604(b) for the purposes of accounting for indirect teaching costs.

Closure of an IRF's residency training program has the same meaning as ''closure of a hospital residency training program'' as defined in § 413.79(h)(1)(ii) as applied to an IRF meeting the requirements of § 412.604(b) for the purposes of accounting for indirect teaching costs.

CMS stands for the Centers for Medicare & Medicaid Services.

Comorbidity means a specific patient condition that is secondary to the patient's principal diagnosis that is the primary reason for the inpatient rehabilitation stay.

Discharge. A Medicare patient in an inpatient rehabilitation facility is considered discharged when—

(1) The patient is formally released from the inpatient rehabilitation facility; or

(2) The patient dies in the inpatient rehabilitation facility.

Displaced resident has the same meaning as a ''displaced resident'' as defined in § 413.79(h)(1)(iii) as applied to an IRF, for purposes of accounting for indirect teaching costs.

Encode means entering data items into the fields of the computerized patient assessment software program.

Functional-related groups refers to the distinct groups under which inpatients are classified using proxy measurements of inpatient rehabilitation relative resource usage.

Interrupted stay means a stay at an inpatient rehabilitation facility during which a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The duration of the interruption of the stay of 3 consecutive calendar days begins with the day of discharge from the inpatient rehabilitation facility and ends on midnight of the third day.

Outlier payment means an additional payment beyond the standard Federal prospective payment for cases with unusually high costs.

Patient assessment instrument refers to a document that contains clinical, demographic, and other information on a patient.

Rural area means: For cost-reporting periods beginning on or after January 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before October 1, 2005, an area as defined in § 412.62(f)(1)(iii). For discharges occurring on or after October 1, 2005, rural area means an area as defined in § 412.64(b)(1)(ii)(C).

Transfer means the release of a Medicare inpatient from an inpatient rehabilitation facility to another inpatient rehabilitation facility, a short-term, acute-care prospective payment hospital, a long-term care hospital as described in § 412.23(e), or a nursing home that qualifies to receive Medicare or Medicaid payments.

Urban area means: For cost-reporting periods beginning on or after January 1, 2002, with respect to discharges occurring during the period covered by such cost reports but before October 1, 2005, an area as defined in § 412.62(f)(1)(ii). For discharges occurring on or after October 1, 2005, urban area means an area as defined in §§ 412.64(b)(1)(ii)(A) and 412.64(b)(1)(ii)(B).

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 68 FR 45699, Aug. 1, 2003; 70 FR 47952, Aug. 15, 2005; 87 FR 47090, Aug. 1, 2022]

§ 412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.

(a) *General requirements.* (1) Effective for cost reporting periods beginning on or after January 1, 2002, an inpatient rehabilitation facility must meet the conditions of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare Part A fee-for-service beneficiaries.

(2) If an inpatient rehabilitation facility fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare Part A fee-for-service beneficiaries, CMS or its Medicare fiscal intermediary may, as appropriate—

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient rehabilitation facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient rehabilitation facility as an inpatient hospital that is subject to the conditions of subpart C of this part and is paid under the prospective payment systems specified in § 412.1(a)(1).

(b) *Inpatient rehabilitation facilities subject to the prospective payment system.* Subject to the special payment provisions of § 412.22(c), an inpatient rehabilitation facility must meet the general criteria set forth in § 412.22 and the criteria to be classified as a rehabilitation hospital or rehabilitation unit set forth in §§ 412.23(b), 412.25, and 412.29 for exclusion from the inpatient hospital prospective payment systems specified in § 412.1(a)(1).

(c) *Completion of patient assessment instrument.* For each Medicare part A fee-for-service patient admitted to or discharged from an IRF on or after January 1, 2002, the inpatient rehabilitation facility must complete a patient assessment instrument in accordance with § 412.606. IRFs must also complete a patient assessment instrument in accordance with § 412.606 for each Medicare Part C (Medicare Advantage) patient admitted to or discharged from an IRF on or after October 1, 2009. In addition, IRFs must complete a patient assessment instrument in accordance with § 412.606 for all other patients, regardless of payer, admitted to or discharged from an IRF on or after October 1, 2024.

(d) *Limitation on charges to beneficiaries*—(1) *Prohibited charges.* Except as provided in paragraph (d)(2) of this section, an inpatient rehabilitation facility may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's costs of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) *Permitted charges.* An inpatient rehabilitation facility receiving payment under this subpart for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this subchapter and for items or services as specified under § 489.20(a) of this chapter.

(e) *Furnishing of inpatient hospital services directly or under arrangement.* (1) Subject to the provisions of § 412.622(b), the applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in § 409.10 of this subchapter. Inpatient

hospital services do not include the following:

(i) Physicians' services that meet the requirements of §415.102(a) of this subchapter for payment on a fee schedule basis.

(ii) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(iii) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(iv) Certified nurse midwife services, as defined in section 1861(gg) of the Act.

(v) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(vi) Services of an anesthetist, as defined in §410.69 of this chapter.

(2) Medicare does not pay any provider or supplier other than the inpatient rehabilitation facility for services furnished to a Medicare beneficiary who is an inpatient of the inpatient rehabilitation facility, except for services described in paragraphs (e)(1)(i) through (e)(1)(vi) of this section.

(3) The inpatient rehabilitation facility must furnish all necessary covered services to the Medicare beneficiary either directly or under arrangements (as defined in §409.3 of this subchapter).

(f) The prospective payment system includes payment for inpatient operating costs of preadmission services that are—

(1) Otherwise payable under Medicare Part B;

(2) Furnished to a beneficiary on the date of the beneficiary's inpatient admission, and during the calendar day immediately preceding the date of the beneficiary's inpatient admission, to the inpatient rehabilitation facility, or to an entity wholly owned or wholly operated by the inpatient rehabilitation facility; and

(i) An entity is wholly owned by the inpatient rehabilitation facility if the inpatient rehabilitation facility is the sole owner of the entity.

(ii) An entity is wholly operated by an inpatient rehabilitation facility if the inpatient rehabilitation facility has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the inpatient rehabilitation facility also has policymaking authority over the entity.

(3) Related to the inpatient stay. A preadmission service is related if—

(i) It is diagnostic (including clinical diagnostic laboratory tests); or

(ii) It is nondiagnostic when furnished on the date of the beneficiary's inpatient admission; or

(iii) On or after June 25,, 2010, it is nondiagnostic when furnished on the calendar day preceding the date of the beneficiary's inpatient admission and the hospital does not attest that such service is unrelated to the beneficiary's inpatient admission.

