

payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (e)(2) of this section a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period. If either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the intermediary must convert the discharges to a monthly figure and multiply this figure by 12 to estimate the total number of discharges for a 12-month cost reporting period.

(2) To qualify for a payment adjustment on the basis of a decrease in discharges, a sole community hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement—

(i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges, and the resulting effect on per discharge costs; and

(ii) Show that the decrease is due to circumstances beyond the hospital's control.

(3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105).

(i) In determining the adjustment amount, the intermediary considers—

(A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;

(B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and

(C) The length of time the hospital has experienced a decrease in utilization.

(ii) The intermediary makes its determination within 180 days from the date it receives the hospital's request and all other necessary information.

(iii) The intermediary determination is subject to review under subpart R of part 405 of this chapter.

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§ 412.96 Special treatment: Referral centers.

(a) *Criteria for classification as a referral center: Basic rule.* CMS classifies a hospital as a referral center only if the hospital is a Medicare participating acute care hospital and meets the applicable criteria of paragraph (b) or (c) of this section.

(b) *Criteria for cost reporting periods beginning on or after October 1, 1983.* The hospital meets either of the following criteria:

(1) The hospital is located in a rural area (as defined in subpart D of this part) and has the following number of beds, as determined under the provisions of § 412.105(b) available for use:

(i) Effective for discharges occurring before April 1, 1988, the hospital has 500 or more beds.

(ii) Effective for discharges occurring on or after April 1, 1988, the hospital has 275 or more beds during its most recently completed cost reporting period unless the hospital submits written documentation with its application that its bed count has changed since the close of its most recently completed cost reporting period for one or more of the following reasons:

(A) Merger of two or more hospitals.

§412.96

42 CFR Ch. IV (10-1-06 Edition)

(B) Reopening of acute care beds previously closed for renovation.

(C) Transfer to the prospective payment system of acute care beds previously classified as part of an excluded unit.

(D) Expansion of acute care beds available for use and permanently maintained for lodging inpatients, excluding beds in corridors and other temporary beds.

(2) The hospital shows that—(i) At least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the staff of the hospital; and

(ii) At least 60 percent of the hospital's Medicare patients live more than 25 miles from the hospital, and at least 60 percent of all the services that the hospital furnishes to Medicare beneficiaries are furnished to beneficiaries who live more than 25 miles from the hospital.

(c) *Alternative criteria.* For cost reporting periods beginning on or after October 1, 1985, a hospital that does not meet the criteria of paragraph (b) of this section is classified as a referral center if it is located in a rural area (as defined in subpart D of this part) and meets the criteria specified in paragraphs (c)(1) and (c)(2) of this section and at least one of the three criteria specified in paragraphs (c)(3), (c)(4), and (c)(5) of this section.

(1) *Case-mix index.* CMS sets forth national and regional case-mix index values in each year's annual notice of prospective payment rates published under §412.8(b). The methodology CMS uses to calculate these criteria is described in paragraph (h) of this section. The case-mix index value to be used for an individual hospital in the determination of whether it meets the case-mix index criteria is that calculated by CMS from the hospital's own billing records for Medicare discharges as processed by the fiscal intermediary and submitted to CMS. The hospital's case-mix index for discharges (not including discharges from units excluded from the prospective payment system under subpart B of this part) during the most recent Federal fiscal year that ended at least one year prior to the beginning of the cost reporting period for

which the hospital is seeking referral center status must be at least equal to—

(i) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the national or regional case-mix index value; or

(ii) For hospitals applying for rural referral center status for cost-reporting periods beginning on or after October 1, 1986, the national case-mix index value as established by CMS or the median case-mix index value for urban hospitals located in each region. In calculating the median case-mix index for each region, CMS excludes the case-mix indexes of hospitals receiving indirect medical education payments as provided in §412.105.

(2) *Number of discharges.* (i) CMS sets forth the national and regional number of discharges in each year's annual notice of prospective payment rates published under §412.8(b). The methodology CMS uses to calculate these criteria is described in paragraph (i) of this section. Except as provided in paragraph (c)(2)(ii) of this section for an osteopathic hospital, for the hospital's cost reporting period that began during the same fiscal year as the cost reporting periods used to compute the regional median discharges under paragraph (i) of this section, its number of discharges (not including discharges from units excluded from the prospective payments system under subpart B of this part or from newborn units) is at least equal to—

(A) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1985 and before October 1, 1986, the number of discharges under either the national or regional criterion; or

(B) For hospitals applying for rural referral center status for cost reporting periods beginning on or after October 1, 1986, 5,000 discharges or, if less, the median number of discharges for urban hospitals located in each region.

(ii) For cost reporting periods beginning on or after January 1, 1986, an osteopathic hospital, recognized by the American Osteopathic Healthcare Association (or any successor organization), that is located in a rural area

must have at least 3,000 discharges during its cost reporting period that began during the same fiscal year as the cost reporting periods used to compute the regional median discharges under paragraph (i) of this section to meet the number of discharges criterion.

(3) *Medical staff.* More than 50 percent of the hospital's active medical staff are specialists who meet one of the following conditions:

(i) Are certified as specialists by one of the Member Boards of the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists.

(ii) Have completed the current training requirements for admission to the certification examination of one of the Member Boards of the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists.

(iii) Have successfully completed a residency program in a medical specialty accredited by the Accreditation Council of Graduate Medical Education or the American Osteopathic Association.

(4) *Source of inpatients.* At least 60 percent of all its discharges are for inpatients who reside more than 25 miles from the hospital.

