

## §412.75

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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 and for subsequent years.* For Federal fiscal year 2003 and subsequent years, 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).

(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]

### §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).

(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 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 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 admin-

istrative 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

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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]

### **§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)(15).

(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.