under section 330 of the Public Health Service Act under a contract with the beneficiary of such a grant, and continues to meet the requirements to receive a grant under section 330 of the Public Health Service Act; or

(2) Based on the recommendation of the Public Health Service, was determined by CMS on or before April 7, 2000 to meet the requirements for receiving a grant under section 330 of the Public Health Service Act, and continues to meet such requirements.

(o) *Effective date of provider-based status*—(1) *General rule.* Provider-based status for a facility or organization is effective on the earliest date all of the requirements of this part have been met.

(2) *Inappropriate treatment as provider-based or not reporting material change.* Effective for any period on or after October 1, 2002 (or, in the case of facilities or organizations described in paragraph (b)(2) of this section, for cost reporting periods starting on or after July 1, 2003), if a facility or organization is found by CMS to have been inappropriately treated as provider-based under paragraph (j) of this section for those periods, or previously was determined by CMS to be provider-based but no longer qualifies as provider-based because of a material change occurring during those periods that was not reported to CMS under paragraph (c) of this section, CMS will not treat the facility or organization as provider-based for payment purposes until CMS has determined, based on documentation submitted by the provider, that the facility or organization meets all requirements for provider-based status under this part

[65 FR 18538, Apr. 7, 2000, as amended at 65 FR 58920, Oct. 3, 2000; 66 FR 1599, Jan. 9, 2001; 66 FR 59920, Nov. 30, 2001; 67 FR 50114, Aug. 1, 2002; 68 FR 46070, Aug. 4, 2003; 68 FR 53261, Sept. 9, 2003; 70 FR 47487, Aug. 12, 2005; 74 FR 44000, Aug. 27, 2009; 82 FR 38515, Aug. 14, 2017]

§ 413.70 Payment for services of a CAH.

(a) *Payment for inpatient services furnished by a CAH (other than services of distinct part units).* (1) Effective for cost reporting periods beginning on or after January 1, 2004, payment for inpatient services of a CAH, other than services of a distinct part unit of the CAH and other than the items included in the incentive payment described in paragraph (a)(5) of this section and subject to the adjustments described in paragraph (a)(6) of this section, is 101 percent of the reasonable costs of the CAH in providing CAH services to its inpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH inpatient services:

(i) Lesser of cost or charges;

(ii) Ceilings on hospital operating costs;

(iii) Reasonable compensation equivalent (RCE) limits for physician services to providers; and

(iv) The payment window provisions for preadmission services, specified in §412.2(c)(5) of this subchapter and §413.40(c)(2) of this part.

(2) Except as specified in paragraph (a)(3) of this section, payment to a CAH for inpatient services does not include any costs of physician services or other professional services to CAH inpatients, and is subject to the Part A hospital deductible and coinsurance, as determined under subpart G of part 409 of this chapter.

(3) If a CAH meets the criteria in §412.113(c) of this subchapter for passthrough of costs of anesthesia services furnished by qualified nonphysician anesthetists employed by the CAH or obtained under arrangements, payment to the CAH for the costs of those services is made in accordance with §412.113(c).

(4) Payment for inpatient services of distinct part psychiatric or rehabilitation units is described in paragraph (e) of this section.

(5) A qualifying CAH receives an incentive payment for the reasonable costs of purchasing certified EHR technology in a cost reporting period during a payment year as determined under §495.106 of this chapter in lieu of payment for such reasonable costs under paragraph (a)(1) of this section.

(6)(i) For cost reporting periods beginning in or after FY 2015, if a CAH is not a qualifying CAH for the applicable

EHR reporting period, as defined in §§ 495.4 and 495.106(a) of this chapter, then notwithstanding the percentage applicable in paragraph (a)(1) of this section, the reasonable costs of the CAH in providing CAH services to its inpatients are adjusted by the following applicable percentage:

(A) For cost reporting periods beginning in FY 2015, 100.66 percent.

(B) For cost reporting periods beginning in FY 2016, 100.33 percent.

(C) For cost reporting periods beginning in FY 2017 and each subsequent fiscal year, 100 percent.