(5) *Volume of referrals.* At least 40 percent of all inpatients treated at the hospital are referred from other hospitals or from physicians not on the hospital's staff.

(d) *Payment to rural referral centers.* Effective for discharges occurring on or after April 1, 1988, and before October 1, 1994, a hospital that is located in a rural area and meets the criteria of paragraphs (b)(1), (b)(2) or (c) of this section is paid prospective payments for inpatient operating costs per discharge based on the applicable other urban payment rates as determined in accordance with § 412.63, as adjusted by the hospital's area wage index.

(e)-(f) [Reserved]

(g) *Hospital cancellation of referral center status.* (1) A hospital may at any time request cancellation of its status as a referral center and be paid prospective payments per discharge based on the applicable rural rate, as determined in accordance with subpart D of this part.

(2) The cancellation becomes effective no later than 30 days after the date the hospital submits its request.

(3) If a hospital requests that its referral center status be canceled, it may not be reclassified as a referral center unless it meets the qualifying criteria set forth in paragraph (a) of this section in effect at the time it reapplies.

(h) *Methodology for calculating case-mix index criteria.* CMS calculates the national and regional case-mix index value criteria as described in paragraphs (h)(1) through (h)(4) of this section.

(1) *Updating process.* CMS updates the national and regional case-mix index standards using the latest available data from hospitals subject to the prospective payment system for the Federal fiscal year.

(2) *Source of data.* In making the calculations described in paragraph (h)(1) of this section, CMS uses all inpatient hospital bills received for discharges subject to prospective payment during the Federal fiscal year being monitored.

(3) *Effective date.* CMS sets forth the national and regional criteria in the annual notice of prospective payment rates published under § 412.8(b). These criteria are used to determine if a hospital qualifies for referral center status for cost reporting periods beginning on or after October 1 of the Federal fiscal year to which the notice applies.

(i) *Methodology for calculating number of discharges criteria.* For purposes of determining compliance with the national or regional number of discharges criterion under paragraph (c)(2) of this section, CMS calculates the criteria as follows:

(1) *Updating process.* CMS updates the national and regional number of discharges using the latest available data for levels of admissions or discharges or both.

(2) *Source of data.* In making the calculations described in paragraph (i)(1) of this section, CMS uses the most recent hospital admissions or discharge data available.

(3) *Annual notice.* CMS sets forth the national and regional criteria in the annual notice of prospective payment rates published under § 412.8(b). These criteria are compared to an applying

§ 412.98

hospital's number of discharges for the same cost reporting period used to develop the regional criteria in this section in determining if the hospital qualifies for referral center status for cost reporting periods beginning on or after October 1 of the Federal fiscal year to which the notice applies.

[50 FR 12741, Mar. 29, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 412.96, see the List of Sections Affected, which appears in the Finding Aids section of the printed volume and on GPO Access.

§ 412.98 [Reserved]

§ 412.100 Special treatment: Renal transplantation centers.

(a) *Adjustments for renal transplantation centers.* (1) CMS adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part for hospitals approved as renal transplantation centers (described at §§ 405.2170 and 405.2171 of this chapter) to remove the estimated net expenses associated with kidney acquisition.

(2) Kidney acquisition costs are treated apart from the prospective payment rate for inpatient operating costs, and payment to the hospital is adjusted in each reporting period to reflect an amount necessary to compensate the hospital for reasonable expenses of kidney acquisition.

(b) *Costs of kidney acquisition.* Expenses recognized under this section include costs of acquiring a kidney, from a live donor or a cadaver, irrespective of whether the kidney was obtained by the hospital or through an organ procurement agency. These costs include—

(1) Tissue typing, including tissue typing furnished by independent laboratories;

(2) Donor and recipient evaluation;

(3) Other costs associated with excising kidneys, such as donor general routine and special care services;

(4) Operating room and other inpatient ancillary services applicable to the donor;

(5) Preservation and perfusion costs;

(6) Charges for registration of recipient with a kidney transplant registry;

(7) Surgeons' fees for excising cadaver kidneys;

42 CFR Ch. IV (10–1–06 Edition)

(8) Transportation;

(9) Costs of kidneys acquired from other providers or kidney procurement organizations;

(10) Hospital costs normally classified as outpatient costs applicable to kidney excisions (services include donor and donee tissue typing, work-up, and related services furnished prior to admission);

(11) Costs of services applicable to kidney excisions which are rendered by residents and interns not in approved teaching programs; and

(12) All pre-admission physician services, such as laboratory, electroencephalography, and surgeon fees for cadaver excisions, applicable to kidney excisions including the costs of physician services.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39824, Sept. 1, 1992]

§ 412.101 Special treatment: Inpatient hospital payment adjustment for low-volume hospitals.

(a) *General considerations.* (1) CMS provides an additional payment to a qualifying hospital for the higher incremental costs associated with a low volume of discharges. The amount of any additional payment for a qualifying hospital is calculated in accordance with paragraph (b) of this section.

(2) In order to qualify for this adjustment, a hospital must have less than 200 discharges during the fiscal year, as reflected in its cost report specified in paragraph (a)(3) of this section, and be located more than 25 road miles from the nearest subsection (d) hospital.

(3) The fiscal intermediary makes the determination of the discharge count for purposes of determining a hospital's qualification for the adjustment based on the hospital's most recent submitted cost report.

(4) In order to qualify for the adjustment, a hospital must provide its fiscal intermediary with sufficient evidence that it meets the distance requirement specified under paragraph (a)(2) of this section. The fiscal intermediary will base its determination of whether the distance requirement is satisfied upon the evidence presented by the hospital and other relevant evidence, such as maps, mapping software, and inquiries