(4) Not one of the following—

(i) Ambulance services.

(ii) Maintenance renal dialysis services.

(g) *Reporting and recordkeeping requirements.* All inpatient rehabilitation facilities participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements of §§413.20 and 413.24 of this subchapter.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 68 FR 45699, Aug. 1, 2003; 74 FR 39810, Aug. 7, 2009; 75 FR 50417, Aug. 16, 2010; 87 FR 47090, Aug. 1, 2022]

§412.606 Patient assessments.

(a) *Patient assessment instrument.* An inpatient rehabilitation facility must use the CMS inpatient rehabilitation facility patient assessment instrument to assess Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) inpatients who are admitted on or after January 1, 2002, or were admitted before January 1, 2002, and are still inpatients as of January 1, 2002.

(1) Starting on October 1, 2024, inpatient rehabilitation facilities must use the CMS inpatient rehabilitation facility patient assessment instrument to assess all inpatients, regardless of payer, who are admitted on or after October 1, 2024, or who were admitted before October 1, 2024 and are still inpatients as of October 1, 2024.

(2) [Reserved]

(b) *Comprehensive assessments.* (1) A clinician of the inpatient rehabilitation facility must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare Part A fee-for-service inpatient

using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of this section as part of his or her patient assessment in accordance with the schedule described in §412.610. IRFs must also complete a patient assessment instrument in accordance with §412.606 for each Medicare Part C (Medicare Advantage) patient admitted to or discharged from an IRF on or after October 1, 2009. In addition, IRFs must complete a patient assessment instrument in accordance with §412.606 for all other patients, regardless of payer, admitted to or discharged from an IRF on or after October 1, 2024.

(2) A clinician employed or contracted by an inpatient rehabilitation facility who is trained on how to perform a patient assessment using the inpatient rehabilitation facility patient assessment instrument specified in paragraph (b) of the section must record appropriate and applicable data accurately and completely for each item on the patient assessment instrument.

(3) The assessment process must include—

(i) Direct patient observation and communication with the patient; and

(ii) When appropriate and to the extent feasible, patient data from the patient's physician(s), family, someone personally knowledgeable about the patient's clinical condition or capabilities, the patient's clinical record, and other sources.

[66 FR 41388, Aug. 7, 2001, as amended at 74 FR 39810, Aug. 7, 2009; 83 FR 38573, Aug. 6, 2018; 87 FR 47090, Aug. 1, 2022]

§412.608 Patients' rights regarding the collection of patient assessment data.

(a) Before performing an assessment using the inpatient rehabilitation facility patient assessment instrument, a clinician of the inpatient rehabilitation facility must give a Medicare inpatient—

(1) The form entitled ''Privacy Act Statement—Health Care Records''; and

(2) The simplified plain language description of the Privacy Act Statement—Health Care Records which is a form entitled ''Data Collection Information Summary for Patients in Inpatient Rehabilitation Facilities.''

(b) The inpatient rehabilitation facility must document in the Medicare inpatient's clinical record that the Medicare inpatient has been given the documents specified in paragraph (a) of this section.

(c) By giving the Medicare inpatient the forms specified in paragraph (a) of this section the inpatient rehabilitation facility will inform the Medicare patient of—

(1) Their privacy rights under the Privacy Act of 1974 and 45 CFR 5b.4(a)(3); and

(2) The following rights:

(i) The right to be informed of the purpose of the collection of the patient assessment data;

(ii) The right to have the patient assessment information collected be kept confidential and secure;

(iii) The right to be informed that the patient assessment information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

(iv) The right to refuse to answer patient assessment questions; and

(v) The right to see, review, and request changes on his or her patient assessment.

(d) The patient rights specified in this section are in addition to the patient rights specified in §82.13 of this chapter.

[68 FR 45699, Aug. 1, 2003]

§412.610 Assessment schedule.

(a) *General.* For each inpatient, an inpatient rehabilitation facility must complete a patient assessment instrument as specified in §412.606 that covers a time period that is in accordance with the assessment schedule specified in paragraph (c) of this section.

(b) *Starting the assessment schedule day count.* The first day that the inpatient is furnished services during his or her current inpatient rehabilitation facility hospital stay is counted as day one of the patient assessment schedule.

(c) *Assessment schedules and references dates.* The inpatient rehabilitation facility must complete a patient assessment instrument upon the patient's admission and discharge as specified in paragraphs (c)(1) and (2) of this section.

(1) *Admission assessment*—(i) *General rule.* The admission assessment—

(A) *General.* Time period is a span of time that covers calendar days 1 through 3 of the patient's current hospitalization.

(B) Has an admission assessment reference date that is the third calendar day of the span of time specified in paragraph (c)(1)(i)(A) of this section; and

(C) Must be completed by the calendar day that follows the admission assessment reference day.

(ii) *Exception to the general rule.* We may specify in the patient assessment instrument item-by-item guide and in other issued instructions, items that have a different admission assessment time period to most appropriately capture patient information for payment and quality of care monitoring objectives.

(2) *Discharge assessment*—(i) *General rule.* The discharge assessment—

(A) Time period is a span of time that covers 3 calendar days, and is the discharge assessment reference date itself specified in paragraph (c)(2)(ii) of this section and the 2 calendar days prior to the discharge assessment reference date; and

(B) Must be completed on the 5th calendar day that follows the discharge assessment reference date specified in paragraph (c)(2)(ii) of this section with the discharge assessment reference date itself being counted as the first day of the 5 calendar day time span.

(ii) *Discharge assessment reference date.* The discharge assessment reference date is the actual day that the first of either of the following two events occurs:

(A) The patient is discharged from the inpatient rehabilitation facility; or

(B) The patient stops being furnished inpatient rehabilitation services.

(iii) *Exception to the general rule.* We may specify in the patient assessment instrument item-by-item guide and in other issued instructions, items that have a different discharge assessment time period to most appropriately capture patient information for payment and quality of care monitoring objectives.

(d) *Encoding dates.* The admission and discharge patient assessments must be encoded by the 7th calendar day from the completion dates specified in paragraph (c) of this section.

(e) *Accuracy of the patient assessment data.* The encoded patient assessment data must accurately reflect the patient's clinical status at the time of the patient assessment.