(ii) The Secretary may on a case-by-case basis, exempt a CAH that is not a qualifying CAH from the application of the payment adjustment under paragraph (a)(6)(i) of this section if the Secretary determines that compliance with the requirement for being a meaningful user would result in a significant hardship for the CAH. In order to be considered for an exception, a CAH must submit an application demonstrating that it meets one or more of the criteria specified in this paragraph (a)(6) for the applicable payment adjustment year no later than November 30 after the close of the applicable EHR reporting period, or a later date specified by CMS. The Secretary may grant an exception for one or more of the following:

(A) During any 90-day period from the beginning of the cost reporting period that begins in the fiscal year before the payment adjustment year to November 30 after the end of 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.

(B) A CAH that faces extreme and uncontrollable circumstances that prevent it from becoming a meaningful EHR user during the payment adjustment year.

(C) The CAH 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 the purposes of this exception, the following CAHs are not considered new CAHs:

(*1*) A CAH 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 CAH that closes and subsequently reopens.

(*3*) A CAH that has been converted from an eligible hospital as defined at § 495.4 of this chapter.

(iii) *Exception for decertified EHR technology*. Beginning with the fiscal year 2018 payment adjustment year, the Secretary shall exempt a CAH that is not a qualifying CAH from the application of the payment adjustment under paragraph (a)(6)(i) 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 CAH has been decertified under ONC's Health IT Certification Program. In order to be considered for an exception, a CAH 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 CAH made a good faith effort to obtain another certified EHR technology for that EHR reporting period. Applications requesting this exception must be submitted by November 30 after the end of the applicable payment adjustment year, or a later date specified by CMS.

(iv) Exceptions granted under paragraphs (a)(6)(ii) and (iii) of this section are subject to annual renewal, but in no case may a CAH be granted such an exception for more than 5 years.

(7) There is no administrative or judicial review under section s1869 and 1878 of the Actor otherwise of the following:

(i) The methodology and standards for determining the amount of payment under paragraph (a)(5) of this section, including the calculation of reasonable costs under §495.106(c) of this chapter.

(ii) The methodology and standards for determining the amount of payment adjustments made under paragraph (a)(6).

(iii) The methodology and standards for determining a CAH to be a qualifying CAH under §495.106 of this chapter.

(iv) The methodology and standards for determining if the hardship exemption applies to a CAH under paragraph (a)(6)(ii) of this section.

(v) The specification of the cost reporting periods, payment years, or fiscal years as applied under this paragraph.

(b) *Payment for outpatient services furnished by CAH*—(1) *General.* (i) Unless the CAH elects to be paid for services to its outpatients under the method specified in paragraph (b)(3) of this section, the amount of payment for outpatient services of a CAH is determined under paragraph (b)(2) of this section.

(ii) Except as specified in paragraph (b)(6) of this section, payment to a CAH for outpatient services does not include any costs of physician services or other professional services to CAH outpatients.

(2) *Reasonable costs for facility services.* (i) Effective for cost reporting periods beginning on or after January 1, 2004, payment for outpatient services of a CAH is 101 percent of the reasonable costs of the CAH in providing CAH services to its outpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH outpatient services:

(A) Lesser of cost or charges; and

(B) RCE limits.

(ii) Payment to a CAH under paragraph (b)(2) of this section does not include any costs of physician services or other professional services to CAH outpatients and, other than for clinical diagnostic laboratory tests, is subject to the Part B deductible and coinsurance amounts as determined under §§410.152(k), 410.160, and 410.161 of this chapter.

(iii) [Reserved]

(3) *Election to be paid reasonable costs for facility services plus fee schedule for professional services.* (i) A CAH may elect to be paid for outpatient services in any cost reporting period beginning on or after July 1, 2004 under the method described in paragraphs (b)(3)(ii) and (b)(3)(iii) of this section.

(A)*(1) For cost reporting periods beginning before October 1, 2010.* The election must be made in writing, made on an annual basis, and delivered to the contractor or MAC servicing the CAH at least 30 days before the start of the cost reporting period for which the election is made. An election, once made for a cost reporting period, remains in effect for all of that period.

