

§412.86

sets forth these parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published under §412.8(b).

(i) If any of the services are determined to be noncovered, the charges for these services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.

(j) Except as provided in paragraph (k) of this section, the additional amount is derived by first taking 80 percent of the difference between the hospital's adjusted operating cost for the discharge (as determined under paragraph (g) of this section) and the operating threshold criteria established under §412.80(a)(1)(ii); 80 percent is also taken of the difference between the hospital's adjusted capital cost for the discharge (as determined under paragraph (g) of this section) and the capital threshold criteria established under §412.80(a)(1)(ii). The resulting capital amount is then multiplied by the applicable Federal portion of the payment as determined in §412.340(a) or §412.344(a).

(k) For discharges occurring on or after April 1, 1988, the additional payment amount for the DRGs related to burn cases, which are identified in the most recent annual notice of prospective payment rates published in accordance with §412.8(b), is computed under the provisions of paragraph (j) of this section except that the payment is made using 90 percent of the difference between the hospital's adjusted cost for the discharge and the threshold criteria.

[50 FR 12741, Mar. 29, 1985, as amended at 50 FR 35689, Sept. 3, 1985; 51 FR 31496, Sept. 3, 1986; 53 FR 38529, Sept. 30, 1988; 54 FR 36494, Sept. 1, 1989; 55 FR 15174, Apr. 20, 1990; 56 FR 43448, Aug. 30, 1991; 57 FR 39823, Sept. 1, 1992; 59 FR 45398, Sept. 1, 1994; 62 FR 46028, Aug. 29, 1997]

§412.86 Payment for extraordinarily high-cost day outliers.

For discharges occurring before October 1, 1997, if a discharge that qualifies for an additional payment under the provisions of §412.82 has charges adjusted to costs that exceed the cost

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outlier threshold criteria for an extraordinarily high-cost case as set forth in §412.80(a)(1)(ii), the additional payment made for the discharge is the greater of—

(a) The applicable per diem payment computed under §412.82 (c) or (d); or

(b) The payment that would be made under §412.84 (i) or (j) if the case had not met the day outlier criteria threshold set forth in §412.80(a)(1)(i).

[53 FR 38529, Sept. 30, 1988, as amended at 62 FR 46028, Aug. 29, 1997]

Subpart G—Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Operating Costs

§412.90 General rules.

(a) *Sole community hospitals.* HCFA may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries. If a hospital meets the criteria for such an exception under §412.92(a), its prospective payment rates for inpatient operating costs are determined under §412.92(d).

(b) *Referral center.* HCFA may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital acts as a referral center for patients transferred from other hospitals. Criteria for identifying such referral centers are set forth in §412.96.

(c) [Reserved]

(d) *Kidney acquisition costs incurred by hospitals approved as renal transplantation centers.* HCFA pays for kidney acquisition costs incurred by renal transplantation centers on a reasonable cost basis. The criteria for this special payment provision are set forth in §412.100.

(e) *Hospitals located in areas that are reclassified from urban to rural.* (1) HCFA adjusts the rural Federal payment amounts for inpatient operating costs for hospitals located in geographic areas that are reclassified from urban

to rural as defined in § 412.62(f). This adjustment is set forth in § 412.102.

(2) HCFA establishes a procedure by which certain individual hospitals located in urban areas may apply for reclassification as rural. The criteria for reclassification are set forth in § 412.103.

(f) *Hospitals that have a high percentage of ESRD beneficiary discharges.* HCFA makes an additional payment to a hospital if ten percent or more of its total Medicare discharges in a cost reporting period beginning on or after October 1, 1984 are ESRD beneficiary discharges. In determining ESRD discharges, discharges in DRG Nos. 302, 316, and 317 are excluded. The criteria for this additional payment are set forth in § 412.104.

(g) *Hospitals that incur indirect costs for graduate medical education programs.* HCFA makes an additional payment for inpatient operating costs to a hospital for indirect medical education costs attributable to an approved graduate medical education program. The criteria for this additional payment are set forth in § 412.105.

(h) *Hospitals that serve a disproportionate share of low-income patients.* For discharges occurring on or after May 1, 1986, HCFA makes an additional payment for inpatient operating costs to hospitals that serve a disproportionate share of low-income patients. The criteria for this additional payment are set forth in § 412.106.

(i) *Hospitals that receive an additional update for FYs 1998 and 1999.* For FYs 1998 and 1999, HCFA makes an upward adjustment to the standardized amounts for certain hospitals that do not receive indirect medical education or disproportionate share payments and are not Medicare-dependent, small rural hospitals. The criteria for identifying these hospitals are set forth in § 412.107.

(j) *Medicare-dependent, small rural hospitals.* For cost reporting periods beginning on or after April 1, 1990 and before October 1, 1994, or beginning on or after October 1, 1997 and before October 1, 2006, HCFA adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part if a hospital is classified

as a Medicare-dependent, small rural hospital.

(k) *Essential access community hospitals (EACHs).* If a hospital was designated as an EACH by HCFA as described in § 412.109(a) and is located in a rural area as defined in § 412.109(b), HCFA determines the prospective payment rate for that hospital, as it does for sole community hospitals, under § 412.92(d).

[57 FR 39823, Sept. 1, 1992, as amended at 58 FR 30669, May 26, 1993; 62 FR 46028, Aug. 29, 1997; 64 FR 67051, Nov. 30, 1999; 65 FR 47047, Aug. 1, 2000]

§ 412.92 Special treatment: Sole community hospitals.

(a) *Criteria for classification as a sole community hospital.* HCFA classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in § 412.83(b)) and meets one of the following conditions:

(1) The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:

(i) No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area;

(ii) The hospital has fewer than 50 beds and the intermediary certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital; or

(iii) Because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.

(2) The hospital is located between 15 and 25 miles from other like hospitals