

(iii) *Cost-of-living adjustment.* An additional adjustment is made for hospitals located in Alaska and Hawaii to account for the higher cost-of-living in those States.

(3) *Disproportionate share adjustment.* For hospitals with at least 100 beds located in an urban area and serving low-income patients, a disproportionate share adjustment factor is applied that reflects the higher costs attributable to furnishing services to low income patients.

(4) *Indirect medical education adjustment.* An additional adjustment is made based on the ratio of residents to the average daily patient census of the hospital to account for the indirect costs of medical education.

(c) *Additional payment for outlier cases.* Payment is made for day outlier cases as provided for in § 412.82 and for cost outlier cases if both capital-related and operating-related costs exceed the cost outlier threshold as provided for in § 412.84.

(d) *Payment for transfer cases.* Payment is made for transfer cases as provided for in § 412.4.

§ 412.316 Geographic adjustment factors.

(a) *Local cost variation.* HCFA adjusts for local cost variation based on the hospital wage index value that is applicable to the hospital under § 412.63(k). The adjustment factor equals the hospital wage index value applicable to the hospital raised to the .6848 power and is applied to 100 percent of the Federal rate.

(b) *Large urban location.* HCFA provides an additional payment to a hospital located, for purposes of receiving payment under § 412.63(a), in a large urban area equal to 3.0 percent of what would otherwise be payable to the hospital based on the Federal rate.

(c) *Cost-of-living adjustment.* HCFA provides an additional payment to a hospital located in Alaska and Hawaii equal to $[\frac{3152}{X} \times (\text{the cost-of-living adjustment factor used to determine payments under } § 412.115 - 1)]$ percent.

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.* A hospital is classified as a “dispropor-

tionate share hospital” for the purposes of capital prospective payments if either of the following conditions is met:

(1) The hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b).

(2) The hospital meets the criteria in § 412.106(c)(2).

(b) *Payment adjustment factor.* (1) If a hospital meets the criteria in paragraph (a)(1) of this section for a disproportionate share hospital for purposes of capital prospective payments, the disproportionate share payment adjustment factor equals $[e \text{ raised to the power of } (.2025 \times \text{the hospital's disproportionate patient percentage as determined under } § 412.106(b)(5)), - 1]$, where e is the natural antilog of 1.

(2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of hospital inpatient operating prospective payments, the disproportionate share adjustment factor is the factor that results from deeming the hospital to have the same disproportionate share patient percentage that would yield its operating disproportionate share adjustment.

[56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992, as amended at 58 FR 46339, Sept. 1, 1993]

§ 412.322 Indirect medical education adjustment factor.

(a) *Basic data.* HCFA determines the following for each hospital:

(1) The hospital's number of full-time equivalent residents as determined under § 412.105(f).

(2) The hospital's average daily census is determined by dividing the total number of inpatient days in the acute inpatient area of the hospital by the number of days in the cost reporting period.

(3) The measurement of teaching activity is the ratio of the hospital's full-time equivalent residents to average daily census. This ratio cannot exceed 1.5.

(b) *Payment adjustment factor.* The indirect teaching adjustment factor equals $[e \text{ (raised to the power of$

§ 412.324

.2822×the ratio of residents to average daily census) – 1].

[56 FR 43449, Aug. 30, 1991, as amended at 63 FR 26357, May 12, 1998; 63 FR 41004, July 31, 1998]

DETERMINATION OF TRANSITION PERIOD PAYMENT RATES FOR CAPITAL-RE- LATED COSTS

§ 412.324 General description.

(a) *Hospitals under Medicare in FY 1991.* During the ten-year transition period, payments to a hospital with a hospital-specific rate below the Federal rate are based on the fully prospective payment methodology under § 412.340 or for a hospital with a hospital-specific rate above the Federal rate, the hold-harmless payment methodology under § 412.344.

(b) *New hospitals.* (1) A new hospital, as defined under § 412.300(b), is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its cost reporting period ending at least 2 years after the hospital accepts its first patient.

(2) For the third year through the remainder of the transition period, the hospital is paid based on the fully prospective payment methodology or the hold-harmless payment methodology using the base period determined under § 412.328(a)(2).

(3) If the hospital is paid under the hold-harmless methodology described in § 412.344, the hold-harmless payment for old capital costs described in § 412.344(a)(1) is payable for up to and including 8 years and may continue beyond the first cost reporting period beginning on or after October 1, 2000.

(c) *Hospitals with 52-53 week fiscal years ending September 25 through September 29.* For purposes of this subpart, a hospital with a 52-53 week fiscal year period beginning September 26 through September 30, 1992 is deemed to have the same beginning date for all cost reporting periods beginning before October 1, 2000 (unless the hospital later changes its cost reporting period).

[56 FR 43449, Aug. 30, 1991; 57 FR 3016, Jan. 27, 1992]

42 CFR Ch. IV (10-1-00 Edition)

§ 412.328 Determining and updating the hospital-specific rate.

(a) *Base-year cost reporting period.* (1) *Last 12 month cost reporting period ending on or before December 31, 1990.* For each hospital, the intermediary uses the hospital's latest 12-month or longer cost reporting period ending on or before December 31, 1990 as the base period to determine a hospital's hospital-specific rate.

(2) *New hospitals.* The base-year cost reporting period for a new hospital is its 12-month cost reporting period (or a combination of cost reporting periods covering at least 12 months) that begins at least 1 year after the hospital accepts its first patient.

(3) *Other hospitals.* For other than a new hospital as defined in § 412.300(b), if a hospital does not have a 12-month cost reporting period or does not have adequate Medicare utilization to file a cost report in a period ending on or before December 31, 1990, the hospital-specific rate is based on the hospital's old capital costs (per discharge) in its first 12-month cost reporting period (or combination of cost reporting periods covering at least 12 months) ending after December 31, 1990.

(b) *Base-year costs per discharge.* (1) *Base period allowable inpatient capital costs per discharge.* (i) *Determination.* The intermediary determines the base period allowable inpatient capital costs per discharge for the hospital by dividing the hospital's total allowable Medicare inpatient hospital capital-related cost in the base period by the number of Medicare discharges in the base period.

(ii) *Disposal of assets in the base year.* When a depreciable asset has been disposed of in the base year, only that portion of the gain or loss that is allocated to the base-year cost reporting period is reflected in the hospital-specific rate.

(iii) *Disposal of assets subsequent to the base year.* If an asset for which the Medicare program had recognized depreciation during the base year is disposed of subsequent to the base year, the hospital-specific rate will not be revised to recognize the portion of the gain or loss allocated to the base year.