(f) *Patient assessment instrument record retention.* An inpatient rehabilitation facility must maintain all patient assessment data sets completed on all Medicare Part A fee-for-service patients within the previous 5 years, on Medicare Part C (Medicare Advantage) patients within the previous 10 years, and all other patients within the previous 5 years either in a paper format in the patient's clinical record or in an electronic computer file format that the inpatient rehabilitation facility can easily obtain and produce upon request to CMS or its contractors.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 68 FR 45699, Aug. 1, 2003; 74 FR 39810, Aug. 7, 2009; 87 FR 47090, Aug. 1, 2022]

§412.612 Coordination of the collection of patient assessment data.

(a) *Responsibilities of the clinician.* A clinician of an inpatient rehabilitation facility who has participated in performing the patient assessment must have responsibility for—

(1) The accuracy and thoroughness of the specific data recorded by that clinician on the patient's assessment instrument; and

(2) The accuracy of the assessment reference date inserted on the patient assessment instrument completed under §412.610(c).

(b) *Penalty for falsification.* (1) Under Medicare, an individual who knowingly and willfully—

(i) Completes a material and false statement in a patient assessment is subject to a civil money penalty of not more than $1,000 as adjusted annually under 45 CFR part 102 for each assessment; or

(ii) Causes another individual to complete a material and false statement in a patient assessment is subject to a civil money penalty of not more than $5,000 as adjusted annually under 45 CFR part 102 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

[66 FR 41388, Aug. 7, 2001, as amended at 81 FR 61562, Sept. 6, 2016]

§ 412.614 Transmission of patient assessment data.

(a) *Data format—General rule.* The inpatient rehabilitation facility must encode and transmit data for each inpatient—

(1) Using the computerized version of the patient assessment instrument available from us; or

(2) Using a computer program(s) that conforms to our standard electronic record layout, data specifications, and data dictionary, includes the required patient assessment instrument data set, and meets our other specifications.

(b) *How to transmit data.* The inpatient rehabilitation facility must—

(1) Electronically transmit complete, accurate, and encoded data from the patient assessment instrument for each inpatient to our patient data system in accordance with the data format specified in paragraph (a) of this section; and

(2) Transmit data using electronic communications software that provides a direct telephone connection from the inpatient rehabilitation facility to the our patient data system.

(c) *Transmission dates.* The inpatient rehabilitation facility must transmit both the admission patient assessment and the discharge patient assessments at the same time to the our patient data system by the 7th calendar day in the period beginning with the applicable patient assessment instrument encoding date specified in § 412.610(d).

(d) *Failure to submit complete and timely IRF–PAI data, as required under paragraph (c) of this section*—(1) *Medicare Part-A fee-for-service.* (i) A given Medicare Part-A fee-for-service IRF claim will not be accepted and processed for payment until a corresponding IRF–PAI has been received and accepted by CMS.

(ii) [Reserved]

(2) *Medicare Part C (Medicare Advantage) data.* Failure of the inpatient rehabilitation facility to transmit all of the required patient assessment instrument data for its Medicare Part C (Medicare Advantage) patients to our patient data system in accordance with the transmission timeline in paragraph (c) of this section will result in a forfeiture of the facility's ability to have any of its Medicare Part C (Medicare Advantage) data used in the calculations for determining the facility's compliance with the regulations in § 412.29(b)(1).

(3) *All other payer data.* Failure of the inpatient rehabilitation facility to transmit all of the required patient assessment instrument data for all other patients, regardless of payer, to our patient data system in accordance with the transmission timeline in paragraph (c) of this section will result in a forfeiture of the facility's ability to have any of its other payer data used in the calculations for determining the facility's compliance with the regulations in § 412.29(b)(1).

(e) *Exemption to the consequences for transmitting the IRF–PAI data late for Medicare Part C (Medicare Advantage) patients and all other patients, regardless of payer.* CMS may waive the consequences of failure to submit complete and timely IRF–PAI data specified in paragraph (d) of this section when, due to an extraordinary situation that is beyond the control of an inpatient rehabilitation facility, the inpatient rehabilitation facility is unable to transmit the patient assessment data in accordance with paragraph (c) of this section. Only CMS can determine if a situation encountered by an inpatient rehabilitation facility is extraordinary and qualifies as a situation for waiver of the forfeiture specified in paragraphs (d)(2) or (3) of this section. An extraordinary situation may be due to, but is not limited to, fires, floods, earthquakes, or similar unusual events that inflect extensive damage to an inpatient facility. An extraordinary situation may be one that produces a data transmission problem that is beyond the control of the inpatient rehabilitation facility, as well as other situations determined by CMS to

be beyond the control of the inpatient rehabilitation facility. An extraordinary situation must be fully documented by the inpatient rehabilitation facility.

[66 FR 41388, Aug. 7, 2001, as amended at 68 FR 45699, Aug. 1, 2003; 74 FR 39811, Aug. 7, 2009; 82 FR 36304, Aug. 3, 2017; 87 FR 47091, Aug. 1, 2022]

§ 412.616 Release of information collected using the patient assessment instrument.

(a) *General.* An inpatient rehabilitation facility may release information from the patient assessment instrument only as specified in § 482.24(b)(3) of this chapter.

(b) *Release to the inpatient rehabilitation facility's agent.* An inpatient rehabilitation facility may release information that is patient-identifiable to an agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes specified in the contract and only to the extent the facility itself is permitted to do so under paragraph (a) of this section.

§ 412.618 Assessment process for interrupted stays.

For purposes of the patient assessment process, if any patient has an interrupted stay, as defined under § 412.602, the following applies:

(a) *Assessment requirements.* (1) The initial case-mix group classification from the admission assessment remains in effect (that is, no new admission assessment is performed).

(2) When the patient has completed his or her entire rehabilitation episode stay, a discharge assessment must be performed.

(b) *Recording and encoding of data.* The clinician must record the interruption of the stay on the patient assessment instrument.

(c) If the interruption in the stay occurs during the admission assessment time period, the assessment reference date, completion date, and encoding date for the admission assessment are advanced by the same number of calendar days as the length of the patient's interruption in the stay.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 74 FR 39811, Aug. 7, 2009; 87 FR 47091, Aug. 1, 2022]

§ 412.620 Patient classification system.

(a) *Classification methodology.* (1) A patient classification system is used to classify patients in inpatient rehabilitation facilities into mutually exclusive case-mix groups.

(2) For purposes of this subpart, case-mix groups are classes of Medicare patient discharges by functional-related groups that are based on a patient's impairment, age, comorbidities, functional capabilities, and other factors that may improve the ability of the functional-related groups to estimate variations in resource use.

(3) Data from admission assessments under § 412.610(c)(1) are used to classify a Medicare patient into an appropriate case-mix group.