(2) For cost reporting periods beginning on or after October 1, 2010. If a CAH had elected the method specified in paragraph (b)(3)(i) of this section in its most recent cost reporting period beginning prior to October 1, 2010, that election remains in effect for all of that period and for all subsequent cost reporting periods, unless the CAH submits a termination request to the contractor or MAC servicing the CAH at least 30 days before the start of the next cost reporting period. However, for cost reporting periods beginning in October 2010 and November 2010, if a CAH wishes to terminate its previous election, the CAH must submit a termination request to the contractor or MAC servicing the CAH prior to December 1, 2010. If a CAH had no election in effect in its most recent preceding cost reporting period and chooses to elect the method specified in paragraph (b)(3)(i) of this section on or after October 1, 2010, the election must be made in writing and delivered to the contractor or MAC servicing the CAH at least 30 days before the start of the first cost reporting period for which the election is made. Once the election is made, it remains in effect for all of that period and for all subsequent cost reporting periods unless the CAH submits a termination request to the contractor or MAC servicing the CAH at

least 30 days before the start of the next cost reporting period.

(B) An election of the payment method specified under paragraph (b)(3)(i) of this section applies to all services furnished to outpatients by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with subpart F of part 424 of this chapter. If a physician or other practitioner does not reassign his or her billing rights to the CAH in accordance with subpart F of part 424 of this chapter, payment for the physician's or practitioner's services furnished to CAH outpatients will be made on a fee schedule or other applicable basis as specified in subpart B of part 414 of this subchapter.

(C) In the case of a CAH that made an election under this section before November 1, 2003, for a cost reporting period beginning before December 1, 2003, the rules in paragraph (b)(3)(i)(B) of this section are applicable to cost reporting periods beginning on or after July 1, 2001.

(D) An election made under paragraph (b)(3)(i) of this section is effective as provided for under paragraph (b)(3)(i)(A) or paragraph (b)(3)(i)(C) of this section and does not apply to an election that was terminated prior to the start of the cost reporting period for which it would otherwise apply.

(ii) If the CAH elects payment under this method, payment to the CAH for each outpatient visit will be the sum of the following:

(A) Effective for cost reporting periods beginning on or after January 1, 2004, for facility services not including any services for which payment may be made under paragraph (b)(3)(ii)(B) of this section, 101 percent of the reasonable costs of the services as determined under paragraph (b)(2)(i) of this section; and

(B) For professional services that are furnished by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with part 424, subpart F of this chapter, and that would otherwise be payable to the physician or other practitioner if the rights to bill for them had not been reassigned, 115 percent of the amounts that otherwise would be paid for the service if the CAH had not elected payment under this method. Effective for primary care services furnished by primary care practitioners (as defined in § 414.80(a)) and major surgical procedures furnished by general surgeons in health professional shortage areas (as defined in § 414.2) furnished on or after January 1, 2011 and before January 1, 2016, incentive payments specified under § 414.80 and § 414.67(b), respectively, of this title must not be included in determining payment made under this paragraph.

(iii) Payment to a CAH, other than for clinical diagnostic laboratory tests, is subject to the Part B deductible and coinsurance amounts, as determined under §§ 410.152(k), 410.160, and 410.161 of this chapter.

(4) *Costs of certain emergency room on-call providers.* (i) Effective for cost reporting periods beginning on or after October 1, 2001, the reasonable costs of outpatient CAH services under paragraph (b) of this section may include amounts for reasonable compensation and related costs for an emergency room physician who is on call but who is not present on the premises of the CAH involved, is not otherwise furnishing physicians' services, and is not on call at any other provider or facility. Effective for costs incurred for services furnished on or after January 1, 2005, the payment amount of 101 percent of the reasonable costs of outpatient CAH services may also include amounts for reasonable compensation and related costs for the following emergency room providers who are on call but who are not present on the premises of the CAH involved, are not otherwise furnishing physicians' services, and are not on call at any other provider or facility: physician assistants, nurse practitioners, and clinical nurse specialists.

(ii) For purposes of this paragraph (b)(4)—

(A) ''Amounts for reasonable compensation and related costs'' means all allowable costs of compensating emergency room physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on call to the extent that the costs are found to be reasonable under the rules specified in paragraph (b)(2) of this section and

the applicable sections of part 413. Costs of compensating these specified medical emergency room staff are allowable only if the costs are incurred under written contracts that require the physician, physician assistant, nurse practitioner, or clinical nurse specialist to come to the CAH when the physician's or other practitioner's presence is medically required.

