

§412.109

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for the hospital to apply for that review.

[55 FR 15175, Apr. 20, 1990; 55 FR 32088, Aug. 7, 1990, as amended at 55 FR 36070, Sept. 4, 1990; 57 FR 39824, Sept. 1, 1992; 58 FR 46339, Sept. 1, 1993; 58 FR 67350, Dec. 21, 1993; 59 FR 45400, Sept. 1, 1994; 62 FR 46030, Aug. 29, 1997; 62 FR 52034, Oct. 6, 1997; 65 FR 47048, Aug. 1, 2000; 66 FR 32194, June 13, 2001; 66 FR 39932, Aug. 1, 2001; 67 FR 50112, Aug. 1, 2002; 69 FR 49247, Aug. 11, 2004; 70 FR 47486, Aug. 12, 2005]

§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