(4) Data from the discharge assessment under § 412.610(c)(2) are used to determine the weighting factors under paragraph (b)(4) of this section.

(b) *Weighting factors*—(1) *General.* An appropriate weight is assigned to each case-mix group that measures the relative difference in facility resource intensity among the various case-mix groups.

(2) *Short-stay outliers.* We will determine a weighting factor or factors for patients that are discharged and not transferred (as defined in § 412.602) within a number of days from admission as specified by us.

(3) *Patients who expire.* We will determine a weighting factor or factors for patients who expire within a number of days from admission as specified by us.

(4) *Comorbidities.* We will determine a weighting factor or factors to account for the presence of a comorbidity, as defined in § 412.602, that is relevant to resource use in the classification system.

(c) *Revision of case-mix group classifications and weighting factors.* We may periodically adjust the case-mix groups and weighting factors to reflect changes in—

(1) Treatment patterns;

(2) Technology;

(3) Number of discharges; and

(4) Other factors affecting the relative use of resources.

§ 412.622 Basis of payment.

(a) *Method of payment.* (1) Under the prospective payment system, inpatient rehabilitation facilities receive a predetermined amount per discharge for inpatient services furnished to Medicare Part A fee-for-service beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate, including adjustments described in § 412.624 and, if applicable, during a transition period, on a blend of the Federal payment rate and the facility-specific payment rate described in § 412.626.

(3) *IRF coverage criteria.* In order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation that the patient meets all of the following requirements at the time of the patient's admission to the IRF—

(i) Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge during the Public Health Emergency, as defined in § 400.200 of this chapter, requires the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.

(ii) Except during the emergency period described in section 1135(g)(1)(B) of the Act, generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy per week. Benefit from this intensive rehabilitation therapy program is demonstrated by measurable improvement that will be of practical value to the patient in improving the patient's functional capacity or adaptation to impairments. The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF.

(iii) Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge during the Public Health Emergency, as defined in § 400.200 of this chapter, is sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation therapy program that is described in paragraph (a)(3)(ii) of this section.

(iv) Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge during the Public Health Emergency, as defined in § 400.200 of this chapter, requires physician supervision by a rehabilitation physician. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process, except that during a Public Health Emergency, as defined in § 400.200 of this chapter, such visits may be conducted using telehealth services (as defined in section 1834(m)(4)(F) of the Act). Beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law.

(4) *Documentation.* Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute

care hospital capacity in a state (or region, as applicable) that is experiencing a surge during the Public Health Emergency, as defined in §400.200 of this chapter, to document that each patient for whom the IRF seeks payment is reasonably expected to meet all of the requirements in paragraph (a)(3) of this section at the time of admission, the patient's medical record at the IRF must contain the following documentation—

(i) A comprehensive preadmission screening that meets all of the following requirements—

(A) It is conducted by a licensed or certified clinician(s) designated by a rehabilitation physician within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted in person or by telephone to update the patient's medical and functional status within the 48 hours immediately preceding the IRF admission and is documented in the patient's medical record.

(B) It includes a detailed and comprehensive review of each patient's condition and medical history, including the patient's level of function prior to the event or condition that led to the patient's need for intensive rehabilitation therapy, expected level of improvement, and the expected length of time necessary to achieve that level of improvement; an evaluation of the patient's risk for clinical complications; the conditions that caused the need for rehabilitation; the treatments needed (that is, physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics); and anticipated discharge destination.

(C) It serves as the basis for the initial determination of whether or not the patient meets the requirements for an IRF admission to be considered reasonable and necessary in paragraph (a)(3) of this section.

(D) It is used to inform a rehabilitation physician who reviews and documents his or her concurrence with the findings and results of the preadmission screening prior to the IRF admission.

(E) It is retained in the patient's medical record at the IRF.

(ii) An individualized overall plan of care for the patient that meets all of the following requirements—

(A) It is developed by a rehabilitation physician with input from the interdisciplinary team within 4 days of the patient's admission to the IRF.

(B) It is retained in the patient's medical record at the IRF.

(5) *Interdisciplinary team approach to care.* Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge during the Public Health Emergency, as defined in §400.200 of this chapter, in order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, the patient must require an interdisciplinary team approach to care, as evidenced by documentation in the patients' medical record of weekly interdisciplinary team meetings that meet all of the following requirements—

(i) The team meetings are led by a rehabilitation physician and further consist of a registered nurse with specialized training or experience in rehabilitation; a social worker or case manager (or both); and a licensed or certified therapist from each therapy discipline involved in treating the patient. All team members must have current knowledge of the patient's medical and functional status. The rehabilitation physician may lead the interdisciplinary team meeting remotely via a mode of communication such as video or telephone conferencing.

(ii) The team meetings occur at least once per week throughout the duration of the patient's stay to implement appropriate treatment services; review the patient's progress toward stated rehabilitation goals; identify any problems that could impede progress towards those goals; and, where necessary, reassess previously established goals in light of impediments, revise the treatment plan in light of new goals, and monitor continued progress toward those goals.

(iii) The results and findings of the team meetings, and the concurrence by the rehabilitation physician with those

results and findings, are retained in the patient's medical record.

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as described in subpart G of part 409 of this subchapter) for inpatient operating and capital-related costs associated with furnishing Medicare covered services in an inpatient rehabilitation facility, but not for the cost of an approved medical education program described in §§ 413.75 and 413.85 of this chapter.

(2) In addition to payments based on prospective payment rates, inpatient rehabilitation facilities receive payments for the following:

(i) Bad debts of Medicare beneficiaries, as provided in § 413.89 of this chapter; and

(ii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

(c) *Definitions.* As used in this section—

Rehabilitation physician means a licensed physician who is determined by the IRF to have specialized training and experience in inpatient rehabilitation.

State (or region, as applicable) that is experiencing a surge means a state (or region, as applicable) that is in phase 1 of the President's Guidelines for Opening Up America Again (*https://www.whitehouse.gov/openingamerica/*), specifically, a state (or region, as applicable) that satisfies all of the following, as determined by applicable state and local officials:

(i) All vulnerable individuals continue to shelter in place.

(ii) Individuals continue social distancing.

(iii) Individuals avoid socializing in groups of more than 10.

(iv) Non-essential travel is minimized.

(v) Visits to senior living facilities and hospitals are prohibited.

(vi) Schools and organized youth activities remain closed.

Week means a period of 7 consecutive calendar days beginning with the date of admission to the IRF.