(B) Effective for costs incurred on or after January 1, 2005, an ''emergency room physician, physician assistant, nurse practitioner, or clinical nurse specialist who is on call'' means a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care who is immediately available by telephone or radio contact, and is available onsite within the timeframes specified in § 485.618(d) of this chapter.

(5) *Costs of ambulance services.* (i)(A) Effective for services furnished on or after December 21, 2000 and on or before December 31, 2003, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity.

(B) Effective for cost reporting periods beginning on or after January 1, 2004 and on or before September 30, 2011, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is 101 percent of the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity.

(C) Effective for cost reporting periods beginning on or after October 1, 2011 and on or before September 30, 2019, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is 101 percent of the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH. If there is no provider or supplier of ambulance services located within a 35-mile drive of the CAH and there is an entity that is owned and operated by a CAH that is more than a 35-mile drive from the CAH, payment for ambulance services furnished by that entity is 101 percent of the reasonable costs of the entity in furnishing those services, but only if the entity is the closest provider or supplier of ambulance services to the CAH.

(D) Effective for cost reporting periods beginning on or after October 1, 2019, payment for ambulance services furnished by a CAH or by a CAH-owned and operated entity is 101 percent of the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH, excluding ambulance providers or suppliers that are not legally authorized to furnish ambulance services to transport individuals to or from the CAH. If there is no provider or supplier of ambulance services located within a 35-mile drive of the CAH and there is an entity that is owned and operated by a CAH that is more than a 35-mile drive from the CAH, payment for ambulance services furnished by that entity is 101 percent of the reasonable costs of the entity in furnishing those services, but only if the entity is the closest provider or supplier of ambulance services to the CAH.

(ii) For purposes of paragraph (b)(5) of this section, the distance between the CAH or the entity and the other provider or supplier of ambulance services will be determined as the shortest distance in miles measured over improved roads between the CAH or the entity and the site at which the vehicles of the closest provider or supplier of ambulance services are garaged. 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 will be considered to include the paved surface up to the front entrance of the hospital and the front entrance of the garage.

(6) If a CAH meets the criteria in § 412.113(c) of this subchapter for pass-through of costs of anesthesia services

furnished by nonphysician anesthetists employed by the CAH or obtained under arrangement, payment to the CAH for the costs of those services is made in accordance with § 412.113(c) of this chapter.

(7) *Payment for clinical diagnostic laboratory tests included as outpatient CAH services.* (i) Payment for clinical diagnostic laboratory tests is not subject to the Medicare Part B deductible and coinsurance amounts.

(ii) Subject to the provisions of paragraphs (b)(7)(iii) through (b)(7)(vi) of this section, payment to a CAH for clinical diagnostic laboratory tests will be made at 101 percent of reasonable costs of the services as determined in accordance paragraph (b)(2)(i) of this section.

(iii) For services furnished before July 1, 2009, payment to a CAH for clinical diagnostic laboratory tests will be made under paragraph (b)(7)(ii) of this section only if the individual is an outpatient of the CAH, as defined in § 410.2 of this chapter, and is physically present in the CAH at the time the specimen is collected.

(iv) Except as provided in paragraphs (b)(7)(iii) and (b)(7)(v) of this section, payment to a CAH for clinical diagnostic laboratory tests will be made under paragraph (b)(7)(ii) of this section only if the individual is an outpatient of the CAH, as defined in § 410.2 of this chapter, without regard to whether the individual is physically present in the CAH at the time the specimen is collected and at least one of the following conditions is met:

(A) The individual is receiving outpatient services in the CAH on the same day the specimen is collected; or

(B) The specimen is collected by an employee of the CAH.

(v) Notwithstanding paragraph (b)(7)(iv) of this section, payment for outpatient clinical diagnostic laboratory tests will not be made under paragraph (b)(7)(ii) of this section if the billing rules under § 411.15(p) of this chapter apply.

(vi) Payment for clinical diagnostic laboratory tests for which payment may not be made under paragraph (b)(7)(iii) or paragraph (b)(7)(iv) of this section will be made in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act.

(c) *Final payment based on cost report.* Final payment to the CAH for CAH facility services to inpatients and outpatients furnished during a cost reporting is based on a cost report for that period, as required under § 413.20(b).

