

(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 § 413.86(g)(11) of this subchapter.

(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 §§ 413.86(d)(3)(i) through (d)(3)(v) 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 Sections Affected, which appears in the Finding

Aids section of the printed volume and on GPO Access.

§ 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) The number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others.

(iii) The hospital's location, in an urban or rural area, is determined in accordance with the definitions in § 412.62(f).

(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 covered 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 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 patient days that—

(A) Are associated with discharges that occur during that period; and

(B) Are furnished to patients entitled to Medicare Part A.

(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 which patients were eligible for Medicaid but not entitled to Medicare Part A, and 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) A patient is deemed eligible for Medicaid on a given day if the patient is eligible for medical assistance under an approved State Medicaid plan on such day, regardless of whether particular items or services were covered or paid under the State plan.

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

(iii) 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.

(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 dis-

proportionate 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.* (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, for discharges prior to 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. For discharges occurring on or after April 1, 2001, 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 15 percent and the hospital's disproportionate patient percentage.

(2) If the hospital's disproportionate patient percentage is greater than 19.3 percent and less than 30 percent, the payment adjustment factor is 5.25 percent.

(3) 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.

(B) If the hospital is classified as a sole community hospital, for discharges prior to April 1, 2001, the payment adjustment factor is 10 percent. For discharges occurring on or after April 1, 2001, the following applies:

(1) If the hospital's disproportionate patient percentage is less than 19.3 percent, the 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 equal to or greater than 19.3 percent and less than 30 percent, the payment adjustment factor is 5.25 percent.

(3) If the hospital's disproportionate patient percentage is equal to or greater than 30 percent the applicable payment adjustment factor is 10 percent.

(C) If the hospital is classified as both a rural referral center and a sole community hospital, the payment adjustment factor 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, the greater of the adjustments determined under paragraph (d)(2)(ii)(A) or (d)(2)(ii)(B) of this section.

(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, for discharges prior to April 1, 2001, the payment adjustment factor is 4 percent. For discharges occurring on or after April 1, 2001, 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.

(iii) If the hospital meets the criteria of paragraph (c)(1)(iii) of this section, the payment adjustment factor is as follows:

(A) For discharges occurring before April 1, 2001, 5 percent.

(B) For discharges occurring on or after April 1, 2001:

(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.

(iv) If the hospital meets the criteria of paragraph (c)(1)(iv) of this section, the payment adjustment factor is as follows:

(A) For discharges occurring before April 1, 2001, 4 percent.

(B) For discharges occurring on or after April 1, 2001:

(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.

(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.

[54 FR 36494, Sept. 1, 1989, as amended at 55 FR 14283, Apr. 17, 1990; 55 FR 15174, Apr. 20, 1990; 55 FR 32088, Aug. 7, 1990; 56 FR 573, Jan. 7, 1991; 56 FR 9633, Mar. 7, 1991; 57 FR 39824, Sept. 1, 1992; 60 FR 45848, Sept. 1, 1995; 62 FR 46029, Aug. 29, 1997; 63 FR 41004, July 31, 1998; 65 FR 3139, Jan. 20, 2000; 65 FR 47108, Aug. 1, 2000; 66 FR 32193, June 13, 2001; 66 FR 39934, Aug. 1, 2001; 67 FR 50112, Aug. 1, 2002]

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)