[66 FR 41388, Aug. 7, 2001, as amended at 70 FR 47952, Aug. 15, 2005; 74 FR 39811, Aug. 7, 2009; 83 FR 38573,Aug. 6, 2018; 84 FR 39172, Aug. 8, 2019; 85 FR 19287, Apr. 6, 2020; 85 FR 27622, May 8, 2020; 85 FR 48462, Aug. 10, 2020; 85 FR 59023, Sept. 18, 2020]

§ 412.624 Methodology for calculating the Federal prospective payment rates.

(a) *Data used.* To calculate the prospective payment rates for inpatient hospital services furnished by inpatient rehabilitation facilities, we use—

(1) The most recent Medicare data available, as of the date of establishing the inpatient rehabilitation facility prospective payment system, to estimate payments for inpatient operating and capital-related costs made under part 413 of this subchapter;

(2) An appropriate wage index to adjust for area wage differences;

(3) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient rehabilitation services; and

(4) Patient assessment data described in § 412.606 and other data that account for the relative resource utilization of different patient types.

(b) *Determining the average costs per discharge for fiscal year 2001.* We determine the average inpatient operating and capital costs per discharge for which payment is made to each inpatient rehabilitation facility using the available data specified under paragraph (a)(1) of this section. The cost per discharge is adjusted to fiscal year 2001 by an increase factor, described in paragraph (a)(3) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year through the midpoint of fiscal year 2001.

(c) *Determining the Federal prospective payment rates*—(1) *General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the standard payment conversion factor. The standard payment conversion factor is a standardized payment amount based on

average costs from a base year that reflects the combined aggregate effects of the weighting factors, various facility and case level adjustments, and other adjustments.

(2) *Update the cost per discharge.* CMS applies the increase factor described in paragraph (a)(3) of this section to the facility's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for fiscal year 2002. Based on the updated cost per discharge, CMS estimates the payments that would have been made to the facility for fiscal year 2002 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Computation of the standard payment conversion factor.* The standard payment conversion factor is computed as follows:

(i) *For fiscal year 2002.* Based on the updated costs per discharge and estimated payments for fiscal year 2002 determined in paragraph (c)(2) of this section, CMS computes a standard payment conversion factor for fiscal year 2002, as specified by CMS, that reflects, as appropriate, the adjustments described in paragraph (d) of this section.

(ii) *For fiscal years after 2002.* The standard payment conversion factor for fiscal years after 2002 will be the standardized payments for the previous fiscal year updated by the increase factor described in paragraph (a)(3) of this section, including adjustments described in paragraph (d) of this section as appropriate.

(4) Applicable increase factor for FY 2014 and for subsequent FY. Subject to the provisions of paragraphs (c)(4)(i) and (c)(4)(ii) of this section, the applicable increase factor for FY 2014 and for subsequent years for updating the standard payment conversion factor is the increase factor described in paragraph (a)(3) of this section, including adjustments described in paragraph (d) of this section as appropriate.

(i) In the case of an IRF that is paid under the prospective payment system specified in §412.1(a)(3) that does not submit quality data to CMS in accordance with §412.634, the applicable increase factor specified in paragraph (a)(3) of this section, after application of subparagraphs (C)(iii) and (D) of section 1886(j)(3) of the Act, is reduced by 2 percentage points.

(ii) Any reduction of the increase factor will apply only to the fiscal year involved and will not be taken into account in computing the applicable increase factor for a subsequent fiscal year.

(iii) The 2 percentage point reduction described in paragraph (c)(4)(i) of this section may result in the applicable increase factor specified in paragraph (a)(3) of this section being less than 0.0 for a fiscal year, and may result in payment rates under the prospective payment system specified in §412.1(a)(3) for a fiscal year being less than such payment rates for the preceding fiscal year.

(5) *Determining the Federal prospective payment rate for each case-mix group.* The Federal prospective payment rates for each case-mix group is the product of the weighting factors described in §412.620(b) and the standard payment conversion factor described in paragraph (c)(3) of this section.

(d) *Adjustments to the standard payment conversion factor.* The standard payment conversion factor described in paragraph (c)(3) of this section will be adjusted for the following:

(1) *Outlier payments.* CMS determines a reduction factor equal to the estimated proportion of additional outlier payments described in paragraph (e)(5) of this section.

(2) *Budget neutrality.* CMS adjusts the Federal prospective payment rates for fiscal year 2002 so that aggregate payments under the prospective payment system, excluding any additional payments associated with elections not to be paid under the transition period methodology under §412.626(b), are estimated to equal the amount that would have been made to inpatient rehabilitation facilities under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Coding and classification changes.* CMS adjusts the standard payment conversion factor for a given year if CMS determines that revisions in case-mix classifications or weighting factors for a previous fiscal year (or estimates that those revisions for a future

fiscal year) did result in (or would otherwise result in) a change in aggregate payments that are a result of changes in the coding or classification of patients that do not reflect real changes in case-mix.

(4) *Payment adjustment for Federal fiscal year 2006 and applicable Federal fiscal years.* CMS adjusts the standard payment conversion factor based on any updates to the adjustments specified in paragraph (e)(2), (3), (4) and (6), of this section, and to any revision specified in § 412.620(c) by a factor as specified by the Secretary.

(e) *Calculation of the adjusted Federal prospective payment.* For each discharge, an inpatient rehabilitation facility's Federal prospective payment is computed on the basis of the Federal prospective payment rate that is in effect for its cost reporting period that begins in a Federal fiscal year specified under paragraph (c) of this section. A facility's Federal prospective payment rate will be adjusted, as appropriate, to account for area wage levels, payments for outliers and transfers, and for other factors as follows:

(1) *Adjustment for area wage levels.* The labor portion of a facility's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index.

(i) The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in § 412.602.

(ii) Starting on October 1, 2022, CMS applies a cap on decreases to the wage index such that the wage index applied to an IRF is not less than 95 percent of the wage index applied to that IRF in the prior FY.

(iii) Adjustments or updates to the wage data used to adjust a facility's Federal prospective payment rate under paragraph (e)(1) of this section will be made in a budget neutral manner. CMS determines a budget neutral wage adjustment factor, based on any adjustment or update to the wage data, to apply to the standard payment conversion factor.

(2) *Adjustments for low-income patients.* We adjust the Federal prospective payment, on a facility basis, for the proportion of low-income patients that receive inpatient rehabilitation services as determined by us.

(3) *Adjustments for rural areas.* We adjust the Federal prospective payment by a factor, as specified by us for facilities located in rural areas, as defined in § 412.602.