(d) *Periodic interim payments.* Subject to the provisions of § 413.64(h), a CAH receiving payments under this section may elect to receive periodic interim payments (PIP) for Part A inpatient CAH services, effective for payments made on or after July 1, 2004. Payment is made biweekly under the PIP method unless the CAH requests a longer fixed interval (not to exceed one month) between payments. The biweekly interim payment amount is based on the total estimated Medicare payment (after estimated beneficiary deductibles and coinsurance) for the cost reporting period. Each payment is made 2 weeks after the end of a biweekly period of service, as described in § 413.64(h)(6). These PIP provisions are further described in § 413.64(h)(6). Under certain circumstances that are described in § 413.64(g), a CAH that is not receiving PIP may request an accelerated payment.

(e) *Payment for service of distinct part psychiatric and rehabilitation units of CAHS.* Payment for inpatient services of distinct part psychiatric units of CAHs—

(1) For cost reporting periods beginning before January 1, 2005, payment is made on a reasonable cost basis, subject to the provisions of § 413.40.

(2) For cost reporting periods beginning on or after January 1, 2005, payment is made in accordance with regulations governing inpatient psychiatric facilities at subpart N (§ 412.400 through § 412.432) of Part 412 of this subchapter.

(3) Payment for inpatient services of distinct part rehabilitation units of CAHs is made in accordance with regulations governing the inpatient rehabilitation facilities prospective payment system at subpart P (§ 412.600 through § 412.632) of part 412 of this subchapter.

[65 FR 47109, Aug. 1, 2000]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 413.70, see the List of CFR Sections Affected, which appears in the

Finding Aids section of the printed volume and at *www.govinfo.gov*.

§ 413.74 Payment to a foreign hospital.

(a) *Principle.* Section 1814(f) of the Act provides for the payment of emergency and nonemergency inpatient hospitals services furnished by foreign hospitals to Medicare beneficiaries. Subpart H of part 424 of this chapter, together with this section, specifies the conditions for payment.

(b) *Amount of payment.* Effective with admissions on or after January 1, 1980, the reasonable cost for services covered under the Medicare program furnished to beneficiaries by a foreign hospital will be equal to 100 percent of the hospital's customary charges (as defined in § 413.13(b)) for the services.

(c) *Submittal of claims.* The hospital must establish its customary charges for the services by submitting an itemized bill with each claim it files in accordance with its election under § 424.104 of this chapter.

(d) *Exchange rate.* Payment to the hospital will be subject to the official exchange rate on the date the patient is discharged and to the applicable deductible and coinsurance amounts described in §§ 409.80 through 409.83.

[51 FR 34793, Sept. 30, 1986, as amended at 51 FR 41351, Nov. 14, 1986; 53 FR 6648, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988; 71 FR 48141, Aug. 18, 2006]

Subpart F—Specific Categories of Costs

§ 413.75 Direct GME payments: General requirements.

(a) *Statutory basis and scope*—(1) *Basis.* This section and §§ 413.76 through 413.83 implement section 1886(h) of the Act by establishing the methodology for Medicare payment of the cost of direct graduate medical educational activities.

(2) *Scope.* This section and §§ 413.76 through 413.83 apply to Medicare payments to hospitals and hospital-based providers for the costs of approved residency programs in medicine, osteopathy, dentistry, and podiatry for cost reporting periods beginning on or after July 1, 1985.

(b) *Definitions.* For purposes of this section and §§ 413.76 through 413.83, the following definitions apply:

All or substantially all of the costs for the training program in the nonhospital setting means—

(1) Effective on or after January 1, 1999 and for cost reporting periods beginning before July 1, 2007, the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education (GME); and

(2) Effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010, at least 90 percent of the total of the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to nonpatient care direct GME activities.

Approved geriatric program means a fellowship program of one or more years in length that is approved by one of the national organizations listed in § 415.152 of this chapter under that respective organization's criteria for geriatric fellowship programs.

Approved medical residency program means a program that meets one of the following criteria:

(1) Is approved by one of the national organizations listed in § 415.152 of this chapter.

(2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(i) The Directory of Graduate Medical Education Programs published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications, 515 North State Street, Chicago, Illinois 60610; or

(ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties, and available from American Board of Medical Specialties, One Rotary Center, Suite 805, Evanston, Illinois 60201.

(3) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(4) Is a program that would be accredited except for the accrediting