

(1) Matches the long descriptor of the category code established by CMS.

(2) Conforms to guidance issued by CMS relating to the definition of terms and other information in conjunction with the category descriptors and codes.

(g) *Limited period of payment for devices.* CMS limits the eligibility for a pass-through payment established under this section to a period of at least 2 years, but not more than 3 years beginning on the date that CMS establishes a category of devices.

(h) *Amount of pass-through payment.* Subject to any reduction determined under §419.62(b), the pass-through payment for a device is the hospital's charge for the device, adjusted to the actual cost for the device, minus the amount included in the APC payment amount for the device.

Subpart H—Transitional Corridors

SOURCE: 65 FR 18542, Apr. 7, 2000, unless otherwise noted. Redesignated at 66 FR 55856, Nov. 2, 2001.

§419.70 Transitional adjustment to limit decline in payment.

(a) *Before 2002.* Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished before January 1, 2002, for which the prospective payment system amount (as defined in paragraph (e) of this section) is—

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in paragraph (f) of this section), the amount of payment under this part is increased by 80 percent of the amount of this difference;

(2) At least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.71 and the pre-BBA amount exceeds the product of 0.70 and the prospective payment system amount;

(3) At least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.63 and the pre-BBA amount, exceeds the product of 0.60 and the PPS amount; or

(4) Less than 70 percent of the pre-BBA amount, the amount of payment under this part shall be increased by 21 percent of the pre-BBA amount.

(b) *For 2002.* Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished during 2002, for which the prospective payment system amount is—

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this part is increased by 70 percent of the amount of this difference;

(2) At least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.61 and the pre-BBA amount exceeds the product of 0.60 and the prospective payment system amount; or

(3) Less than 80 percent of the pre-BBA amount, the amount of payment under this part is increased by 13 percent of the pre-BBA amount.

(c) *For 2003.* Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished during 2003, for which the prospective payment system amount is—

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this part is increased by 60 percent of the amount of this difference; or

(2) Less than 90 percent of the pre-BBA amount, the amount of payment under this part is increased by 6 percent of the pre-BBA amount.

(d) *Hold harmless provisions—(1) Temporary treatment for small rural hospitals.* For covered hospital outpatient services furnished in a calendar year before January 1, 2004 for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by the amount of that difference if the hospital—

(i) Is located in a rural area as defined in §412.63(b) of this chapter or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act; and

(ii) Has 100 or fewer beds as defined in §412.105(b) of this chapter.

(2) *Permanent treatment for cancer hospitals and children's hospitals.* In the

case of a hospital described in § 412.23(d) or § 412.23(f) of this chapter for which the prospective payment system amount is less than the pre-BBA amount for covered hospital outpatient services, the amount of payment under this part is increased by the amount of this difference.

(e) *Prospective payment system amount defined.* In this paragraph, the term “prospective payment system amount” means, with respect to covered hospital outpatient services, the amount payable under this part for these services (determined without regard to this paragraph or any reduction in coinsurance elected under § 419.42), including amounts payable as copayment under § 419.41, coinsurance under section 1866(a)(2)(A)(ii) of the Act, and the deductible under section 1833(b) of the Act.

(f) *Pre-BBA amount defined—(1) General rule.* In this paragraph, the “pre-BBA amount” means, with respect to covered hospital outpatient services furnished by a hospital or a community mental health center (CMHC) in a year, an amount equal to the product of the reasonable cost of the provider for these services for the portions of the provider’s cost reporting period (or periods) occurring in the year and the base provider outpatient payment-to-cost ratio for the provider (as defined in paragraph (f)(2) of this section).

(2) *Base payment-to-cost-ratio defined.* For purposes of this paragraph, CMS shall determine these ratios as if the amendments to sections 1833(i)(3)(B)(i)(II) and 1833(n)(1)(B)(i) of the Act made by section 4521 of the BBA, to require that the full amount beneficiaries paid as coinsurance under section 1862(a)(2)(A) of the Act are taken into account in determining Medicare Part B Trust Fund payment to the hospital, were in effect in 1996. The “base payment-to-cost ratio” for a hospital or CMHC means the ratio of—

(i) The provider’s payment under this part for covered outpatient services furnished during the cost reporting period ending in 1996, including any payment for these services through cost-sharing described in paragraph (e) of this section; and

(ii) The reasonable cost of these services for this period.

(g) *Interim payments.* CMS makes payments under this paragraph to hospitals and CMHCs on an interim basis, subject to retrospective adjustments based on settled cost reports.

(h) *No effect on coinsurance.* No payment made under this section affects the unadjusted coinsurance amount or the coinsurance amount described in § 419.41.

(i) *Application without regard to budget neutrality.* The additional payments made under this paragraph—

(1) Are not considered an adjustment under § 419.43(f); and

(2) Are not implemented in a budget neutral manner.

[65 FR 18542, Apr. 7, 2000, as amended at 65 FR 67829, Nov. 13, 2000; 66 FR 59923, Nov. 30, 2001]

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