(4) *Adjustments for teaching hospitals.* (i) *General.* For discharges on or after October 1, 2005, CMS adjusts the Federal prospective payment on a facility basis by a factor as specified by CMS for facilities that are teaching institutions or units of teaching institutions.

(A) An IRF's teaching adjustment is based on the ratio of the number of full-time equivalent residents training in the IRF divided by the facility's average daily census.

(B) As described in § 412.105(f)(1)(iii)(A), residents with less than full-time status are counted as partial full time equivalent based on the proportion of time assigned to the inpatient rehabilitation facility compared to the total time necessary to fill a residency slot. Residents rotating to more than one hospital or non-hospital setting will be counted in proportion to the time they are assigned to inpatient rehabilitation facility compared to the total time worked in all locations. An inpatient rehabilitation facility cannot claim time spent by the resident at another inpatient rehabilitation facility or hospital.

(C) Except as described in paragraph (e)(4)(i)(D) of this section, the actual number of current year full-time equivalent residents used in calculating the teaching adjustment is limited to the number of full-time equivalent residents in the IRF's final settled cost report for the most recent cost reporting period ending on or before November 15, 2004 (base year).

(D) If the inpatient rehabilitation facility first begins training residents in a new approved graduate medical education program after November 15, 2004, the number of full-time equivalent residents determined under paragraph (e)(4)(i)(C) of this section may be adjusted using the method described in § 413.79(e)(1)(i).

(E) The teaching adjustment is made on a claim basis as an interim payment, and the final payment in full for

the claim is made during the final settlement of the cost report.

(ii) *Closure of an IRF or IRF residency training program.* (A) *Closure of an IRF.* For cost reporting periods beginning on or after October 1, 2011, an IRF may receive a temporary adjustment to its FTE cap to reflect displaced residents added because of another IRFs closure if the IRF meets the following criteria:

(*1*) The IRF is training additional displaced residents from an IRF that closed on or after October 1, 2011.

(*2*) No later than 60 days after the IRF begins to train the displaced residents, the IRF submits a request to its Medicare contractor for a temporary adjustment by identifying the displaced residents who have come from the closed IRF and have caused the IRF to exceed its cap, and specifies the length of time the adjustment is needed.

(B) *Closure of an IRF's residency training program.* If an IRF that closes its residency training program on or after October 1, 2011, agrees to temporarily reduce its FTE cap according to the criteria specified in paragraph (e)(4)(ii)(A)(*2*) of this section, another IRF(s) may receive a temporary adjustment to its FTE cap to reflect displaced residents added because of the closure of the residency training program if the criteria specified in paragraph (e)(4)(ii)(A)(*1*) of this section are met.

(*1*) *Receiving IRF(s).* For cost reporting periods beginning on or after October 1, 2011, an IRF may receive a temporary adjustment to its FTE cap to reflect displaced residents added because of the closure of another IRF's residency training program if the IRF is training additional displaced residents from the residency training program of an IRF that closed a program; and if no later than 60 days after the IRF begins to train the displaced residents the IRF submits to its Medicare Contractor a request for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the displaced residents who have come from another IRF's closed program and have caused the IRF to exceed its cap, specifies the length of time the adjustment is needed, and submits to its Medicare Contractor a copy of the FTE reduction statement by the hospital that closed its program, as specified in paragraph (e)(4)(ii)(A)(*2*) of this section.

(*2*) *IRF that closed its program.* An IRF that agrees to train displaced residents who have been displaced by the closure of another IRF's program may receive a temporary FTE cap adjustment only if the hospital with the closed program temporarily reduces its FTE cap based on the FTE of displaced residents in each program year training in the program at the time of the programs closure. This yearly reduction in the FTE cap will be determined based on the number of those displaced residents who would have been training in the program during that year had the program not closed. No later than 60 days after the displaced residents who were in the hospital that closed its program(s) begin training at another hospital must submit to its Medicare Contractor a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the IRF training the displaced residents to obtain a temporary adjustment to its cap; identifies the displaced residents who were in the training at the time of the program's closure; identifies the IRFs to which the displaced residents are transferring once the program closes; and specifies the reduction for the applicable program years.

(5) *Adjustment for high-cost outliers.* CMS provides for an additional payment to an inpatient rehabilitation facility if its estimated costs for a patient exceed a fixed dollar amount (adjusted for area wage levels and factors to account for treating low-income patients, for rural location, and for teaching programs) as specified by CMS. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will be subject to the adjustments at §412.84(i), except that CMS calculates a single overall (combined operating and capital) cost-to-charge

ratio and national averages that will be used instead of statewide averages. Effective for discharges occurring on or after October 1, 2003, additional payments made under this section will also be subject to adjustments at § 412.84(m), except that CMS calculates a single overall (combined operating and capital) cost-to-charge ratio.

(6) *Adjustments for certain facilities geographically redesignated in FY 2006*— (i) *General.* For a facility defined as an urban facility under § 412.602 in FY 2006 that was previously defined as a rural facility in FY 2005 as the term rural was defined in FY 2005 under § 412.602 and whose payment, after applying the adjustment under this paragraph, will be lower only because of being defined as an urban facility in FY 2006 and it no longer qualified for the rural adjustment under § 412.624(e)(3) in FY 2006, CMS will adjust the facility's payment using the following method:

(A) For discharges occurring on or after October 1, 2005, and on or before September 30, 2006, the facility's payment will be increased by an adjustment of two thirds of its prior FY 2005 19.14 percent rural adjustment.

(B) For discharges occurring on or after October 1, 2006, and on or before September 30, 2007, the facility's payment will be increased by an adjustment of one third of its FY 2005 19.14 percent rural adjustment.

(ii) *Exception.* For discharges occurring on or after October 1, 2005 and on or before September 30, 2007, facilities whose payments, after applying the adjustment under this paragraph (e)(7)(i) of this section, will be higher because of being defined as an urban facility in FY 2006 and no longer being qualified for the rural adjustment under § 412.624(e)(3) in FY 2006, CMS will adjust the facility's payment by a portion of the applicable additional adjustment described in paragraph (e)(6)(i)(A) and (B) of this section as determined by us.

(f) *Special payment provision for patients that are transferred.* (1) A facility's Federal prospective payment will be adjusted to account for a discharge of a patient who—

(i) Is transferred from the inpatient rehabilitation facility to another site of care, as defined in § 412.602; and

(ii) Stays in the facility for a number of days that is less than the average length of stay for nontransfer cases in the case-mix group to which the patient is classified.

(2) We calculate the adjusted Federal prospective payment for patients who are transferred in the following manner:

(i) By dividing the Federal prospective payment by the average length of stay for nontransfer cases in the case-mix group to which the patient is classified to equal the payment per day.

(ii) By multiplying the payment per day under paragraph (f)(2)(i) of this section by the number of days the patient stayed in the facility prior to being discharged to equal the per day payment amount.

(iii) By multiplying the payment per day under paragraph (f)(2)(i) by 0.5 to equal an additional one half day payment for the first day of the stay before the discharge.

(iv) By adding the per day payment amount under paragraph (f)(2)(ii) and the additional one-half day payment under paragraph (f)(2)(iii) to equal the unadjusted payment amount.

(v) By applying the adjustment described in paragraphs (e)(1), (2), (3), (4), and (6) of this section to the unadjusted payment amount determined in paragraph (f)(2)(iv) of this section to equal the adjusted transfer payment amount and making a payment in accordance with paragraph (e)(5) of this section, if applicable.

(g) *Special payment provision for interrupted stays.* When a patient in an inpatient rehabilitation facility has one or more interruptions in the stay, as defined in § 412.602 and as indicated on the patient assessment instrument in accordance with § 412.618(b), we will make payments in the following manner:

(1) *Patient is discharged and returns on the same day.* Payment for a patient who is discharged and returns to the same inpatient rehabilitation facility on the same day will be the adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in § 412.618(a)(1). Payment for a patient who is discharged and returns to the same inpatient rehabilitation facility on the same day will only be

made to the inpatient rehabilitation facility.

(2) *Patient is discharged and does not return by the end of the same day.* Payment for a patient who is discharged and does not return on the same day but does return to the same inpatient rehabilitation facility by or on midnight of the third day, defined as an interrupted stay under §412.602, will be—

(i) The adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in §412.618(a)(1) made to the inpatient rehabilitation facility; and

(ii) If the reason for the interrupted patient stay is to receive inpatient acute care hospital services, an amount based on the prospective payment systems described in §412.1(a)(1) made to the acute care hospital.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002; 68 FR 45700, Aug. 1, 2003; 70 FR 47952, Aug. 15, 2005; 71 FR 48408, Aug. 18, 2006; 72 FR 44312, Aug. 7, 2007; 76 FR 47892, Aug. 5, 2011; 82 FR 36305, Aug. 3, 2017; 83 FR 38573, Aug. 6, 2018; 87 FR 47091, Aug. 1, 2022]

§412.626 Transition period.

(a) *Duration of transition period and proportion of the blended transition rate.* (1) Except for a facility that makes an election under paragraph (b) of this section, for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, an inpatient rehabilitation facility receives a payment comprised of a blend of the adjusted Federal prospective payment, as determined under §412.624(e) or §412.624(f) and a facility-specific payment as determined under paragraph (a)(2) of this section.

(i) For cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, payment is based on 33⅓ percent of the facility-specific payment and 66⅔ percent of the adjusted FY 2002 Federal prospective payment.

(ii) For cost reporting periods beginning on or after October 1, 2002, payment is based entirely on the adjusted Federal prospective payment.

(2) *Calculation of the facility-specific payment.* The facility-specific payment is equal to the payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility's Medicare fiscal intermediary calculates the facility-specific payment for inpatient operating costs and capital-related costs in accordance with part 413 of this chapter.

(b) *Election not to be paid under the transition period methodology.* An inpatient rehabilitation facility may elect a payment that is based entirely on the adjusted Federal prospective payment for cost reporting periods beginning before fiscal year 2003 without regard to the transition period percentages specified in paragraph (a)(1)(i) of this section.

(1) *General requirement.* An inpatient rehabilitation facility will be required to request the election under this paragraph (b) within 30 days of its first cost reporting period for which payment is based on the inpatient rehabilitation facility prospective payment system for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002.

(2) *Notification requirement to make election.* The request by the inpatient rehabilitation facility to make the election under this paragraph (b) must be made in writing to the Medicare fiscal intermediary. The intermediary must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the 30th day before the cost reporting period begins will not be approved. If the 30th day before the cost reporting period begins falls on a day that the postal service or other delivery sources are not open for business, the inpatient rehabilitation facility is responsible for allowing sufficient time for the delivery of the request before the deadline. If an inpatient rehabilitation facility's request is not received timely or is otherwise not approved, payment will be based on the transition period rate specified in paragraph (a)(1)(i) of this section.

[66 FR 41388, Aug. 7, 2001, as amended at 67 FR 44077, July 1, 2002]

§ 412.628 Publication of the Federal prospective payment rates.

We publish information pertaining to the inpatient rehabilitation facility prospective payment system effective for each fiscal year in the FEDERAL REGISTER. This information includes the unadjusted Federal payment rates, the patient classification system and associated weighting factors, and a description of the methodology and data used to calculate the payment rates. This information is published on or before August 1 prior to the beginning of each fiscal year.

§ 412.630 Limitation on review.

Administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

[78 FR 47934, Aug. 6, 2013]

§ 412.632 Method of payment under the inpatient rehabilitation facility prospective payment system.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, an inpatient rehabilitation facility receives payment under this subpart for inpatient operating costs and capital-related costs for each discharge only following submission of a discharge bill.

(b) *Periodic interim payments*—(1) *Criteria for receiving periodic interim payments.* (i) An inpatient rehabilitation facility receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of § 413.64(h) of this subchapter.

(ii) To be approved for PIP, the inpatient rehabilitation facility must meet the qualifying requirements in § 413.64(h)(3) of this subchapter.

(iii) Payments to a rehabilitation unit are made under the same method of payment as the hospital of which it is a part as described in § 412.116.

(iv) As provided in § 413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

(2) *Frequency of payment.* For facilities approved for PIP, the intermediary estimates the inpatient rehabilitation facility's Federal prospective payments net of estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If the inpatient rehabilitation facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP.* (i) *Request by the inpatient rehabilitation facility.* Subject to the provisions of paragraph (b)(1)(iii) of this section, an inpatient rehabilitation facility receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the inpatient rehabilitation facility no longer meets the requirements of § 413.64(h) of this chapter.

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected

changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(e) *Accelerated payments*—(1) *General rule.* Upon request, an accelerated payment may be made to an inpatient rehabilitation facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient rehabilitation facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient rehabilitation facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient rehabilitation facility's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* An inpatient rehabilitation facility's request for an accelerated payment must be approved by the intermediary and us.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as inpatient rehabilitation facility bills are processed or by direct payment by the inpatient rehabilitation facility.

§ 412.634 Requirements under the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP).

(a) *Participation.*(1) For the FY 2018 payment determination and subsequent years, an IRF must begin reporting data under the IRF QRP requirements no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter, which designates the IRF as operating in the CMS designated data submission system.

(2) [Reserved]

(b) *Submission requirements.* (1) IRFs must submit to CMS data on measures specified under sections 1886(j)(7)(D), 1899B(c)(1), 1899B(d)(1) of the Act, and standardized patient assessment data required under section 1899B(b)(1) of the Act, as applicable. Such data must be submitted in the form and manner, and at a time, specified by CMS.

(2) CMS may remove a quality measure from the IRF QRP based on one or more of the following factors:

(i) Measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made;

(ii) Performance or improvement on a measure does not result in better patient outcomes;

(iii) A measure does not align with current clinical guidelines or practice;

(iv) The availability of a more broadly applicable (across settings, populations, or conditions) measure for the particular topic;

(v) The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic;

(vi) The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic;

(vii) The collection or public reporting of a measure leads to negative unintended consequences other than patient harm;

(viii) The costs associated with a measure outweigh the benefit of its continued use in the program.

(c) *Exception and Extension Requirements.* (1) An IRF may request and CMS may grant exceptions or extensions to

the measures data or standardized patient assessment data reporting requirements, for one or more quarters, when there are certain extraordinary circumstances beyond the control of the IRF.

(2) An IRF must request an exception or extension within 90 days of the date that the extraordinary circumstances occurred.

(3) Exception and extension requests must be submitted to CMS from the IRF by sending an email to *IRFQRPReconsiderations@cms.hhs.gov* containing all of the following information:

(i) IRF CMS Certification Number (CCN).

(ii) IRF Business Name.

(iii) IRF Business Address.

(iv) CEO or CEO-designated personnel contact information including name, telephone number, title, email address, and mailing address. (The address must be a physical address, not a post office box.)

(v) IRF's reason for requesting the exception or extension.

(vi) Evidence of the impact of extraordinary circumstances, including, but not limited to, photographs, newspaper, and other media articles.

(vii) Date when the IRF believes it will be able to again submit IRF QRP data and a justification for the proposed date.

(4) CMS may grant exceptions or extensions to IRFs without a request if it is determined that one or more of the following has occurred:

(i) An extraordinary circumstance affects an entire region or locale.

(ii) A systemic problem with one of CMS's data collection systems directly affected the ability of an IRF to submit data.

(5) Email is the only form of submission that will be accepted. Any reconsideration requests received through another channel will not be considered as a valid exception or extension request.

(d) *Reconsideration.* (1) IRFs that do not meet the requirement in paragraph (b) of this section for a program year will receive a written notification of non-compliance through at least one of the following methods: The CMS designated data submission system, the United States Postal Service, or via an email from the Medicare Administrative Contractor (MAC).

(2) Reconsideration requests must be submitted to CMS by sending an email to *IRFQRPReconsiderations@cms.hhs.gov* containing all of the following information:

(i) IRF CCN.

(ii) IRF Business Name.

(iii) IRF Business Address.

(iv) CEO or CEO-designated personnel contact information including name, telephone number, title, email address, and mailing address. (The address must be a physical address, not a post office box.)

(v) CMS identified reason(s) for non-compliance from the non-compliance letter.

(vi) Reason(s) for requesting reconsideration.

(3) The request for reconsideration must be accompanied by supporting documentation demonstrating compliance. This documentation must be submitted electronically as an attachment to the reconsideration request email. Any request for reconsideration that does not contain sufficient evidence of compliance with the IRF QRP requirements will be denied.

(4) Email is the only form of submission that will be accepted. Any reconsideration requests received through another channel will not be considered as a valid exception or extension request.

(5) CMS will notify the IRF, in writing, of its final decision regarding any reconsideration request through at least one of the following methods: CMS designated data submission system, the United States Postal Service, or via email from the CMS Medicare Administrative Contractor (MAC). CMS will grant a timely request for reconsideration, and reverse an initial finding of non-compliance, only if CMS determines that the IRF was in full compliance with the IRF QRP requirements for the applicable program year.

(6) An IRF may request, and CMS may grant, an extension to file a reconsideration request if, during the period to request a reconsideration as set forth in paragraph (d)(2) of this section,

the IRF was affected by an extraordinary circumstance beyond the control of the IRF (for example, a natural or man-made disaster). IRFs must submit the reconsideration extension request no later than 30 calendar days from the date of the written notification of noncompliance. The reconsideration extension request must be submitted to CMS via email to *IRFQRPReconsiderations@cms.hhs.gov*, and must contain the following information:

(i) The CCN for the IRF.

(ii) The business name of the IRF.

(iii) The business address of the IRF.

(iv) Contact information for the IRF's chief executive officer or designated personnel, including the name, telephone number, title, email address, and physical mailing address, which may not be a post office box.

(v) A statement of the reason for the request for the extension.

(vi) Evidence of the impact of the extraordinary circumstances, including, for example, photographs, newspaper articles, and other media.

(7) CMS will notify the IRF in writing of its final decision regarding its request for an extension to file a reconsideration of noncompliance request via an email from CMS.

(e) *Appeals.* (1) An IRF may appeal the decision made by CMS on its reconsideration request by filing with the Provider Reimbursement Review Board (PRRB) under 42 CFR part 405, subpart R.

(2) [Reserved]

(f) *Data Completion Thresholds.* (1) IRFs must meet or exceed two separate data completeness thresholds: One threshold set at 95 percent for completion of required quality measures data and standardized patient assessment data collected using the IRF–PAI submitted through the CMS designated data submission system; and a second threshold set at 100 percent for measures data collected and submitted using the CDC NHSN.

(2) These thresholds (95 percent for completion of required quality measures data and standardized patient assessment data on the IRF–PAI; 100 percent for CDC NHSN data) will apply to all measures and standardized patient assessment data requirements adopted into the IRF QRP.

(3) An IRF must meet or exceed both thresholds to avoid receiving a 2 percentage point reduction to their annual payment update for a given fiscal year, beginning with FY 2016 and for all subsequent payment updates.

[80 FR 47138, Aug. 6, 2015, as amended at 81 FR 52140, Aug. 5, 2016; 82 FR 36305, Aug. 3, 2017; 83 FR 38573, Aug. 6, 2018; 84 FR 39172, Aug. 8, 2019; 90 FR 37724, Aug. 5, 2025]

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END–STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES; PAYMENT FOR ACUTE KIDNEY INJURY DIALYSIS

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